STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	151583	A. BUILDING 00 B. WING	09/29/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
UNITY HOSPICE OF NORTHWEST INDIANA LLC	3313 EAST 83RD PLACE MERRILLVILLE, IN 46410

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E 0000 Bldg. 00	At this Emergency Preparedness survey, Unity Hospice of Northwest Indiana LLC was found to be in compliance with 42 CFR 418.113 Emergency Preparedness requirements for Medicare participating Providers and Suppliers for Hospice agencies.	E 0000	This plan of correction constitutes Unity Hospice's written allegation of compliance for the deficiencies cited. However, submission of this plan of correction is not an admission that a deficiency exists or that one was correctly cited. This plan of correction is submitted to comply with State and Federal laws.	
L 0000 Bldg. 00	This was a federal hospice recertification survey with one complaint. Facility ID: 002379 Provider # 151583 Date of Survey: 9/23, 9/24/ 9/25, 9/28, 9/29/2020 Active Home Patient Census: 26 Active General Inpatient (GIP) Census: 0 Active Continuous Care (CC) Patient Census: 0 Active Assisted Living Facility (ALF) Patient Census: 13 Active Skilled Nursing Facility (SNF) Patient Census: 17 Active Respite Patient Census: 0 Unduplicated census: 401 Sample Selection: Record review for 14 patients with 3 home visits	L 0000	This plan of correction constitutes Unity Hospice's written allegation of compliance for the deficiencies cited. However, submission of this plan of correction is not an admission that a deficiency exists or that one was correctly cited. This plan of correction is submitted to comply with State and Federal laws.	

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

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	Complaint # IN00264493- Substantiated with related and unrelated findings Unity Hospice of Northwest Indiana LLC was found to be out of compliance with the Conditions of Participation 42 CFR 418.54 Initial and comprehensive assessment of the patient, 42 CFR 418.56 Interdisciplinary group, care planning, and coordination of services, and 42 CFR 418.100 Organization and administration of services. Quality Review Completed 11/4/2020 Area 1			
L 0502 Bldg. 00	418.52(a)(1) NOTICE OF RIGHTS AND RESPONSIBILITIES (1) During the initial assessment visit in advance of furnishing care the hospice must provide the patient or representative with verbal (meaning spoken) and written notice of the patient's rights and responsibilities in a language and manner that the patient understands. Based on observation and record review, the agency failed to provide the patient or representative with verbal (spoken) or written notice of the patient's rights and responsibilities in a language and manner that the patient understands for 1 of 1 records reviewed where the patient's primary/preferred language was Spanish (#1). The findings include: 1. Review of an agency policy updated 01/2014 titled "Patient Rights Policy, Addendum A: Indiana Hospice Patient Rights and Responsibilities" stated "... the hospice must	L 0502	**CMS Tag L502 Hospice Hospice-CoP Standard: 418.52(a)(1)-Notice of Rights and Responsibilities** **Findings:** The Hospice failed to provide the patient or representative with verbal (spoken) or written notice of the patient's rights and responsibilities in a language that the patient understands for 1 of 1 patient whose primary language was Spanish.	11/13/2020

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	provide the patient or their representative with ... written notice of the patient's rights and responsibilities in a language and manner that the patient understands...." 2. During a home visit with patient #1 on 9/25/2020 at 8:00 a.m., employee W (hospice aide) indicated the patient spoke only Spanish (she was teaching herself how to speak Spanish to communicate with him). The patient's spouse indicated their primary/preferred language was Spanish and the home folder failed to evidence written notice of the patient's rights and responsibilities in a language and manner the patient/family understood. Clinical record review of patient #1 was completed on 9/29/20, with hospice election date 8/26/2020, certification from 8/26/20 to 11/23/20, and primary diagnosis of Parkinson's Disease. The clinical record indicated the patient's primary language was Spanish. Review of a document dated and signed on 8/26/20 by employee A, titled "Comprehensive Assessment" stated "Immediate needs for problem/symptom management: Communication, Decline in ADL [activity of daily living] /Self care deficit, dysphagia, edema, falls/safety, nutrition ... Communication [failed to provide information regarding Spanish speaking] ..." The agency failed to assign an interpreter to translate from patient to nurse. Review of a document dated and signed on 8/25/2020, by a family member, titled "Hospice Patient Rights and Responsibilities" was written in English, not Spanish, which was the patient and spouse's preferred language.		**Plan to correct specific deficiency cited:** · Patient #1: o The Administrator reviewed the current patient caseload on 11/11/2020 to ensure that all patients for whom English is a second language receive agency translation services to provide the patient rights and responsibility documents, consents and benefit election forms verbally, and in writing, as appropriate by 11/13/2020. o For Patient #1, patient is unable to sign his own consents related to cognitive issues. Healthcare Power of Attorney's primary language is English, therefore, the consents, patient rights and responsibilities, benefit election form are all in English and present in the chart. Spanish copies of consents, patient rights and responsibilities, and benefit election form was given to the patient on 11/12/2020, along with information about translation services. The RN Case Manager and Home Health/Hospice Aide will offer to use translational services at each visit. If this patient prefers to use family to translate, this will be documented. If not family present to translate, translation services will always be used, and this will be documented.	

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	Review of a document dated and signed on 8/25/2020, by a family member, titled "Informed Consent/Disclosure Statement" was written in English, not Spanish, which was the patient and spouse's preferred language. This deficient practice had the potential to affect all patients who spoke a language other than English.		**Measures/Systematic Changes that will be put into place to ensure that the deficiency does not recur:** · The Administrator will ensure availability of paper consent documents in Spanish by 11/11/2020. · Administrator will educate all staff on the current availability of consent materials in Spanish by 11/13/2020. · All hospice staff will receive education on the Patient Rights Policy, Addendum A: Indiana Hospice Patient Rights and Responsibilities Policy by 11/13/2020. · Human Resources Manager will educate all staff on available translation telephone services, how to utilize them, and all languages available for translation by 11/13/2020. · IT department will add to the intake/face sheet an area to document the primary language of the patient for quick reference and easy access by 11/20/2020. Education on this new feature will be given by 11/18/2020. · Evidence of training will be noted in attendance logs. The Administrator or designee will review in-service attendance logs to ensure all staff receive this training. · This training will be incorporated into the agency's	

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			annual in-services and the new-employee orientation by 11/13/2020. · The Clinical Manager or designee will conduct a clinical record review of 100% of all admission records as a component of admission document workflow to: o Verify patient's primary language has been documented o If other than English, documented that translators have been offered and patient (or family as appropriate) educated this as an option o If Spanish is primary language, consents are given in Spanish; audit 100% of these charts. **How the agency will monitor its quality assessment/performance improvement functions to ensure that the corrective measure or systemic change is sustained:** · The Director of Clinical Services or designee will review 10% of hospice admission records monthly to verify the following: o If other than English, documented that translators have been offered and family educated this as an option o If Spanish is primary language, consents are given in Spanish. · The threshold for compliance is 100% for three months. If the threshold for	

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			compliance is not met the Director of Clinical Services will continue clinical record reviews and provide continuing education to individual employees, counseling, and disciplinary action in accordance with agency policy if needed. · Once the threshold is met this review item will be incorporated into the agency's quarterly clinical record review; a minimum of 10% of all live charts will be audited quarterly. · Results of the above audits and analysis of trends will be included in the agency's Quarterly Quality review data and reported to the Administrator and Governing Body. **Person Responsible:** Administrator **Completion Date:** November 13, 2020	
L 0512 Bldg. 00	418.52(c)(1) RIGHTS OF THE PATIENT The patient has a right to the following: (1) Receive effective pain management and symptom control from the hospice for conditions related to the terminal illness; Based on observation, record review, and interview, the agency failed to ensure all patients received effective pain management and symptom control for 2 of 2 clinical record reviewed with patients complaining of severe pain (#2, #3), in a total of 14 clinical records reviewed.	L 0512	**CMS Tag L512 Hospice Hospice-CoP Standard: 418.52(c)(1)-Rights of the Patient** **Findings:** The Hospice failed to address the patient's right to effective pain management and	11/20/2020

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	The findings include: 1. Review of an agency policy last updated 01/2014, titled "Patient Rights Policy, Addendum A: Indiana Hospice Patient Rights and Responsibilities" stated "... The patient has the right ... To receive effective pain management and symptom control from the hospice ...." 2. A home visit was made with patient #3 on 9/28/20 at 10:30 a.m. When queried, the patient stated his pain was 8 out of 10 [on a scale of 0 - 10, with 0 being no pain and 10 being the most severe], the pain was severe for quite some time, he wasn't aware of other medication choices that might help manage his pain better, and he thought he just had to live with it. When queried if he would prefer to be pain free, he indicated that he would. Employee O (registered nurse) indicated that she would call the physician to talk about medication options for pain control. Clinical record review for patient #3 on 9/29/2020, with hospice election date of 5/21/2020, benefit period 5/21/2020 - 8/18/2020, and primary diagnosis of Severe Caloric Malnutrition, evidenced a document dated and signed on 5/21/2020 by employee A (registered nurse), titled "Comprehensive Assessment" which stated "... patient/family's current chief complaint: pain ... Describe patient/family's goals: Comfort care ... pain rating ... verbal ... 9 ... patient/family pain management goals ... pain free ... maximum pain control with minimal symptoms ...." Review of an agency document titled "Nursing Visit Note" signed and dated 9/14/2020 by employee O (registered nurse), evidenced the patient's pain level 7 out of 10, failed to evidence the physician was notified, and failed to evidence		symptom control for 2 of 2 patients who required pain management and symptom control based on clinical record review, observation, and hospice personnel interview. **Plan to correct specific deficiency cited:** · Patient #2: o Revoked on 9/24/2020. Readmitted on 10/8/20 and expired on 10/26/2020. The RN Case Manager and all visit nurses that provided care will be counseled and will receive additional training as noted below by November 18, 2020 regarding the Hospice Program Client Rights and Responsibilities Policy as well as re-education regarding pain and symptom assessment on admission and ongoing, management and follow up to ensure patient's pain and other symptom management needs are addressed timely, notification to the attending physician and/or Medical Director regarding any changes in patient status requiring intervention to address pain and symptom management, ensure that medications are ordered, received and administered timely. · Patient #3: o Revoked services on 9/29/2020 to seek aggressive treatment. On 10/2/2020, this patient chose our Palliative Care services over hospice care. The RN Case	

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	the nurse reviewed the patient's pain medication regimen such as non-medicinal methods to mitigate pain, or how often he was taking his current pain medications. Review of an agency document titled "Nursing Visit Note (Abridged)" signed and dated 9/18/2020 by employee O (registered nurse), evidenced the patient's pain level 7 out of 10, failed to evidence the physician was notified, and failed to evidence the nurse reviewed the patient's pain medication regimen such as non-medicinal methods to mitigate pain, or how often he was taking his current pain medications. Review of an agency document titled "IDG [interdisciplinary group] Update" dated and signed 9/23/2020 by employee D (director of clinical services), employee O, employee J (social worker), employee Z (spiritual counselor, bereavement coordinator), and employee AA (volunteer coordinator), evidenced the patient's pain level was "... 6-7 out of 10, but states he is comfortable ...." The document failed to evidence the patient's personal goal to be pain free was discussed. 3. Clinical record review for patient #2 on 9/29/2020, with hospice election date of 9/15/2020, benefit period 9/15 - 12/13/2020, and primary diagnosis of Ovarian Cancer evidenced a document dated and signed on 9/15/2020 by employee A, titled "Comprehensive Assessment". This document stated "... patient/family's current chief complaint: Family wishes for patient to be comfortable during the disease process ... Describe patient/family's goals: Comfort ... pain rating ... verbal ... 10 ... patient/family pain management goals ... pain free ... maximum pain control with minimal symptoms ... pain is not well		Manager will be counseled and will receive additional training as noted below by November 18, 2020 regarding the Hospice Program Client Rights and Responsibilities Policy as well as re-education regarding pain and symptom assessment on admission and ongoing, management and follow up to ensure patient's pain and other symptom management needs are addressed timely, notification to the attending physician and/or Medical Director regarding any changes in patient status requiring intervention to address pain and symptom management, ensure that medications are ordered, received and administered timely. · The Interdisciplinary Group will review the current patient caseload on 11/18/2020 to ensure that all patient pain goals were documented and that each patient has an effective pain management plan and interventions in place. **Measures/Systematic Changes that will be put into place to ensure that the deficiency does not recur:** · The Director of Clinical Services will educate all nursing staff on pain and non-pain symptom management principles by 11/18/2020. The Director of Clinical Services to ensure nursing staff testing/competency validation	

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	managed with current POC [plan of care] ... immediate needs for problem/symptom management ... pain ...."The document failed to evidence the physician was notified of the patient's severe pain or any immediate interventions were taken. Review of an undated, unsigned agency document titled "Medication List" evidenced an entry dated 9/16/2020, which listed (but was not limited to) dilaudid 10mg/ml (milligrams per milliliter), 8mg sublingual (under the tongue) every four hours as needed for pain. Six doses was the maximum the patient could take in a 24 hour period. The patient was also prescribed a fentanyl (pain patch) that was changed every three days, and acetaminophen (generic Tylenol) for pain as needed every four hours. Review of an agency document titled "Nursing Visit Note (Abridged)" signed and dated 9/16/2020 by employee H (registered nurse), stated "... [pain] 10/10 ... PRN [as needed] medication usage last 24 hours: 8 doses of Dilaudid ...." The patient took two more doses than prescribed by the physician, the nurse failed to notify the physician of the patient's severe pain or the medication error, and failed to educate the family on correct medication administration. Review of an agency document titled "Nursing Visit Note (Abridged)" signed and dated 9/17/2020 by employee H, indicated the patient's pain level was 8 out of 10 (severe), and failed to evidence the physician was notified for severe pain. Review of an agency document titled "Triage Note" signed and dated 9/19/2020 by employee HH (registered nurse), evidenced an on-call call		on pain and non-pain symptom management principles upon completion of training by 11/18/2020. · The Director of Clinical Services will educate nursing staff on proper documentation of symptom assessment and management by 11/18/2020. · RN staff will be re-educated regarding their role as Hospice Primary Care Nurse in accordance with the agency's policies on Care of the Dying Patient, Facility Resident, Ongoing Assessments, and Patient Plan of Care, along with, the job description which includes the responsibility to include management of the patient's pain and symptoms in accordance with the patient's pain goals by 11/18/2020. · The Director of Clinical Services will provide to all nursing staff bi-monthly symptom management training and conferencing to address patient specific situations and staff knowledge deficits for one calendar year to start 12/2020. · Nursing staff new-employee orientation includes expanded and more specialized training on pain and non-pain symptom management principles effective 11/20/2020. · All hospice IDG staff will receive education by November 18, 2020 regarding the following: o Client Rights and	

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	was placed to agency by the patient's daughter which stated "... Questions regarding pain control options ... patient does not like the liquid it makes her nauseous [sic] ....", the nurse suggested mixing the medication in palatable fluids, but failed to evidence the physician was contacted. Review of an agency document titled "Hospice Aide Visit Note" dated and signed 9/21/2020 by employee GG (hospice aide), evidenced a visit was made from 2:00 p.m. - 2:30 p.m., and stated "... Patient was not cooperative today. She stated that she was in a lot of pain and she did not want a bath. I notified the hospice nurse." Review of an agency document titled "Nursing Visit Note" signed and dated 9/21/2020 by employee H, evidenced a visit was made from 2:30 p.m. - 3:00 p.m., the nursing visit began immediately after the aide visit ended, failed to evidence she responded to the report from the aide that the patient "was in a lot of pain and did not want a bed bath", failed to evidence the physician was notified for ongoing nausea or severe pain, failed to evidence if the nurse administered any pain or anti-emetic medications during her visit, or how much pain medications had been administered by family that day. Review of an agency document titled "IDG Update" dated and signed 9/23/2020 by employee D (director of clinical services), employee H, and employee F (social worker), evidenced the patient's pain at 10 out of 10 (most severe), failed to evidence the patient disliked the liquid pain medication or that it made her nauseated, and failed to evidence new or additional interventions to mitigate ongoing severe pain.		Responsibilities Policy and the hospice patient's right to effective and timely pain and symptom management, and be able to demonstrate understanding symptom management includes, but is not limited to, assessment and intervention related to pain, dyspnea, anxiety, confusion and other symptoms associated with terminal illness and related conditions. · Evidence of training will be noted in attendance logs. The Director of Clinical Services or designee will review in-service attendance logs to ensure all staff receive this training. · This training will be incorporated into the agency's annual in-services by 1/30/21 and the new-employee orientation by 11/20/2020. · The IDG will address and document each patient's pain goal and pain/symptom management interventions during each IDG meeting effective 11/18/2020. **How the agency will monitor its quality assessment/performance improvement functions to ensure that the corrective measure or systemic change is sustained:** · The Director of Clinical Services will track and ensure 100% compliance of bi-monthly training through 12/2021 and	

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			ensure evidence of sign in sheets and testing for proof of completion. The threshold for compliance is 100%. · The Director of Clinical Services or designee will ensure 100% of all clinical charts are audited for pain/non pain symptom management for 4 weeks starting 11/20/2020. · Once the initial threshold is met, the Director of Clinical Services or designee will conduct a clinical record review of 10% of active patient records monthly to ensure evidence of effective and timely pain and symptom management. The threshold for compliance is 100% for three months. · If the threshold for compliance is not met the Director of Clinical Services will continue to conduct clinical record reviews and provide continuing education to individual employees, counseling, and disciplinary action in accordance with agency policy if needed. · Once the threshold is met this review item will be incorporated into the agency's quarterly clinical record review; a minimum of 10% of all live charts will be audited quarterly. · Results of the above audits and analysis of trends will be included in the agency's Quarterly Quality review data and reported to the Administrator and Governing	

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			Body. **Person Responsible:** Director of Clinical Services **Completion Date:** November 20, 2020	
L 0520 Bldg. 00	Based on observation, record review and interview, the hospice failed to ensure all patients' comprehensive assessments evidenced a drug regimen review was completed (L530); and failed to ensure all patients' updated comprehensive assessments evidenced progress toward desired outcomes or a reassessment of the response to care (L533). These practices impacted patients (#1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, and 14). The cumulative effect of these systemic problems resulted in the hospice's inability to be in compliance with the Condition of Participation §418.54 Initial and comprehensive assessment of the patient.	L 0520	**CMS Tag L520-CoP: 418.54 COMPREHENSIVE ASSESSMENT OF PATIENT-CONDITION** **Finding:** The Hospice failed to ensure all patients' comprehensive assessments evidenced a drug regimen review was completed (L530); and failed to ensure all patients' updated comprehensive assessments evidenced progress toward desired outcomes or a reassessment of the response to care (L533) impacting 14 of 14 patients based on clinical record reviews. Unity Hospice of Northwest Indiana is presenting a credible allegation of compliance with this CONDITION based on the implementation of the plan of correction stated in CMS Tags L530 and L533. Unity Hospice of Northwest Indiana has a history of having maintained a commitment of compliance as evidenced by prior survey experience and commitment to follow up and	11/20/2020

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			correction. Unity Hospice of Northwest Indiana will ensure that the plan of correction submitted for CMS Tags L530 and L533 are realistic and will be accomplished between the date of the last survey and November 20, 2020 and will demonstrate resolution of the problem by this date.. Refer to the plans of correction for L530 and L533.	
L 0530 Bldg. 00	418.54(c)(6) CONTENT OF COMPREHENSIVE ASSESSMENT [The comprehensive assessment must take into consideration the following factors:] (6) Drug profile. A review of all of the patient's prescription and over-the-counter drugs, herbal remedies and other alternative treatments that could affect drug therapy. This includes, but is not limited to, identification of the following: (i) Effectiveness of drug therapy (ii) Drug side effects (iii) Actual or potential drug interactions (iv) Duplicate drug therapy (v) Drug therapy currently associated with laboratory monitoring. Based on record review and interview, the hospice failed to ensure the comprehensive assessments evidenced a drug profile which included a drug regimen review that identified effectiveness of drug therapy, medication side effects, actual or potential drug interactions, duplicate drug therapy, and drug therapy currently associated with laboratory monitoring was completed to meet the needs of the patients for 14 of 14 clinical records reviewed (#1, #2, #3, #4, #5, #6, #7, #8, #9,	L 0530	**CMS Tag L530 Hospice-CoP Standard: 418.54(c)(6)-Content of Comprehensive Assessment Findings:** The Agency failed to ensure the comprehensive assessments evidenced a drug profile which included a drug regimen review containing all required elements for 14 of 14 clinical records reviewed.	11/18/2020

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	151583	A. BUILDING 00 B. WING	09/29/2020

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	#10, #11, #12, #13, and #14). Findings include: 1. Review of an agency policy last updated 01/2014, titled "Medications" stated "... Medication profiles shall be maintained for each patient ... Periodic review and monitoring ...." Review of an agency policy last updated 01/2014, titled "Medication Profile" stated "... Patients ... will have a current, accurate medication profile in the medical record ... Upon admission ... admitting clinician will initiate a medication profile ...." Review of an agency policy last updated 01/2014, titled "Initial Hospice Assessment" stated "... guidelines for the initial assessment and Plan of Care ... During the initial patient assessment, all baseline data and other relevant information is documented ... including at least ... medications, including prescription and over-the-counter ...." 2. Clinical record review for patient #1 was completed on 9/29/2020, with hospice election date of 8/26/2020, benefit period 8/26/2020 - 11/23/2020, and primary diagnosis of Parkinson's disease. Record review failed to evidence a drug regimen review was ever conducted for the patients current prescribed and over the counter medications. 3. Clinical record review for patient #2 was completed on 9/29/2020, with hospice election date of 9/15/2020, benefit period 9/15/2020 - 12/13/2020, and primary diagnosis of Ovarian Cancer. Record review failed to evidence a drug regimen review was ever conducted for the patients current prescribed and over the counter medications.		**Plan to correct specific deficiency cited:** · The Interdisciplinary Group will review the current patient caseload on 11/18/2020 to ensure that a drug regimen review is completed in accordance with regulations for all active patients per Agency's policies on Medications, Identification of Medications for Administration, Medication Profile, Admission Criteria and Process, and Patient Plan of Care. · Medication review as required by regulation is initially indicated on IPOC document and updates and changes is on the IDG update parts of patient medical record. **Measures/Systematic Changes that will be put into place to ensure that the deficiency does not recur:** · Optum's (our PBM) pharmacists, Uvanta's pharmacist, or Hospice Medical Director to review all medications of each new admission for effectiveness of drug therapy, medication side effects, actual or potential drug interactions, duplicate drug therapy, and drug therapy currently associated with laboratory monitoring to be sent to the Medical Director for final review	

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	4. Clinical record review for patient #3 was completed on 9/29/2020, with hospice election date of 5/21/2020, benefit period 5/21/2020 - 8/18/2020, and primary diagnosis of Severe Calorie Malnutrition. Record review failed to evidence a drug regimen review was ever conducted for the patients current prescribed and over the counter medications. 5. Clinical record review for patient #4 was completed on 9/29/2020, with hospice election date of 2/26/2019, benefit period 8/19/2020 - 10/17/2020, and primary diagnosis of Cerebral Vascular Accident [CVA- stroke]. Record review failed to evidence a drug regimen review was ever conducted for the patients current prescribed and over the counter medications. 6. Clinical record review for patient #5 was completed on 9/29/2020, with hospice election date of 2/3/2020, benefit period 2/3/2020 - 5/2/2020, and primary diagnosis of COPD (chronic obstructive pulmonary/lung disease). Record review failed to evidence a drug regimen review was ever conducted for the patients current prescribed and over the counter medications. 7. Clinical record review for patient #6 was completed on 9/29/2020 with hospice election date of 6/1/2018, benefit period 7/20/2020 - 9/17/2020, and primary diagnosis of Muscular Dystrophy. Record review failed to evidence a drug regimen review was ever conducted for the patients current prescribed and over the counter medications. 8. Clinical record review for patient #7 was completed on 9/29/2020 with hospice election date of 8/21/2020, benefit period 8/21/2020 - 11/18/2020		within 5 days of the admission date and uploaded into the charts. This will be indicated as completed on the Initial Plan of Care by the admission nurse. Calls to start this pharmacist review program with Optum and Uvanta Pharmacy will be completed by 11/13/2020. Program to be in place by 11/18/2020 IDG meeting. Training on new process to be completed by 11/18/2020. · The Director of Clinical Services will electronically educate the nursing staff that at admission visit, the RN must begin the medication review conversation with both patient/family and hospice MD, document this conversation including marking the medication review as completed on the IDG update and IPOC document per this agency's policies on Medications, Identification of Medications for Administration, Medication Profile, Admission Criteria and Process, and Patient Plan of Care. This education to be completed electronically by 11/13/2020; and follow-up education to be completed by 11/18/2020. · Director of Clinical Services to re-educate nursing staff that all new or changing medication orders must be reviewed by hospice MD at time of change and conversation must be documented	

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	and primary diagnosis of Multiple Sclerosis. Record review failed to evidence a drug regimen review was ever conducted for the patients current prescribed and over the counter medications. 9. During an interview on 9/25/2020 at 1:30 p.m., when queried how drug regimen reviews were performed, employee B and the director of clinical services (employee D) indicated there were no forms in the agency software system (electronic medical record) for completion of a drug regimen review. During an interview on 9/28/2020 at 11:00 a.m., when queried how drug regimen reviews were performed, employee O (registered nurse) indicated nurses did not do drug regimen reviews, and medications were not discussed at interdisciplinary group meetings unless there was a change in medications, there was no plan of care or medication list in the patients' homes, and they just write down what medication the patient and family indicated they are on. 10. Clinical record review for patient #8 was completed on 9/29/2020, with hospice election date of 9/19/20, hospice benefit period 9/19/20 to 12/17/20, and primary diagnosis of Cancer of upper lobe, right bronchus or lung. Clinical record review of an agency document titled "Comprehensive Assessment" dated and signed on 9/19/2020 by employee FF, failed to evidence the nurse performed a drug regimen review. 11. Clinical record review for patient #9 was completed on 9/29/20, with hospice election date 5/22/2019, hospice benefit period 5/22/19 to 8/19/19, and primary diagnosis of COPD(chronic obstructive pulmonary disease). Clinical record		in the medical record by 11/13/2020 per this agency's polices on Medications, Medication Profile, and Patient Plan of Care. · Evidence of training will be noted in attendance logs. The Director of Clinical Services will review in-service attendance logs to ensure all staff receive this training. · This training will be incorporated into the agency's annual in-services by 1/30/21 and the new-employee orientation by 11/20/2020. · Effective 11/18/2020, RN case managers will hand in medication profile review sheets to medical records at conclusion of each interdisciplinary group meeting after discussion with hospice MD. · Effective 11/18/2020, RN case manager to add documentation in IDG regarding specifics of medication review with hospice MD. **How the agency will monitor its quality assessment/performance improvement functions to ensure that the corrective measure or systemic change is sustained:** · The Director of Clinical Services or designee will ensure 100% of all clinical charts are	

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	review of an agency document titled "Comprehensive Assessment" dated and signed on 5/22/2019 by employee X, failed to evidence the nurse performed a drug regimen review. 12. Clinical record review for patient #10 was completed on 9/29/20, with hospice election date 6/23/2018, hospice benefit period 8/11/20 to 10/9/20, and primary diagnosis of Alzheimer's disease. Clinical record review of an agency document titled "Comprehensive Assessment" dated and signed on 6/23/2018 by employee CC, failed to evidence the nurse performed a drug regimen review. 13. Clinical record review for patient #11 was completed on 9/29/20, with hospice election date 2/8/2018, hospice benefit period 2/8/18 to 5/8/18, and primary diagnosis of Pancreatic cancer. Clinical record review of an agency document titled "Comprehensive Assessment" dated and signed on 2/8/2018 by employee BB, failed to evidence the nurse performed a drug regimen review. 14. Clinical record review of patient #12 was completed on 9/29/20, with hospice election date 8/26/2020, hospice benefit period 8/26/20 to 11/23/20, and primary diagnosis of Malignant Neoplasm of Tongue. Clinical record review of an agency document titled "Comprehensive Assessment" dated and signed on 8/26/2020 by employee I, failed to evidence the nurse performed a drug regimen review. 15. Clinical record review for patient #13 was completed on 9/29/2020, with hospice election date of 1/29/18, hospice benefit period 1/29/18 to 4/28/18, and primary diagnosis of Lung Cancer. Clinical record review of an agency document		audited for evidence of medication review during each admission narrative and IDG update which contains all elements for 4 weeks starting 11/18/2020. The threshold for compliance is 100%. · Once the initial threshold is met, the Director of Clinical Services or designee will conduct a clinical record review of 10% of active patient records monthly to ensure evidence of drug regimen review. The threshold for compliance is 100% for three months. · If the threshold for compliance is not met the Director of Clinical Services will continue to conduct clinical record reviews and provide continuing education to individual employees, counseling, and disciplinary action in accordance with agency policy if needed. · Once the threshold is met this review item will be incorporated into the agency's quarterly clinical record review; a minimum of 10% of all live charts will be audited quarterly. · Results of the above audits and analysis of trends will be included in the agency's Quarterly Quality review data and reported to the Administrator and Governing Body. **Person Responsible:** Director of Clinical Services **Completion Date:** November 18,	

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	titled "Comprehensive Assessment" dated and signed on 1/29/18 by employee BB, failed to evidence the nurse performed a drug regimen review. 16. Clinical record review of patient #14 was completed on 9/29/20, with hospice election date 2/8/2020, hospice benefit period 2/8/20 to 5/7/20, and primary diagnosis of Chronic obstructive pulmonary disease. Clinical record review of an agency document titled "Comprehensive Assessment" dated and signed on 2/8/2020 by employee A, failed to evidence the nurse performed a drug regimen review.		2020	
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 hospice failed to ensure the update of the comprehensive assessments were completed for all of the agency's patients as frequently as the condition of the patients required, but no less frequently than every fifteen days to meet the needs of the patients for 13 of 14 clinical records reviewed (#1, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, and 14).	L 0533	**CMS Tag L533 Hospice-CoP Standard: 418.54(d)Update of the Comprehensive Assessment** **Findings:** The Hospice failed to ensure the update of the comprehensive assessments were completed for all of the agency's	11/20/2020

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	Findings include: 1. Review of an agency policy last updated 01/2014, titled "Patient Plan of Care" stated "... The Plan of Care will reflect ... based on the problems identified in the initial, comprehensive, and updated comprehensive assessments ... at a minimum of every fifteen days ... revised plan of care will include information from the ... updated comprehensive assessment ...." 2. Clinical record review for patient #1 was completed on 9/29/2020, with hospice election date of 8/26/2020, benefit period 8/26/2020 - 11/23/2020, and primary diagnosis of Parkinson's disease. Clinical record review failed to evidence a comprehensive assessment was completed every 15 days and failed to evidence a comprehensive reassessment after the patient was hospitalized for an amputation on 9/12/20. 3. Clinical record review for patient #3 was completed on 9/29/2020, with hospice election date of 5/21/2020, benefit period 5/21/2020 - 8/18/2020, and primary diagnosis of Severe Calorie Malnutrition. The clinical record evidenced an agency document titled "Comprehensive Assessment" dated and signed on 5/21/2020 by employee A. This was the only comprehensive assessment evidenced in the clinical record for this benefit period. The clinical record failed to evidence a comprehensive assessment every 15 days. 4. Clinical record review for patient #4 was completed on 9/29/2020, with hospice election date of 2/26/2019, benefit period 8/19/2020 - 10/17/2020, and primary diagnosis of Cerebral Vascular Accident [CVA- stroke]. The clinical		patients as frequently as the condition of the patients required, but no less frequently than every fifteen days to meet the needs of the patients for 13 of 14 clinical records reviewed. **Plan to correct specific deficiency cited:** · The Director of Clinical Services and Interdisciplinary Group will review the current patient caseload on 11/18/2020 to ensure that the comprehensive assessment is completed and updated minimally every 15 days, or more frequently including when there is a change in patient status or hospitalization in accordance with regulations for all active patients per agency's policies on Patient Plan of Care. · Updates to the patient's Comprehensive Assessment is contained in RN visit notes of patient's medical record which are sufficiently comprehensive to meet the re-assessment requirements of the applicable regulations. **Measures/Systematic Changes that will be put into place to ensure that the deficiency does not recur:** · The Director of Clinical Services will educate RN case managers by 11/18/2020 regarding the Patient Plan of Care Policy and the requirement that	

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	record evidenced a nursing recertification dated and signed by employee on 8/10/2020 by employee H. This was the only comprehensive assessment evidenced in the clinical record for this benefit period. The clinical record failed to evidence a comprehensive assessment every 15 days. 5. Clinical record review for patient #5 was completed on 9/29/2020 with hospice election date of 2/3/2020, benefit period 2/3/2020 - 5/2/2020, and primary diagnosis of COPD (chronic obstructive pulmonary/lung disease). The clinical record evidenced a comprehensive assessment dated and signed on 2/3/2020 by employee L. This was the only comprehensive assessment evidenced in the clinical record for this benefit period. The clinical record failed to evidence a comprehensive assessment every 15 days. 6. Clinical record review for patient #6 was completed on 9/29/2020, with hospice election date of 6/1/2018, benefit period 7/20/2020 - 9/17/2020, and primary diagnosis of Muscular Dystrophy. The clinical record evidenced a document titled "Nurse Recertification" (updated comprehensive assessment) dated and signed on 9/8/2020, by the director of clinical services (for the subsequent benefit period). This was the only comprehensive assessment evidenced in the clinical record for this benefit period. The clinical record failed to evidence a comprehensive assessment every 15 days. 7. Clinical record review for patient #7 was completed on 9/29/2020, with hospice election date of 8/21/2020, benefit period 8/21/2020 - 11/18/2020 and primary diagnosis of Multiple Sclerosis. The clinical record evidenced a document titled "Comprehensive Assessment"		the comprehensive assessment is completed and updated minimally every 15 days, or more frequently including when there is a change in patient status or hospitalization in accordance with regulations. · The Director of Clinical Services will educate RN case managers by 11/18/2020 that nursing visit notes are considered a reassessment supporting the comprehensive assessment update and each nursing visit note needs to clearly document progress towards goals established by patient/family for optimal management. · Evidence of training will be noted in attendance logs. The Director of Clinical Services will review in-service attendance logs to ensure all staff receive this training. · This training will be incorporated into the agency's annual in-services by 1/30/21 and the new-employee orientation by 11/20/2020. · The Director of Clinical Services and Interdisciplinary Group will review the each patient's record presented during each IDG to ensure that the comprehensive assessment is completed and updated minimally every 15 days, or more frequently including when there is a change in patient status or hospitalization in accordance with regulations for all active patients per agency's	

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	dated and signed on 8/21/2020 by employee O. This was the only comprehensive assessment evidenced in the clinical record for this benefit period. The clinical record failed to evidence a comprehensive assessment every 15 days. 8. During an interview on 9/25/2020 at 1:30 p.m., the director of clinical services indicated the agency did an initial comprehensive assessment and then comprehensive re-assessments would be completed again for patients that recertified for additional episodes. When queried if a routine nursing visit was the same as a comprehensive assessment, employee B, the administrator, and director of clinical services indicated a routine nursing visit did not meet the requirements of a comprehensive assessment or re-assessment. 9. During an interview on 9/29/2020 at 2:04 p.m., when queried if comprehensive re-assessments were completed on patients who had a significant change in condition, such as return from hospital stay with changes in care or services to meet the patients' needs, the administrator and director of clinical services indicated they were not performed.10. Clinical record review for patient #8 was completed on 9/29/2020, with hospice election date of 9/19/20, benefit period 9/19/20 to 12/17/20, and primary diagnosis of Cancer of upper lobe, right bronchus or lung. Clinical record review evidenced an agency document titled "Comprehensive Assessment" dated 1/1/11 and electronically signed by employee A. The clinical record failed to evidence a comprehensive assessment was completed every 15 days. 11. Clinical record review for patient #9 was completed on 9/29/20, with hospice election date 5/22/2019, hospice benefit period 5/22/19 to 8/19/19 and primary diagnosis of COPD (chronic		policies on Patient Plan of Care starting 11/18/2020. **How the agency will monitor its quality assessment/performance improvement functions to ensure that the corrective measure or systemic change is sustained:** · The Director of Clinical Services or designee will ensure 100% of all clinical charts are audited for evidence of the comprehensive assessment update minimally every 15 days, or more frequently including when there is a change in patient status or hospitalization for 4 weeks starting 11/18/2020. The threshold for compliance is 100%. · Once the initial threshold is met, the Director of Clinical Services or designee will conduct a clinical record review of 10% of active patient records monthly to ensure evidence of timely comprehensive assessments. The threshold for compliance is 100% for three months. · If the threshold for compliance is not met the Director of Clinical Services will continue to conduct clinical record reviews and provide continuing education to individual employees, counseling, and disciplinary action in accordance with agency policy if needed. · Once the threshold is met this review item will be	

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	obstructive pulmonary disease). Clinical record review evidenced an agency document titled "Comprehensive Assessment" dated 5/22/2019 and electronically signed by employee X and evidenced an agency document titled "Nurse Recertification" dated 8/16/2019 and electronically signed by employee O. The clinical record failed to evidence a comprehensive assessment was completed every 15 days. 12. Clinical record review for patient #10 was completed on 9/29/20, with hospice election date 6/23/2018, hospice benefit period 8/11/20 to 10/9/20, and primary diagnosis of Alzheimer's disease. Clinical record review evidenced an agency document titled "Comprehensive Assessment" dated 6/23/2018 and electronically signed by employee CC. The clinical record failed to evidence a comprehensive assessment was completed every 15 days. 13. Clinical record review for patient #11 was completed on 9/29/20, with hospice election date 2/8/2018, hospice benefit period 2/8/19 to 5/8/18, and primary diagnosis of Pancreatic cancer. Clinical record review evidenced an agency document titled "Comprehensive Assessment" dated 2/8/2018 and electronically signed by employee BB. The clinical record failed to evidence a comprehensive assessment was completed every 15 days. 14. Clinical record review of patient #12 was completed on 9/29/20, with hospice election date 8/26/2020, hospice benefit period 8/26/20 to 11/23/20, and primary diagnosis of Malignant Neoplasm of Tongue. Clinical record review evidenced an agency document titled "Comprehensive Assessment" dated 2/8/2018 and electronically signed by employee I. The clinical		incorporated into the agency's quarterly clinical record review; a minimum of 10% of all live charts will be audited quarterly. · Results of the above audits and analysis of trends will be included in the agency's Quarterly Quality review data and reported to the Administrator and Governing Body. **Person Responsible:** Director of Clinical Services **Completion Date:** November 20, 2020	

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	record failed to evidence a comprehensive assessment was completed every 15 days. 15. Clinical record review for patient #13 was completed on 9/29/2020, with hospice election date of 1/29/18, hospice benefit period 1/29/18 to 4/28/18, and primary diagnosis of Lung Cancer. Clinical record review evidenced an agency document titled "Comprehensive Assessment" dated 1/29/2018 and electronically signed by employee BB. The clinical record failed to evidence a comprehensive assessment was completed every 15 days. 16. Clinical record review of patient #14 was completed on 9/29/20, with hospice election date 2/8/2020, hospice benefit period 2/8/20 to 5/7/20, and primary diagnosis of Chronic obstructive pulmonary disease. Clinical record review evidenced an agency document titled "Comprehensive Assessment" dated 2/8/2020 and electronically signed by employee A. The clinical record failed to evidence a comprehensive assessment was completed every 15 days.			
L 0536 Bldg. 00	Based on observation, record review and interview, the hospice failed to ensure all patients had a plan of care identifying patient and family specific needs (L538); failed to ensure all patients had an individualized plan of care (See tag L545); failed to ensure all patients' plans of care evidenced measurable outcomes/goals (See tag L548); failed to ensure all patients' plans of care included drugs and treatments necessary to meet the needs of the patients (See tag L549); failed to ensure all patients' plans of care included medical supplies and appliances necessary to meet the	L 0536	**CMS Tag L536-CoP: 418.56 IDG, CARE PLANNING, COORDINATION OF SERVICES** **Finding:** The hospice failed to ensure all patients had a plan of care identifying patient and family specific needs (L538); failed to ensure all patients had an individualized plan of care (See tag L545); failed to ensure all patients' plans of care evidenced	11/20/2020

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	needs of the patients (See tag L550); failed to ensure the agency's interdisciplinary group (IDG) updated the patients' plans of care as often as needed for a patient change in condition (See tag L552). These practices impacted 14 of 14 patients (#1, #2, #3, #4, #5, #6,# 7, #8, #9, #10, #11, #12, #13, and #14). The cumulative effect of these systemic problems resulted in the hospice's inability to be in compliance with the Condition of Participation §418.56 Interdisciplinary group, care planning, and coordination of services.		measurable outcomes/goals (See tag L548); failed to ensure all patients' plans of care included drugs and treatments necessary to meet the needs of the patients (See tag L549); failed to ensure all patients' plans of care included medical supplies and appliances necessary to meet the needs of the patients (See tag L550); failed to ensure the agency's interdisciplinary group (IDG) updated the patients' plans of care as often as needed for a patient change in condition (See tag L552), impacting 14 of 14 patients based on clinical record review, observation and interview. Unity Hospice of Northwest Indiana is presenting a credible allegation of compliance with this CONDITION based on the implementation of the plan of correction stated in CMS Tags L538, L545, L548, L549, L550 and L552. Unity Hospice of Northwest Indiana has a history of having maintained a commitment of compliance as evidenced by prior survey experience and commitment to follow up and correction. Unity Hospice of Northwest Indiana will ensure that the plan of correction submitted for CMS Tags 538, L545, L548, L549, L550 and L552.are realistic and will be accomplished between the date of the last survey and	

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			November 20, 2020 and will demonstrate resolution of the problem by this date.. Refer to the plans of correction for 538, L545, L548, L549, L550 and L552.	
L 0538 Bldg. 00	418.56 IDG, CARE PLANNING, COORDINATION OF SERVICES The plan of care must specify the hospice care and services necessary to meet the patient and family-specific needs identified in the comprehensive assessment as such needs relate to the terminal illness and related conditions. Based on observation, record review and interview, the hospice failed to ensure all patients had a plan of care that specified the hospice care and services necessary to meet the patient and family-specific needs identified in the comprehensive assessments for 14 of 14 clinical records reviewed (#1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, and 14). Findings include: 1. Review of an agency policy last updated 01/2014, titled "Patient Plan of Care" stated "... The Plan of Care shall specify the hospice care and services necessary to meet the patient and family-specific needs identified in the comprehensive assessment ...." Review of an agency policy last updated 01/2014, titled "Initial Hospice Assessment" stated "... guidelines for the initial assessment and Plan of Care ... During the initial patient assessment, all baseline data and other relevant information is documented ... including at least ... specific	L 0538	**CMS Tag L538 Hospice-CoP Standard: 418.56 IDG, Care Planning, Coordination of Services** **Findings:** The hospice failed to ensure all patients had a plan of care that specified the hospice care and services necessary to meet the patient and family-specific needs identified in the comprehensive assessments for 14 of 14 clinical records reviewed. **Plan to correct specific deficiency cited:** · The Director of Clinical Services and Interdisciplinary Group will review the current patient caseload on 11/18/2020 to ensure that each patient's plan of care is updated based on the comprehensive assessment to reflect the patient's status per	11/20/2020

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	individualized patient needs/problems pertinent to the hospice care being provided ... assessment should determine ... patient goals ... types of services, frequency and duration needed ... the plan of care will be established on the day of admission and reviewed by the interdisciplinary group, within three days of admission ...." Review of an agency policy updated 01/2014 titled "Ongoing Assessment" stated "... the RN [registered nurse] Case Manager ... will re-evaluate the patient according to the problems identified during the initial visit and thereafter ... based on the re-assessments, the Plan of Care, including problems, needs, goals and outcomes, will be reviewed and revised accordingly ...." 2. Clinical record review for patient #1 was completed on 9/29/2020, with hospice election date of 8/26/2020, benefit period 8/26/2020-11/23/2020, and primary diagnosis of Parkinson's disease. Record review evidenced an agency document dated and signed on 8/26/2020 by employee A (registered nurse), titled "Comprehensive Assessment" This document stated "... patient/family's current chief complaint: Assistance with ADLs [activities of daily living such as personal care/hygiene assistance], comfort and mobility ... offer soft foods, add thicket [powder used to thicken liquids for patients that have difficulty swallowing]... necrotic [dead skin/cells] area left foot 2nd toe ... Severe PVD [peripheral vascular disease] and increase pain to lower extremities restricts mobility ... difficulty swallowing, at risk for aspiration pneumonia, new onset of incontinency ... immediate needs for problem/symptom management ... communication ... decline in ADLs ... dysphagia [difficulty swallowing] ... edema ... falls/safety ... nutrition ...."		agency's Patient Plan of Care, Initial Hospice Assessment and Ongoing Assessment Policies and that referrals are made to other disciplines as appropriate to meet the patient's needs. · The agency's process for documenting the plan of care and updates which specify care and services necessary to meet the patient and family specific needs as identified in Comprehensive Assessment (as properly and timely updated) is through the Plan of Care documentation part of each patient's unique medical record, which is an addendum to the Initial Plan of Care. This process and structure of each medical record was in place at the time of the survey. Effective 11/18/2020, the agency will reference the Plan of Care document on the Initial Plan of Care, and the Plan of Care will be established based on the comprehensive assessment and updated as appropriate to reflect changes in the patient's status, and ensure referral to additional disciplines as appropriate to meet patient and family needs.. **Measures/Systematic Changes that will be put into place to ensure that the deficiency does not recur:** · The Director of Clinical Services will educate RN case	

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	Review of an agency document titled "Initial Plan of Care" dated and signed 8/26/2020, by the medical director, the director of clinical services, employee A, employee E (social worker), and employee F (spiritual counselor) failed to evidence any patient or family-specific care, treatment(s), or services identified in the comprehensive assessment. 3. Clinical record review for patient #2 was completed on 9/29/2020, with hospice election date of 9/15/2020, benefit period 9/15 - 12/13/2020, and primary diagnosis of Ovarian Cancer. Record review evidenced an agency document dated and signed on 9/15/2020 by employee A, titled "Comprehensive Assessment" This document stated "... patient/family's current chief complaint: Family wishes for patient to be comfortable during the disease process ... pain rating ... verbal ... 10 ... respirations per minute ... 24 [normal rate is 16-20] ... only consumes bites of meals daily ... pain is not well managed with current POC [plan of care] ... immediate needs for problem/symptom management ... [boxes checked for] ... decline in ADL/self care ... diarrhea ... edema ... falls/safety ... nutrition ... pain ... skin breakdown ...." Review of an agency document titled "Initial Plan of Care" dated and signed 9/15/2020, by the medical director, the director of clinical services (employee D), employee A, employee E, and employee F, failed to evidence any patient or family-specific care, treatment(s), or services identified in the comprehensive assessment. 4. Clinical record review for patient #3 was completed on 9/29/2020, with hospice election date of 5/21/2020, benefit period 5/21/2020 - 8/18/2020, and primary diagnosis of Severe Caloric		managers and IDG team members by 11/18/2020 regarding the Patient Plan of Care, Initial Hospice Assessment, and Ongoing Assessment Policy and the updated process to reference the Plan of Care on the Initial Plan of Care. RN Case Managers will receive education regarding the requirement that the Plan of Care must be established based on the comprehensive assessment and updated as appropriate to reflect changes in the patient's status, and ensure referral to additional disciplines as appropriate to meet patient and family needs. · Evidence of training will be noted in attendance logs. The Director of Clinical Services will review in-service attendance logs to ensure all staff receive this training. · This training will be incorporated into the agency's annual in-services by 1/30/21 and the new-employee orientation by 11/20/2020. · The Director of Clinical Services and Interdisciplinary Group will review each patient's record presented during each IDG to ensure that the patient's care plan is established and updated minimally every 15 days based on the comprehensive assessment, as updated, to reflect the patient's status, including when there is a change in patient status, and that referrals are made to other	

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	Malnutrition. Record review evidenced an agency document dated and signed on 5/21/2020 by employee A, titled "Comprehensive Assessment" This document stated "... patient/family's current chief complaint: pain ..... pain rating ... verbal ... 9 ... enteral [nutrition provided through an artificial opening] feedings ... evidence of malnutrition ... feedings of Osmolite 1.4 daily ... wound ... pressure ulcer Stage III [3] right gluteal fold ... surgical incision wound right posterior thigh ... surgical wound right anterior thigh ... Fall risk ... High risk ... immediate needs for problem/symptom management ... [boxes checked for] ... anxiety/agitation ... decline in ADL/self care ... pain ... skin breakdown ...." Review of an agency document titled "Initial Plan of Care" dated and signed 5/21/2020 by the medical director, employee A, employee G (spiritual counselor), and employee E, failed to evidence any patient or family-specific care, treatment(s), or services identified in the comprehensive assessment. 5. Clinical record review for patient #4 was completed on 9/29/2020, with hospice election date of 2/26/2019, benefit period 8/19/2020 - 10/17/2020, and primary diagnosis of Cerebral Vascular Accident [CVA- stroke]. Record review evidenced an agency document dated and signed on 8/10/2020 by employee H (registered nurse), titled "Nurse Recertification" This document stated "... GT [gastrointestinal tube for nutrition] feeding of Osmolite 1.2 at 65ml/hr [milliliters per hour] x 15 hrs ... paralysis ... dysphagia ... seizures ... pressure ulcer risk assessment ... total score 18 [high risk] ... nebulizer treatments ... increased oral secretions ... suction prn [as needed] ... fall risk assessment ... high risk ...."		disciplines as appropriate to meet the patient/family's needs. **How the agency will monitor its quality assessment/performance improvement functions to ensure that the corrective measure or systemic change is sustained:** · The Director of Clinical Services or designee will ensure 100% of all clinical charts are audited for evidence of the reference to the Plan of Care on the Initial Plan of Care; that the Plan of Care is established and updated in accordance with comprehensive assessments minimally every 15 days, or more frequently including when there is a change in patient status, and that referrals are made to other disciplines as appropriate to meet the patient/family's needs for 4 weeks starting 11/18/2020. The threshold for compliance is 100%. · Once the initial threshold is met, the Director of Clinical Services or designee will conduct a clinical record review of 10% of active patient records monthly to ensure evidence of timely plan of care updates. The threshold for compliance is 100% for three months. · If the threshold for compliance is not met the Director of Clinical Services will continue to	

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	Review of an agency document titled "IDG [interdisciplinary group] Update" (updated plan of care) dated and signed 8/12/2020 by the medical director, director of clinical services, employee I (registered nurse), employee F, employee J (social worker), employee K (volunteer coordinator), and employee Z (bereavement coordinator), failed to evidence all patient or family-specific care, treatment(s), or services identified in the comprehensive assessment. 6. Clinical record review for patient #5 was completed on 9/29/2020, with hospice election date of 2/3/2020, benefit period 2/3/2020 - 5/2/2020, and primary diagnosis of COPD (chronic obstructive pulmonary/lung disease). Record review evidenced a document dated and signed on 2/3/2020 by employee L (registered nurse), titled "Comprehensive Assessment" This document stated "... patient/family's current chief complaint: dyspnea [difficulty breathing], coccyx [tailbone area] wound ... risk of aspiration per hospital records, patient choosing not to downgrade diet ... wound ... Stage II [2] coccyx wound [pressure ulcer] ... patient uses oxygen ... nebulizer [breathing] treatments ... immediate needs for problem/symptom management ... [boxes checked for] ... dyspnea ... skin breakdown ...." Review of an agency document titled "Initial Plan of Care" dated and signed 2/4/2020 by the medical director, director of clinical services, employee M (registered nurse), employee J, employee G, employee K, and employee Z, failed to evidence any patient or family-specific care, treatment(s), or services identified in the comprehensive assessment. 7. Clinical record review for patient #6 was		conduct clinical record reviews and provide continuing education to individual employees, counseling, and disciplinary action in accordance with agency policy if needed. · Once the threshold is met this review item will be incorporated into the agency's quarterly clinical record review; a minimum of 10% of all live charts will be audited quarterly. · Results of the above audits and analysis of trends will be included in the agency's Quarterly Quality review data and reported to the Administrator and Governing Body. **Person Responsible:** Administrator **Completion Date:** November 20, 2020	

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	completed on 9/29/2020, with hospice election date of 6/1/2018, benefit period 7/20/2020 - 9/17/2020, and primary diagnosis of Muscular Dystrophy. Record review evidenced a document dated and signed on 9/8/2020 by the director of clinical services, titled "Nurse Recertification" This document stated "... Oxygen liters per minute: 3 ... unable to tolerate oral diet ... enteral feedings ... sunken temples, sunken cheeks, protruding clavicles [collar bones] and scapula [shoulder blades], exposed hip bones ... constipation ... suprapubic catheter [surgically inserted drain tube for urine] ... changed monthly by patient's mother ... Stage II pressure ulcer to right buttock ... oxygen per: trach collar [tracheostomy] ... ventilator support to breathe ... suction ... significant fecal retention ... breathing is more shallow despite ventilator support...." Review of an agency document titled "IDG Update" (updated plan of care) dated and signed 9/9/2020 by the medical director, employee N (physician designee), director of clinical services, employee E, and employee G, failed to evidence any patient or family-specific care, treatment(s), or services identified in the comprehensive assessment. 8. Clinical record review for patient #7 was completed on 9/29/2020, with hospice election date of 8/21/2020, benefit period 8/21/2020 - 11/18/2020, and primary diagnosis of Multiple Sclerosis. Record review evidenced an agency document dated and signed on 8/21/2020 by employee O (registered nurse), titled "Comprehensive Assessment" This document stated "... patient/family's current chief complaint: 'I need help taking care of him [patient's caregiver]' ... enteral feedings ... patient cannot feed himself ... excessive efforts required to maintain dietary			

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	intake ... patient is on Isosource 1.5 1 can 4x day ... paralysis ... tremors ... muscle cramps ... texas [condom type] catheter [for urinary drainage] ... wounds ... DtI [deep tissue injury] to right plantar [bottom] aspect of foot ... left foot DTI patient uses oxygen ... trach collar ... suction ... tracheostomy ... Fall risk ... High risk ... immediate needs for problem/symptom management ... [boxes checked for] ... dyspnea ... skin breakdown ...." Review of an agency document titled "Initial Plan of Care" dated and signed 8/21/2020 by the medical director, director of clinical services, employee I, employee K, employee J, employee Z, employee O, and employee F failed to evidence any patient or family-specific care, treatment(s), or services identified in the comprehensive assessment. 9. During an interview on 9/25/2020 at 2:20 p.m., while discussing the concerns with the agency's plans of care, employee B (corporate director of compliance) indicated the agency had a systemic problem with plans of care, and interventions and measurable outcomes were not evidenced on all patients' plans of care reviewed. 10. During an interview with patient #3 on 9/28/20 at 10:30 a.m., patient #3 indicated pain was 8 [pain scale 1-10, 10 being the worst]. Patient #3 indicated he thinks the medication "is as good as its going to get." Employee O indicated she would speak to the physician regarding medication changes to manage pain after the visit. Upon clinical record review, the chart did not provide evidence of physician communication. The agency failed to provide the necessary services to meet the patient and family-specific needs identified in the comprehensive			

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	assessment. 11. During a home visit on 9/28/20 at 11:00 a.m., employee O was observed providing care to patient #3. Employee O was not observed to have assessed the patient's coccyx wound as directed on the plan of care. Clinical record review of a document signed and dated 5/21/2020, by employee O titled "Care Plan" stated " ...RNCM [registered nurse case manager] will dress both the posterior right thigh and coccyx wounds will have dressing changes: remove old dressing. Cleanse with normal saline. Apply medihoney. Dress with dry dressing ...." During an interview on 9/28/20 at 11:00 a.m., employee O indicated the patient's coccyx wound was healed. Clinical record review of a document titled "Initial Plan of Care" dated and signed on 5/21/2020 by employee A, employee C, employee E, and employee D, stated, " ... Skilled Nursing visits ... Social Worker Visits Evaluation only ... Spiritual Visits evaluation only ... Hospice Aide Visits Patient/family request no Hospice Aide visits at this time ... Therapy visits No therapy needs Identified at this time ...." The agency failed to include services and treatments in the plan of care that address the patient and family-specific needs related to the terminal illness and related conditions. 12. Clinical record review for patient #8 was completed on 9/29/2020, with hospice election date of 9/19/20, hospice benefit period 9/19/20 to			

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	12/17/20, and primary diagnosis of Cancer of upper lobe, right bronchus or lung. Clinical record review of a document signed and dated 9/19/2020, by employee FF, titled "Comprehensive Assessment" stated "... Patient family's goals: POA [power of attorney] [family member name], wishes for hospice to assist in the care of his sister as her condition continues to progress. His wish is for pain free management of her care and comfort for the pt [patient]. Pain/Comfort assessment: verbal scale current: 10 Best: 0 Acceptable: 5 Worst: 10 Pain duration: Intermittent What other symptoms associated with pain? Decreased mobility, increased sleeping, irritability/agitation, decreased appetite. Blood pressure 95/41[normal blood pressure 120/80] Nutritional status current weight: 130 on 9/19/2020 previous weight: 209 12/19/2019 ... Respiratory status Patient uses oxygen 4L [liters] per nasal cannula ....Pt becomes SOB [short of breath] with minimal exertion and will quickly desat below 90% and require 4-5 minutes to get O2 [oxygen] sats[saturation] back above 90%. Cool/cold extermities[sic] Describe: Pts [patient's] hands and feet bilaterally were cool to the touch Breath sounds Rhonchi ... Breathing pattern Irregular, Shallow ...Current Respiratory Medications and Treatments Nebulizer treatments describe: duo nebs PRN [pro re nata, (also known as as needed] Q6h [every 6 hours], Oxygen saturation less than 88% on room air ... Other pertinent information related to respiratory status: Pt unable to string together more than 4-5 sentences without having to stop and catch her breath. Pt will stop and take a 5-6 breaths and then continue on with the conversation ...." Clinical record review of a document titled "IDG Update" (updated plan of care) dated and signed 9/23/20 by the medical director, employee D,			

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	employee J, employee H, employee G, failed to evidence any patient and family needs or goals. The agency failed to include services and treatments in the plan of care that address the patient and family-specific needs related to the terminal illness and related conditions. 13. Clinical record review for patient #9 was completed on 9/29/20, with hospice election date 5/22/2019, hospice benefit period 5/22/19 to 8/19/19 and primary diagnosis of COPD (chronic obstructive pulmonary disease). Clinical record review of a document signed and dated 5/22/2019 by employee X, titled "Comprehensive Assessment" stated " ... Patients family goals: Desires patient to be comfortable ... Patient heavy smoker ... Patients behavior: agitation/restlessness ... Patients Emotions: Anxiety ... Patient on home oxygen nasal cannula 2 liters ... Home safety assessment: No safety problems identified ...." Clinical record review of a document titled "Initial Plan of Care" dated and signed 5/22/2019 by the medical director, employee Y (clinical director), employee BB (registered nurse), employee Z (social worker, spiritual counselor), employee AA (volunteer coordinator), failed to evidence any patient or family specific care, treatment(s), or services identified in the comprehensive assessment dated 5/22/2019. The agency failed to include services and treatments in the plan of care that address the patient and family-specific needs related to the terminal illness and related conditions.			

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	14. Clinical record review for patient #10 was completed on 9/29/20, with hospice election date 6/23/2018, hospice benefit period 8/11/20 to 10/9/20, and primary diagnosis of Alzheimer's disease. Clinical record review of a document signed and dated 6/23/2018, by employee CC (registered nurse), titled "Comprehensive Assessment" stated " ... Patients family goals: Comfortable and pain free passing ... Patient comfort assessment: Verbal scale current 0 ... Patient/Family's view of the origin and meaning of pain : patient is unable to describe pain, able to point to left knee as source of pain with movement ... Pain character, other words used to describe pain, pain to left knee with movement, then stops. Patient unable to describe or rate. Patient is unable to describe character of pain ... Patient wounds DTI(deep tissue injury) left heel, pressure-coccyx ...." Clinical record review on 9/29/20, failed to evidence a plan of care for patient #10. 15. Clinical record review for patient #11 was completed on 9/29/20, with hospice election date 2/8/2018, hospice benefit period 2/8/19 to 5/8/18, and primary diagnosis of Pancreatic cancer. Clinical record review of a document signed and dated 2/8/2018, by employee BB, titled "Comprehensive Assessment" stated " ... Pt had a 20lb [pound] weight loss with mental and physical decline noted during respite stay at NH [nursing home]... Patient/family's current chief complaint: decline ... Patient not eating due to loss of appetite ... Patient/Comfort assessment non-verbal scale: current 2/10. Symptoms associated with the pain: decreased mobility, decreased ADL [activities of daily living], poor concentration, decreased socialization, increased			

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	sleeping, withdrawal, irritability/agitation, decreased appetite ... Respiratory rate 22 [normal 12-20 breaths per minute] on room air ... Heart rate 103 [normal 60-100 beats per minute] ... Blood pressure 150/76 ... Behavior: agitated/restlessness ... Bowel constipation ... Urinary incontinence ...." Clinical record review of a document signed and dated 2/8/2018, titled "Initial Plan of Care" signed by medical director, employee DD, employee EE, and employee Z, failed to evidence any patient or family specific care, treatment(s), or services identified in the comprehensive assessment and incorporated into the patient's individualized plan of care. 16. Clinical record review of patient #12 was completed on 9/29/20, with hospice election date 8/26/2020, hospice benefit period 8/26/20 to 11/23/20, and primary diagnosis of Malignant Neoplasm of Tongue. Clinical record review of the document signed and dated 8/26/2020, by employee I (registered nurse), titled "Comprehensive Assessment" stated " ... Patient was admitted at .... for suicidal ideation and major depression. Was also admitted 08/09/20 for multiple falls. HX [history] of cataracts, glaucoma, hypertensive, anorexia, and AKI [acute kidney injury]. Patient alert and oriented X 1-2, incontinent of bowel and bladder, ambulates with unsteady gaits, verbal, chronic pain to left jaw ... Family is concerned about patient rapid decline in status. Refusing to eat because he wants to starve himself to death ...Patients family goals: Patient to remain at the nursing facility and have a peaceful passing ...Pain/Comfort assessment current: 5/10 ... acceptable: 4. Pain location: mouth ...."			

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	Clinical record review of a document titled "Initial Plan of Care" signed and dated 8/26/2020, by medical director, employee O (registered nurse) , employee Z, employee E, employee I, failed to evidence any patient or family specific care, treatment(s), or services identified in the comprehensive assessment. 17. Clinical record review for patient #13 was completed on 9/29/2020, with hospice election date of 1/29/18, hospice benefit period 1/29/18 to 4/28/18, and primary diagnosis of Lung Cancer. Clinical record review of a document titled "IDG Update" (updated plan of care) dated and signed 1/31/2018 by the medical director, employee BB, employee E, employee G, failed to evidence any patient and family needs or goals identified during the comprehensive assessment. 18. Clinical record review of patient #14 was completed on 9/29/20, with hospice election date 2/8/2020, hospice benefit period 2/8/20 to 5/7/20, and primary diagnosis of Chronic obstructive pulmonary disease. Clinical record review of document signed and dated 2/8/2020, by employee A (registered nurse), titled "Comprehensive Assessment" stated " ... Patient illness respiratory distress ... Patient family goal: to keep patient comfortable ... Patient/Comfort assessment verbal scale current 5/10, acceptable 3/10. Patient on oxygen 15 liters nasal cannula ... Patient had stage 1 wound to left buttock with ecchymosis. Immediate needs for problem/symptom management: decline in ADL/self-care deficit, dyspnea, skin breakdown...."Clinical record review of a document titled "Initial Plan of Care" signed and dated 8/26/2020 by medical director, employee A, employee E, employee G failed to evidence any patient or family specific care, treatment(s), or			

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	services identified in the comprehensive assessment. 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:			
L 0545 Bldg. 00	Based on record review and interview, the hospice failed to ensure it developed individualized plans of care which included individualized patient and family goals and interventions based on the problems identified in the initial, comprehensive, and updated comprehensive assessments for 14 of 14 clinical records reviewed. (#1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, and 14) Findings include: 1. Review of an agency policy last updated 01/2014, titled "Patient Plan of Care" stated "... The Plan of Care will reflect patient and family goals and interventions based on the problems identified in the initial, comprehensive, and updated comprehensive assessments ...." Review of an agency policy last updated 01/2014, titled "Initial Hospice Assessment" stated "... guidelines for the initial assessment and Plan of Care ... During the initial patient assessment, all baseline data and other relevant information is documented ... including at least ... specific individualized patient needs/problems pertinent to	L 0545	**CMS Tag L545 Hospice-CoP Standard: 418.56 (c) Content of the Plan of Care** **Findings:** The hospice failed to failed to ensure it developed individualized plans of care which included individualized patient and family goals and interventions based on the problems identified in the initial, comprehensive and updated assessments for 14 of 14 clinical records reviewed. **Plan to correct specific deficiency cited:** · The Director of Clinical Services and Interdisciplinary Group will review the current patient caseload on 11/18/2020 to ensure that each patient's plan of care is individualized and includes individualized patient and family goals and interventions based on the initial and comprehensive assessment per agency's Patient	11/20/2020

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	the hospice care being provided ... assessment should determine ... patient goals ... types of services, frequency and duration needed ... the plan of care will be established on the day of admission and reviewed by the interdisciplinary group, within three days of admission ...." Review of an agency policy updated 01/2014, titled "Ongoing Assessment" stated "... the RN [registered nurse] Case Manager ... will re-evaluate the patient according to the problems identified during the initial visit and thereafter ... based on the re-assessments, the Plan of Care, including problems, needs, goals and outcomes, will be reviewed and revised accordingly...." 2. Clinical record review for patient #1 was completed on 9/29/2020, with hospice election date of 8/26/2020, benefit period 8/26/2020 - 11/23/2020, and primary diagnosis of Parkinson's disease. Record review evidenced an agency document dated and signed on 8/26/2020 by employee A (registered nurse), titled "Comprehensive Assessment" This document stated "... patient/family's current chief complaint: Assistance with ADLs [activities of daily living such as personal care/hygiene assistance], comfort and mobility ... Describe patient/family's goals: Comfort care in all areas of daily living ... offer soft foods, add thicket [powder used to thicken liquids for patients that have difficulty swallowing] ... In their own words ... patient/family's goals related to hospice care? Family wants patient to be comfortable in all areas ... including but not limited to pain control, mobility ... no further hospitalization or invasive or surgical curative interventions ... Patient/family pain management goals ... enjoyment in life ... maximum pain control with minimum symptoms ... symptom management ... necrotic [dead skin/cells]		Plan of Care, Initial Hospice Assessment, and Ongoing Assessment Policies. · Note that the agency's process for documenting the plan of care and updates is through the Plan of Care documentation, which is an addendum to the Initial Plan of Care. This process was in place at the time of the survey. Effective 11/18/2020, the agency will reference the Plan of Care document on the Initial Plan of Care, and the individualized Plan of Care will be established based on the comprehensive assessment and updated as appropriate to reflect changes in the patient's status. **Measures/Systematic Changes that will be put into place to ensure that the deficiency does not recur:** · The Director of Clinical Services will educate RN case managers and IDG team members by 11/18/2020 regarding the Patient Plan of Care, Initial Hospice Assessment, and Ongoing Assessment Policy and the updated process to reference the Plan of Care on the Initial Plan of Care. RN Case Managers will receive education regarding the requirement that the individualized Plan of Care must be established based on the comprehensive	

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	area left foot 2nd toe ... Severe PVD [peripheral vascular disease] and increase pain to lower extremities restricts mobility ... difficulty swallowing, at risk for aspiration pneumonia, new onset of incontinency ... immediate needs for problem/symptom management ... communication ... decline in ADLs ... dysphagia [difficulty swallowing] ... edema ... falls/safety ... nutrition ...." Review of an agency document titled "Initial Plan of Care" dated and signed 8/26/2020 by the medical director, the director of clinical services, employee A, employee E (social worker), and employee F (spiritual counselor) failed to evidence any patient or family-specific goals or interventions needed based on the comprehensive assessment dated 8/26/2020. 3. Clinical record review for patient #2 was completed on 9/29/2020, with hospice election date of 9/15/2020, benefit period 9/15/2020 - 12/13/2020, and primary diagnosis of Ovarian Cancer. Record review evidenced an agency document dated and signed on 9/15/2020 by employee A, titled "Comprehensive Assessment" This document stated "... patient/family's current chief complaint: Family wishes for patient to be comfortable during the disease process ... Describe patient/family's goals: Comfort ... pain rating ... verbal ... 10 ... patient/family pain management goals ... pain free ... maximum pain control with minimal symptoms ... respirations per minute ... 24 [normal rate is 16-20] ... only consumes bites of meals daily ... pain is not well managed with current POC [plan of care] ... immediate needs for problem/symptom management ... [boxes checked for] ... decline in ADL/self care ... diarrhea ... edema ... falls/safety ... nutrition ... pain ... skin breakdown ...."		assessment and updated as appropriate to reflect changes in the patient's status. · Evidence of training will be noted in attendance logs. The Director of Clinical Services will review in-service attendance logs to ensure all staff receive this training. · This training will be incorporated into the agency's annual in-services by 1/30/21 and the new-employee orientation by 11/20/2020. · The Director of Clinical Services and Interdisciplinary Group will review each patient's record presented during each IDG to ensure that the patient's care plan is individualized, established and updated minimally every 15 days based on the comprehensive assessment to reflect the patient's status. **How the agency will monitor its quality assessment/performance improvement functions to ensure that the corrective measure or systemic change is sustained:** · The Director of Clinical Services or designee will ensure 100% of all clinical charts are audited for evidence of the reference to the Plan of Care on the Initial Plan of Care and the patient's individualized Plan of	

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	Review of an agency document titled "Initial Plan of Care" dated and signed 9/15/2020 by the medical director, the director of clinical services (employee D), employee A, employee E, and employee F, failed to evidence any patient or family-specific goals or interventions needed based on the comprehensive assessment dated 9/15/2020. 4. Clinical record review for patient #3 was completed on 9/29/2020, with hospice election date of 5/21/2020, benefit period 5/21/2020 - 8/18/2020, and primary diagnosis of Severe Caloric Malnutrition. Record review evidenced an agency document dated and signed on 5/21/2020 by employee A, titled "Comprehensive Assessment" This document stated "... patient/family's current chief complaint: pain ... Describe patient/family's goals: Comfort care ... pain rating ... verbal ... 9 ... patient/family pain management goals ... pain free ... maximum pain control with minimal symptoms ... enteral [an artificial opening to receive nutrition] feedings ... evidence of malnutrition ... feedings of Osmolite 1.4 daily ... wound ... pressure ulcer Stage III [3] right gluteal fold ... surgical incision wound right posterior thigh ... surgical wound right anterior thigh ... Fall risk ... High risk ... immediate needs for problem/symptom management ... [boxes checked for] ... anxiety/agitation ... decline in ADL/self care ... pain ... skin breakdown ...." Review of an agency document titled "Initial Plan of Care" dated and signed 5/21/2020 by the medical director, employee A, employee G (spiritual counselor), and employee E, failed to evidence any patient or family-specific goals or interventions needed based on the comprehensive assessment dated 5/21/2020.		Care is established based on the comprehensive assessment and updated as appropriate to reflect changes in the patient's status for 4 weeks starting 11/18/2020. The threshold for compliance is 100%. · Once the initial threshold is met, the Director of Clinical Services or designee will conduct a clinical record review of 10% of active patient records monthly to ensure evidence of timely plan of care updates. The threshold for compliance is 100% for three months. · If the threshold for compliance is not met the Director of Clinical Services will continue to conduct clinical record reviews and provide continuing education to individual employees, counseling, and disciplinary action in accordance with agency policy if needed. · Once the threshold is met this review item will be incorporated into the agency's quarterly clinical record review; a minimum of 10% of all live charts will be audited quarterly. · Results of the above audits and analysis of trends will be included in the agency's Quarterly Quality review data and reported to the Administrator and Governing Body. **Person Responsible:** Administrator **Completion Date:** November 20,	

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	5. Clinical record review for patient #4 was completed on 9/29/2020, with hospice election date of 2/26/2019, benefit period 8/19/2020 - 10/17/2020, and primary diagnosis of Cerebral Vascular Accident [CVA- stroke]. Record review evidenced an agency document dated and signed on 8/10/2020 by employee H (registered nurse), titled "Nurse Recertification" This document stated "... GT [gastrointestinal tube for nutrition] feeding of Osmolite 1.2 at 65ml/hr [milliliters per hour] x 15 hrs ... paralysis ... dysphagia ... seizures ... pressure ulcer risk assessment ... total score 18 [high risk] ... nebulizer treatments ... increased oral secretions ... suction prn [as needed] ... fall risk assessment ... high risk ...." Review of an agency document titled "IDG Update" (updated plan of care) dated and signed 8/12/2020 by the medical director, director of clinical services, employee I (registered nurse), employee F, employee J (social worker), employee K (volunteer coordinator), and employee Z (bereavement coordinator), failed to evidence any patient or family-specific goals or interventions needed based on the comprehensive assessment dated 8/10/2020. 6. Clinical record review for patient #5 was completed on 9/29/2020, with hospice election date of 2/3/2020, benefit period 2/3/2020 - 5/2/2020, and primary diagnosis of COPD (chronic obstructive pulmonary/lung disease). Record review evidenced an agency document dated and signed on 2/3/2020 by employee L (registered nurse), titled "Comprehensive Assessment" This document stated "... patient/family's current chief complaint: dyspnea [difficulty breathing], coccyx [tailbone area] wound ... Describe patient/family's		2020	

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	goals: to keep her comfortable ... patient/family pain management goals ... pain free ... maximum pain control with minimal symptoms ... symptom management ... risk of aspiration per hospital records, patient choosing not to downgrade diet ... wound ... Stage II [2] coccyx wound [pressure ulcer] ... patient uses oxygen ... nebulizer [breathing] treatments ... immediate needs for problem/symptom management ... [boxes checked for] ... dyspnea ... skin breakdown ...." Review of an agency document titled "Initial Plan of Care" dated and signed 2/4/2020 by the medical director, director of clinical services, employee M (registered nurse), employee J, employee G, employee K, and employee Z, failed to evidence any patient or family-specific goals or interventions needed based on the comprehensive assessment dated 2/3/2020. 7. Clinical record review for patient #6 was completed on 9/29/2020, with hospice election date of 6/1/2018, benefit period 7/20 - 9/17/2020, and primary diagnosis of Muscular Dystrophy. Record review evidenced an agency document dated and signed on 9/8/2020 by the director of clinical services, titled "Nurse Recertification" This document stated "... Oxygen liters per minute: 3 ... unable to tolerate oral diet ... enteral feedings ... sunken temples, sunken cheeks, protruding clavicles [collar bones] and scapula [shoulder blades], exposed hip bones ... constipation ... suprapubic catheter [surgically inserted drain tube for urine] ... changed monthly by patient's mother ... Stage II pressure ulcer to right buttock ... oxygen per: trach collar [tracheostomy] ... ventilator support to breathe ... suction ... significant fecal retention ... breathing is more shallow despite ventilator support ...."			

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	Review of an agency document titled "IDG Update" (updated plan of care) dated and signed 9/9/2020 by the medical director, employee N (physician designee), director of clinical services, employee E, and employee G, failed to evidence any patient or family-specific goals or interventions needed based on the comprehensive assessment dated 9/8/2020. 8. Clinical record review for patient #7 was completed on 9/29/2020, with hospice election date of 8/21/2020, benefit period 8/21 - 11/18/2020, and primary diagnosis of Multiple Sclerosis. Record review evidenced an agency document dated and signed on 8/21/2020 by employee O (registered nurse), titled "Comprehensive Assessment" This document stated "... patient/family's current chief complaint: 'I need help taking care of him [patient's caregiver]' ... Describe patient/family's goals: Family wants a pain free death for their brother ... [caregiver] states she has a small family and there is no one else to help her ... patient/family pain management goals ... pain free ... maximum pain control with minimal symptoms ... enteral feedings ... patient cannot feed himself ... excessive efforts required to maintain dietary intake ... patient is on Isosource 1.5 1 can 4x day ... paralysis ... tremors ... muscle cramps ... texas catheter [condom type catheter for urinary drainage] ... wounds ... DtI [deep tissue injury] to right plantar [bottom] aspect of foot ... left foot DTI patient uses oxygen ... trach collar ... suction ... tracheostomy ... Fall risk ... High risk ... immediate needs for problem/symptom management ... [boxes checked for] ... dyspnea ... skin breakdown ...." Review of an agency document titled "Initial Plan of Care" dated and signed 8/21/2020 by the medical director, director of clinical services,			

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	employee I, employee K, employee J, employee Z, employee O, and employee F failed to evidence any patient or family-specific goals or interventions needed based on the comprehensive assessment dated 8/21/2020. 9. During an interview on 9/25/2020 at 2:20 p.m., employee B (corporate director of compliance) indicated the agency had a systemic problem with plans of care, and interventions and measurable outcomes were not evidenced on all patients' plans of care. 10. Clinical record review for patient #8 was completed on 9/29/2020, with hospice election date of 9/19/20, hospice benefit period 9/19/20 to 12/17/20, and primary diagnosis of Cancer of upper lobe, right bronchus or lung. Review of an agency document signed and dated 9/19/2020 by employee FF, titled "Comprehensive Assessment" stated "... Patient family's goals: POA [family member], wishes for hospice to assist in the care of his sister as her condition continues to progress. His wish is for pain free management of her care and comfort for the pt[patient] Pain/Comfort assessment: verbal scale current: 10 Best: 0 Acceptable: 5 Worst: 10 Pain duration: Intermittent What other symptoms associated with pain? Decreased mobility, increased sleeping, irritability/agitation, decreased appetite. Blood pressure 95/41[normal blood pressure 120/80] Nutritional status current weight: 130 on 9/19/2020 previous weight: 209 12/19/2019 ... Respiratory status Patient uses oxygen 4L per nasal cannula ....Pt becomes SOB with minimal exertion and will quickly desat below 90% [normal range 90-100%]and require 4-5 minutes to get O2 sats back above 90%. Cool/cold extermities[sic] Describe: Pts hands and feet bilaterally were cool to the touch Breath sounds Rhonchi ... Breathing pattern Irregular, Shallow ...Current Respiratory			

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	Medications and Treatments Nebulizer treatments describe: duo nebs PRN Q6h[every 6 hours] , Oxygen saturation less than 88% on room air ... Other pertinent information related to respiratory status: Pt unable to string together more than 4-5 sentences without having to stop and catch her breath. Pt will stop and take a 5-6 breaths and then continue on with the conversation ...." Review of an agency document titled "IDG Update" (updated plan of care) dated and signed 9/23/2020 by the medical director, employee D, employee H, employee J, and employee G, failed to evidence patient or family-specific goals or interventions identified in the comprehensive assessment dated 9/19/2020. 11. Clinical record review for patient #9 was completed on 9/29/20, with hospice election date 5/22/19, hospice benefit period 5/22/19 to 8/19/19 and primary diagnosis of COPD (chronic obstructive pulmonary disease). Review of an agency document signed and dated 5/22/19 by employee X, titled "Comprehensive Assessment" stated " ... Patients family goals: Desires patient to be comfortable ... Patient heavy smoker ... Patients behavior: agitation/restlessness ... Patients Emotions: Anxiety ... Patient on home oxygen nasal cannula 2 liters ... Home safety assessment: No safety problems identified .... " Review of an agency document signed and dated 8/16/2019 by employee O, titled "Nurse Recertification" stated ... "Patient on room air, irregular heart rate 92 [normal 60-100] ... Diminished left and right pedal pulses, pain rating 0/10. Diet general as tolerated, patient decreasing appetite 25% of meals, patient no longer able to feed self. Patient behavior: agitation/restlessness, insomnia, sundowner's syndrome [state of			

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	confusion occurring in the late afternoon and spanning into the night], wandering ... Oriented to person ...Shuffling gait, flapping tremors ... Diarrhea 3-4 times per day with bowel incontinence ...Patient chairbound, nonambulatory ... Nonproductive cough present ... Multiple falls in which she broke her nose. ..." Review of an agency document titled "IDG Update" (updated plan of care) dated and signed 8/17/19 by the medical director, employee Y, employee Z , failed to evidence any patient or family specific goals or interventions identified in the comprehensive assessment dated 8/16/19. 12. Clinical record review for patient #10 was completed on 9/29/20, with hospice election 6/23/2018, hospice benefit period 8/11/20 to 10/9/20 and primary diagnosis of Alzheimer's disease. Review of an agency document signed and dated 6/23/2018 by employee CC, titled "Comprehensive Assessment" stated " ... Patients family goals: Comfortable and pain free passing . ... Patient comfort assessment: Verbal scale current 0/10 ... Patient/Family's view of the origin and meaning of pain : patient is unable to describe pain, able to point to left knee as source of pain with movement ... Pain character, other words used to describe pain, pain to left knee with movement, then stops. Patient unable to describe or rate. Patient is unable to describe character of pain ... Patient wounds DTI [deep tissue injury] left heel, pressure-coccyx ... Patient/Family's goals of hospice: We just want him to be comfortable ...." Review of an agency document titled "IDG Update" (updated plan of care) dated and signed 7/17/19 by the medical director, employee Y, employee Z, failed to evidence any patient or			

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	family-specific goals or interventions identified in the comprehensive assessment dated 7/17/19. 13. Clinical record review for patient #11 was completed on 9/29/20, with hospice election 2/8/2018, hospice benefit period 2/8/18 to 5/8/18, and primary diagnosis of Pancreatic cancer. Review of an agency document signed and dated 2/8/2018 by employee BB (registered nurse), titled "Comprehensive Assessment" stated " ... Pt had a 20lb [pound] weight loss with mental and physical decline noted during respite stay at NH [nursing home] ... Patient/family's current chief complaint: decline ... Patient not eating due to loss of appetite ... Patient/Comfort assessment non-verbal scale: current 2/10 [PAINAD scale 1-10, 10 being most severe pain]. Symptoms associated with the pain: decreased mobility, decreased ADLs(activities of daily living), poor concentration, decreased socialization, increased sleeping, withdrawal, irritability/agitation, decreased appetite ... Respiratory rate 22 [normal rate 12-20 breaths per minute] on room air ... Heart rate 103 ... Blood pressure 150/76 ... Behavior: agitated/restlessness ... Bowel constipation ... Urinary incontinence ...." Clinical record review evidenced an agency document titled "Care Plan" dated 2/8/2018, signed by employee BB (registered nurse), which stated " ... Problem being care planned: Cognitive Loss/Dementia. Goals: Define appropriate support roles for each hospice staff member involved in resident's care. Lay a foundation for reasonable staff and family expectations concerning the resident's capacities and needs. Provide positive/enjoyable experiences for resident that do not involve overly demanding tasks and stress ... Update 1, Patient has Alzheimer's unable to make wants and needs known ... Interventions:			

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	Assist family in coping with loss of functioning in their loved one. Create an environment in which the resident feels valued and respected. Encourage pt to participate in performing ADL's as independently as possible. Review care plan with patient/family/caregiver Review medications to determine interactions and which medications can be discontinued because they are no longer effective ... 2/12/2018 [signed by employee DD (registered nurse)]. Problem description: Pt speech is garbled, unable to communicate wants and needs. Interventions: Assess resident's communication patterns. Assist family in coping with loss of functioning in their loved one. Create an environment in which the resident feels valued and respected. Review care plan with patient/family/caregiver. Encourage resident to participate in performing ADL's as independently as possible ...." Clinical record review evidenced an agency document titled "Initial Plan of Care" signed and dated 2/8/2018 by employee DD, employee BB, employee EE, employee Z, and the hospice medical director. This plan of care failed to evidence the hospice developed an individualized plan of care which included patient or family-specific goals or interventions needed, which were identified during the comprehensive assessment dated 2/8/2018. 14. Clinical record review of patient #12 was completed on 9/29/20, with hospice election date 8/26/2020, hospice benefit period 8/26/20 to 11/23/20 and primary diagnosis of Malignant Neoplasm of Tongue. Review of an agency document signed and dated 8/26/2020 by employee I (registered nurse), titled "Comprehensive Assessment" stated " ... Patient was admitted at .... for suicidal ideation and major			

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	depression. Was also admitted 8/09/2020 for multiple falls. HX [history] of cataracts, glaucoma, hypertensive, anorexia, and AKI [acute kidney injury]. Patient alert and oriented X 1-2, incontinent of bowel and bladder, ambulates with unsteady gaits, verbal, chronic pain to left jaw ... Family is concerned about patient rapid decline in status. Refusing to eat because he wants to starve himself to death ... Patients family goals: Patient to remain at the nursing facility and have a peaceful passing ... Pain/Comfort assessment current: 5 ... acceptable: 4. Pain location: mouth ... Symptoms associated with pain decreased mobility, decreased ADLs, irritability/agitation, decreased appetite, suicide ideation(Notify MD) ... Pain preventing patient from eating ... Patient scheduled opioid Hydrocodone 5-325 mg q [every] 6 hours as needed ... Bowel regimen Colace 100mg by mouth daily as needed ...Patient/family[sic] pain management goals: Maximum pain control with minimal symptoms ... Diet orders pureed with thickened liquids ... Excessive efforts required to maintain dietary intake: Takes nutritional supplements three times a day ... History of a fall within last 6 months: More than 2 falls ... Immediate needs for problem/symptom management: dysphagia, pain ...." Review of an agency document titled "Initial Plan of Care" signed and dated 8/26/2020 by medical director, employee O, employee Z, employee E, employee I, failed to evidence any patient or family specific goals or interventions needed as identified in the comprehensive assessment dated 8/26/2020. Review of an agency document signed and dated 8/26/2020 by employee D (registered nurse), titled "Care Plan" stated, "Problem being care planned:			

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	Pain. Goals: Patient's family will verbalize understanding and comfort with patient's pain management plan and will verbalize confidence in providing pain interventions. Problem description: Patient with chronic pain left jaw. Unable to swallow. On thickened liquid due to oral cancer. Interventions/outcomes: Hospice Nurse will ensure breakthrough pain medication is available. Update 1 Nurse will perform a thorough pain assessment with every nursing visit to determine if pain management is meeting patient's desired goal. RNCM [registered nurse case manager] will review care plan with facility staff. StaFacility [sic] Nurse will administer morphine 0.25ml q 2-3hrs prn for breakthrough pain Hospice nurse will provide narcotic pain medications, start laxatives and stool softeners at the same time as needed for soft, formed, easily passed BM's [bowel movements] at least every 3 days as needed [Update 2 signed and dated 9/2/2020 by employee O (registered nurse)]Problem: Patient continues to have chronic pain to the left jaw. He often refuses medications specifically pain medications. Remains on pureed diet eating mostly Ensure shakes at this time. Interventions: 1. RNCM will assess pain and pain management every visit. 2. RNCM will ensure patient has Morphine 5mg SL [sublingual] q2-3 hours prn available for jaw pain. 3. RNCM and facility staff will encourage patient to take pain medication when offered. 4. Patient will remain on pureed diet sine[sic] he is unable to chew due to pain. Facility staff will ensure that Ensure shakes are available as this is what the patient likes to eat..." Clinical record review of an agency document signed and dated 8/26/2020 by employee O (registered nurse), titled "Care Plan" stated, " ... Problem being care planned: Decline in Activities of Daily Living Goals: Support resident who has			

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	declined in order to lessen the likelihood of complications (I.e., pressure ulcers and contractures) Patient and family will report comfort with and understanding of assistive devices and demonstrate their correct use. Patient's self-care needs will be met. Update 1 Problem description: Patient is alert, oriented. Weak, 2 person assist to transfer. Ambulates unsteadily with walker. Incontinent of bowel and bladder. Requires assistance with most ADLs. Fall risk. Interventions/outcomes: 1. RNCM/DME will provide bed with ½ rail for comfort at night. Standard mattress provided. 2. RNCM/DME will provide the patient a fall mat, walker, and wheelchair as he is a fall risk. 3. RNCM/DME will provide an over the bed table for patient to use for ease of reaching bedside items since he is a fall risk and cannot get up on his own. Update 2 dated 9/2/2020 by employee O Problem description: Patient is alert oriented. Sits in a chair all day, 2 person assist to transfer. Ambulates unsteadily with walker. Interventions/outcomes: 1. RNCM/DME will provide bed with ½ rail for comfort at night. Standard mattress provided. 2. RNCM/DME will provide the patient a fall mat, walker, and wheelchair as he is a fall risk. 3. RNCM/DME will provide a over the bed table for patient to use for ease of reaching bedside items since he is a fall risk and cannot get up on his own..." Review of an agency document titled "IDG Update" (updated plan of care) dated and signed 9/9/2020 by the medical director, employee D, employee E, employee F, employee AA, and employee Z, failed to evidence any patient or family-specific goals or interventions needed as identified in the comprehensive assessment dated 9/9/2020.			

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	15. Clinical record review for patient #13 was completed on 9/29/2020, with hospice election date of 1/29/18, hospice benefit period 1/29/18 to 4/28/18, and primary diagnosis of Lung Cancer. Review of an agency document signed and dated 1/29/18 by employee BB (registered nurse), titled "Comprehensive Assessment" stated "... Pt has had notable wt [weight] loss, generalized weakness, generalized pain and needs assist for ADLs. Cachexic in appearance. OU [both eyes] sunken and dark. Ribs structure visible. Treatment no longer effective ... Pt went to SLMH d/t multiple discharge of defibrillator on 1/28/18 and 3 wks [weeks], prior for same issue ....Patient/family's current chief complaint: pain. Describe patient/family's goals: be comfortable ... Current treatments of pain: dilaudid, oxycontin, norco ... Temporal temperature: 97.7 [temporal normal range 97.4 -100.1°F] ...Respiratory rate: 20 ... Diet orders: general as tolerated, anorexia/not eating, describe: unable to tolerate, evidence of chachexia, describe: skeletal system visible ...Behavior agitation/restlessness. Consciousness alert ... Oriented to person, place, time. Emotions anxiety, cooperative ... Muscle tone muscle wasting ... Gastrointestinal status: constipation, nausea/vomiting Describe: thick grey phlegm ... Integumentary status skin, swollen lymph glands describe: L axillary ... Mobility has a gait and/or balance problem ... Comorbidities: cancer, angina ... Immediate needs for problem/symptom management anxiety/agitation, constipation, pain ...." Review of an agency document titled "IDG Update" (updated plan of care) dated and signed 1/31/2018 by the medical director, employee BB, employee E, employee G, failed to evidence any patient and family specific goals or interventions needed as identified by the skilled nurse in the			

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	comprehensive assessment dated 1/29/2018. 16. Clinical record review of patient #14 was completed on 9/29/20, with hospice election date 2/8/2020, hospice benefit period 2/8/20 to 5/7/20, and primary diagnosis of Chronic obstructive pulmonary disease. Review of an agency document signed and dated 2/8/2020 by employee A (registered nurse), titled "Comprehensive Assessment" stated " ... Patient illness respiratory distress ... Patient family goal: to keep patient comfortable ... Patient/Comfort assessment verbal scale current 5/10, acceptable 3/10 ... Symptoms related to pain: decreased mobility, decreased ADLs, increased sleeping, decreased appetite ... Patient on scheduled opioid ... Bowel regimen medication Bisacodyl ... Respirations 24 per minute ... Patient on oxygen 15 liters nasal cannula ...Diet general as tolerated ... Genitourinary status: decreasing urine output, oliguria (less than 400ml/24hrs) ... Patient had stage 1 wound to left buttock with ecchymosis. Immediate needs for problem/symptom management: decline in ADL/self care deficit, dyspnea, skin breakdown ... Breathing pattern irregular, labored(use of accessory muscles)...." Review of an agency document titled "Initial Plan of Care" signed and dated 2/9/2020 by medical director, employee A, employee E, and employee G, failed to evidence individualized written plan of care that reflects patient and family goals and interventions based on the problems identified in the initial, comprehensive, and updated comprehensive assessments dated 2/8/2020.			
L 0548 Bldg. 00	418.56(c)(3) CONTENT OF PLAN OF CARE [The plan of care must include all services necessary for the palliation and management			

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	of the terminal illness and related conditions, including the following:] (3) Measurable outcomes anticipated from implementing and coordinating the plan of care. Based on record review and interview, the hospice failed to ensure it developed individualized plans of care which included measurable outcomes for 14 of 14 clinical records reviewed (#1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, and 14). Findings include: 1. Review of an agency policy last updated 01/2014, titled "Patient Plan of Care" stated "... The Plan of Care will include ... Measurable outcomes anticipated from implementing and coordinating the plan of care ...." 2. Clinical record review for patient #1 was completed on 9/29/2020, with hospice election date of 8/26/2020, benefit period 8/26 - 11/23/2020, and primary diagnosis of Parkinson's disease. The clinical record evidenced a document titled "Initial Plan of Care" dated and signed 8/26/2020, by the medical director, the director of clinical services (employee D), employee A, employee E (social worker), and employee F (spiritual counselor). This plan of care failed to evidence documentation of any measurable outcomes. 3. Clinical record review for patient #2 was completed on 9/29/2020, with hospice election date of 9/15/2020, benefit period 9/15 - 12/13/2020, and primary diagnosis of Ovarian Cancer. Record review evidenced a document titled "Initial Plan of Care" dated and signed 9/15/2020 by the medical director, the director of clinical services, employee A, employee E, and employee F. This plan of care failed to evidence documentation of any	L 0548	**CMS Tag L548 Hospice-CoP Standard: 418.56 (c)(3) Content of the Plan of Care** **Findings:** The hospice failed to ensure it developed individualized plans of care which included measurable outcomes for 14 of 14 clinical records reviewed. **Plan to correct specific deficiency cited:** · The Director of Clinical Services and Interdisciplinary Group will review the current patient caseload on 11/18/2020 to ensure that each patient's individualized plan of care includes measurable outcomes per agency's Patient Plan of Care, Initial Hospice Assessment, and Ongoing Assessment Policies. · Note that the agency's process for documenting the plan of care and updates is through the Plan of Care documentation, which is an addendum to the Initial Plan of Care. This process was in place at the time of the survey. Effective 11/18/2020, the agency will reference the Plan of Care document on the Initial Plan of Care, and the individualized Plan of Care and measurable outcomes	11/20/2020

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	measurable outcomes. 4. Clinical record review for patient #3 was completed on 9/29/2020, with hospice election date of 5/21/2020, benefit period 5/21 - 8/18/2020, and primary diagnosis of Severe Caloric Malnutrition. Record review evidenced a document titled "Initial Plan of Care" dated and signed 5/21/2020 by the medical director, employee A, employee G (spiritual counselor), and employee E. This plan of care failed to evidence documentation of any measurable outcomes. 5. Clinical record review for patient #4 was completed on 9/29/2020, with hospice election date of 2/26/2019, benefit period 8/19 - 10/17/2020, and primary diagnosis of Cerebral Vascular Accident [CVA- stroke]. Record review evidenced a document titled "IDG [interdisciplinary group] Update" (updated plan of care) dated and signed 8/12/2020 by the medical director, director of clinical services, employee I (registered nurse), employee F, employee J (social worker), employee K (volunteer coordinator), and employee Z (bereavement coordinator). This updated plan of care failed to evidence documentation of any measurable outcomes. 6. Clinical record review for patient #5 was completed on 9/29/2020, with hospice election date of 2/3/2020, benefit period 2/3 - 5/2/2020, and primary diagnosis of COPD (chronic obstructive pulmonary/lung disease). Record review evidenced a document titled "Initial Plan of Care" dated and signed 2/4/2020 by the medical director, director of clinical services, employee M (registered nurse), employee J, employee G, employee K, and employee Z. This plan of care failed to evidence documentation of any measurable outcomes.		will be established based on the comprehensive assessment and updated as appropriate to reflect changes in the patient's status and are reflective of the patient/family's needs and goals. **Measures/Systematic Changes that will be put into place to ensure that the deficiency does not recur:** · The Director of Clinical Services will educate RN case managers and IDG team members by 11/18/2020 regarding the Plan of Care Policy and the requirement for the patient's individualized care plan which includes measurable outcomes that are specific, measurable and time framed and reflective of the patient/family needs and goals. · Evidence of training will be noted in attendance logs. The Director of Clinical Services will review in-service attendance logs to ensure all staff receive this training. · This training will be incorporated into the agency's annual in-services by 1/30/21 and the new-employee orientation by 11/20/2020. · The Director of Clinical Services and Interdisciplinary Group will review each patient's record presented during each IDG to ensure that the individualized patient's care plan contains	

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UNITY HOSPICE OF NORTHWEST INDIANA LLC	3313 EAST 83RD PLACE MERRILLVILLE, IN 46410

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	7. Clinical record review for patient #6 was completed on 9/29/2020, with hospice election date of 6/1/2018, benefit period 7/20 - 9/17/2020, and primary diagnosis of Muscular Dystrophy. Record review evidenced a document titled "IDG Update" (updated plan of care) dated and signed 9/9/2020 by the medical director, employee N (physician designee), director of clinical services, employee E, and employee G. This updated plan of care failed to evidence documentation of any measurable outcomes. 8. Clinical record review for patient #7 was completed on 9/29/2020, with hospice election date of 8/21/2020, benefit period 8/21 - 11/18/2020, and primary diagnosis of Multiple Sclerosis. Record review evidenced a document titled "Initial Plan of Care" dated and signed 8/21/2020 by the medical director, director of clinical services, employee I, employee K, employee J, employee Z, employee O, and employee F. This plan of care failed to evidence documentation of any measurable outcomes. 9. During an interview on 9/25/2020 at 2:20 p.m., when asked if the plans of care were individualized with patient specific interventions, goals, and outcomes, employee B (corporate director of compliance), indicated the agency had a systemic problem with plans of care, and interventions and measurable outcomes were not evidenced on all patients' plans of care reviewed.10. Clinical record review for patient #8 was completed on 9/29/2020, with hospice election date of 9/19/20, benefit period 9/19/20 to 12/17/20, and primary diagnosis of Cancer of upper lobe, right bronchus or lung. Review of an agency document titled "IDG Update" (updated plan of care) dated and signed 9/23/20 by the medical		measurable outcomes that are specific and time framed, and reflective of the patient/family needs and goals. **How the agency will monitor its quality assessment/performance improvement functions to ensure that the corrective measure or systemic change is sustained:** · The Director of Clinical Services or designee will ensure 100% of all clinical charts are audited to ensure that the individualized patient's care plan contains measurable outcomes that are specific and time framed, and reflective of the patient/family needs and goals for 4 weeks starting 11/18/2020. The threshold for compliance is 100%. · Once the initial threshold is met, the Director of Clinical Services or designee will conduct a clinical record review of 10% of active patient records monthly to ensure evidence of timely plan of care updates. The threshold for compliance is 100% for three months. · If the threshold for compliance is not met the Director of Clinical Services will continue to conduct clinical record reviews and provide continuing education to individual employees, counseling, and disciplinary action in accordance with agency policy if needed.	

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	director, employee D, employee J, employee H, employee G, failed to evidence documentation of any measurable outcomes. 11. Clinical record review for patient #9 was completed on 9/29/20, with hospice election date 5/22/2019, hospice benefit period 5/22/19 to 8/19/19 and primary diagnosis of COPD (chronic obstructive pulmonary disease). Review of an agency document titled "IDG Update" (updated plan of care) dated and signed 9/11/2019 by employee J, employee O, employee Z, and employee AA failed to evidence documentation of any measurable outcomes. 12. Clinical record review for patient #10 was completed on 9/29/20, with hospice election date 6/23/2018, hospice benefit period 8/11/20 to 10/9/20, and primary diagnosis of Alzheimer's disease. Review of a document titled "IDG Update" (updated plan of care) dated and signed 7/29/2020 by the medical director, employee E, employee L, employee Z, and employee AA failed to evidence documentation of any measurable outcomes. 13. Clinical record review for patient #11 was completed on 9/29/20, with hospice election date 2/8/2018, hospice benefit period 2/8/18 to 5/8/18, and primary diagnosis of Pancreatic cancer. Review of an agency document titled "IDG Update" (updated plan of care) dated and signed 2/14/2018 by the medical director, employee EE, employee FF, employee Z, and employee DD, failed to evidence documentation of any measurable outcomes. 14. Clinical record review of patient #12 was completed on 9/29/20, with hospice election date 8/26/2020, hospice benefit period 8/26/20 to		· Once the threshold is met this review item will be incorporated into the agency's quarterly clinical record review; a minimum of 10% of all live charts will be audited quarterly. · Results of the above audits and analysis of trends will be included in the agency's Quarterly Quality review data and reported to the Administrator and Governing Body. **Person Responsible:** Administrator **Completion Date:** November 20, 2020	

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	11/23/20, and primary diagnosis of Malignant Neoplasm of Tongue. Review of an agency document titled "IDG Update" (updated plan of care) dated and signed 9/9/2020 by the medical director, employee GG, employee D, employee O, employee E, failed to evidence documentation of any measurable outcomes. 15. Clinical record review for patient #13 was completed on 9/29/2020, with hospice election date of 1/29/18, hospice benefit period 1/29/18 to 4/28/18, and primary diagnosis of Lung Cancer. Review of an agency document titled "IDG Update" (updated plan of care) dated and signed 3/9/2018 by the medical director, employee E, employee G, and employee BB, failed to evidence documentation of any measurable outcomes. 16. Clinical record review of patient #14 was completed on 9/29/20, with hospice election date 2/8/2020, hospice benefit period 2/8/20 to 5/7/20, and primary diagnosis of Chronic obstructive pulmonary disease. Review of an agency document titled "IDG Update" (updated plan of care) dated and signed 2/12/2020 by the medical director, employee Z, employee E, and employee G failed to evidence documentation of any measurable outcomes.			
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 hospice failed to ensure it developed individualized plans of care which included drugs and treatment	L 0549	**CMS Tag L549 Hospice-CoP Standard: 418.56 (c)(4) Content of the Plan of Care**	11/20/2020

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	necessary to meet the needs of the patients for 14 of 14 clinical records reviewed (#1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, and 14). The findings include: 1. Review of an agency policy last updated 01/2014, titled "Patient Plan of Care" stated "... The Plan of Care will include ... Drugs and treatment necessary to meet the needs of the patient ...." 2. Clinical record review for patient #1, was completed on 9/29/2020, with hospice election date of 8/26/2020, benefit period 8/26 - 11/23/2020, and primary diagnosis of Parkinson's disease. Record review evidenced a document dated and signed on 8/26/2020, by employee A (registered nurse), titled "Comprehensive Assessment". This document stated "... patient/family's current chief complaint: Assistance with ADLs [activities of daily living such as personal care/hygiene assistance], comfort and mobility ... offer soft foods, add thicket [powder used to thicken liquids for patients that have difficulty swallowing]... necrotic [dead skin/cells] area left foot 2nd toe ... Severe PVD [peripheral vascular disease] and increase pain to lower extremities restricts mobility ... difficulty swallowing, at risk for aspiration pneumonia, new onset of incontinency ... immediate needs for problem/symptom management ... communication ... decline in ADLs ... dysphagia [difficulty swallowing] ... edema ... falls/safety ... nutrition ...." Review of an agency document titled "Initial Plan of Care" dated and signed 8/26/2020, by the medical director, employee D (director of clinical services), employee A, employee E (social worker), and employee F (spiritual counselor)		**Findings:** The hospice failed to ensure it developed individualized plans of care which included drugs and treatments necessary to meet the needs of the patients for 14 of 14 clinical records reviewed. · The Director of Clinical Services and Interdisciplinary Group will review the current patient caseload on 11/18/2020 to ensure that each patient's individualized plan of care includes a current medication list and all treatments necessary to meet the needs of the patient per agency's Patient Plan of Care Policy. · Note that the agency's process for documenting the plan of care and updates is through the Plan of Care documentation, which is an addendum to the Initial Plan of Care. This process was in place at the time of the survey. Effective 11/18/2020, the agency will reference the Plan of Care document on the Initial Plan of Care, and the individualized Plan of Care, including the current medications/drug regimen and treatments will be established based on the comprehensive assessment and updated as appropriate to reflect the patient's status and are reflective of the patient/family's needs. **Measures/Systematic Changes that will be put into place to**	

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	failed to evidence documentation of current drug regimen, or treatment(s) necessary to meet the needs of the patient, such as specialized dietary requirements, wound care, pain or skin management/treatments as identified by the skilled nurse on the comprehensive assessment dated 8/26/2020. 3. Clinical record review for patient #2 was completed on 9/29/2020, with hospice election date of 9/15/2020, benefit period 9/15 - 12/13/2020, and primary diagnosis of Ovarian Cancer. Record review evidenced an agency document dated and signed on 9/15/2020 by employee A titled "Comprehensive Assessment" This document stated "... patient/family's current chief complaint: Family wishes for patient to be comfortable during the disease process ... pain rating ... verbal ... 10 [with 0 being no pain and 10 being worst pain] ... respirations per minute ... 24 [normal rate is 16-20] ... only consumes bites of meals daily ... pain is not well managed with current POC [plan of care] ... immediate needs for problem/symptom management ... [boxes checked for] ... decline in ADL/self care ... diarrhea ... edema ... falls/safety ... nutrition ... pain ... skin breakdown ...." Review of an agency document titled "Initial Plan of Care" dated and signed 9/15/2020 by the medical director, employee D, employee A, employee E, and employee F, failed to evidence documentation of current drug regimen, or treatment(s) necessary to meet the needs of the patient, such as treatments for pain, dietary requirements, diarrhea, or skin management/treatments as identified on the comprehensive assessment dated 9/15/2020. 4. Clinical record review for patient #3 was		**ensure that the deficiency does not recur:** · The Director of Clinical Services will educate RN case managers and IDG team members by 11/18/2020 regarding the Plan of Care Policy and the requirement for the patient's individualized care plan which includes a current drug regimen and treatments based on the comprehensive assessment and updated as appropriate to reflect the patient's status and that are reflective of the patient/family needs. Examples of specific treatments include, but are not limited to wounds, oxygen, specialized drug treatments for pain/symptom management, fall precautions, catheters, ventilation orders, and specialized dietary requirements. · The Director of Clinical Services will educate RN case managers on the requirement to conduct medication reconciliation and review during each visit to ensure the patient record contains a current drug regimen in accordance with physician orders and the plan of care. · Evidence of training will be noted in attendance logs. The Director of Clinical Services will review in-service attendance logs to ensure all staff receive this training. · This training will be incorporated into the agency's	

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	completed on 9/29/2020, with hospice election date of 5/21/2020, benefit period 5/21 - 8/18/2020, and primary diagnosis of Severe Caloric Malnutrition. Record review evidenced an agency document dated and signed on 5/21/2020 by employee A, titled "Comprehensive Assessment" This document stated "... patient/family's current chief complaint: pain ..... pain rating ... verbal ... 9 ... enteral [feeding through an artificial opening] feedings ... evidence of malnutrition ... feedings of Osmolite 1.4 daily ... wound ... pressure ulcer Stage III [3] right gluteal fold ... surgical incision wound right posterior thigh ... surgical wound right anterior thigh ... Fall risk ... High risk ... immediate needs for problem/symptom management ... [boxes checked for] ... anxiety/agitation ... decline in ADL/self care ... pain ... skin breakdown ...." Review of an agency document titled "Initial Plan of Care" dated and signed 5/21/2020 by the medical director, employee A, employee G (spiritual counselor), and employee E, failed to evidence documentation of current drug regimen, or treatment(s) necessary to meet the needs of the patient, such as specialized dietary requirements or wound care as identified by the skilled nurse on the comprehensive assessment dated 5/21/2020. 5. Clinical record review for patient #4 was completed on 9/29/2020, with hospice election date of 2/26/2019, benefit period 8/19 - 10/17/2020, and primary diagnosis of Cerebral Vascular Accident [CVA- stroke]. Record review evidenced an agency document dated and signed on 8/10/2020 by employee H (registered nurse), titled "Nurse Recertification" This document stated "... GT [gastrointestinal tube for nutrition] feeding of Osmolite 1.2 at 65ml/hr [milliliters per hour] x 15 hrs [hours] ... paralysis ... dysphagia ...		annual in-services by 1/30/21 and the new-employee orientation by 11/20/2020. · The Director of Clinical Services and Interdisciplinary Group will review each patient's record presented during each IDG to ensure that the individualized patient's care plan includes a current drug regimen and treatments based on the comprehensive assessment and updated as appropriate to reflect the patient's status and that are reflective of the patient/family needs. **How the agency will monitor its quality assessment/performance improvement functions to ensure that the corrective measure or systemic change is sustained:** · The Director of Clinical Services or designee will ensure 100% of all clinical charts are audited to ensure individualized patient's care plan includes a current drug regimen and treatments based on the comprehensive assessment and updated as appropriate to reflect the patient's status and that are reflective of the patient/family needs and that medication review and reconciliation is performed each visit for 4 weeks starting 11/18/2020. The threshold for compliance is 100%. · Once the initial threshold is	

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	seizures ... pressure ulcer risk assessment ... total score 18 [high risk] ... nebulizer treatments ... increased oral secretions ... suction prn [as needed] ... fall risk assessment ... high risk ...." Review of an agency document titled "IDG [interdisciplinary group] Update" (updated plan of care) dated and signed 8/12/2020 by the medical director, employee D, employee I (registered nurse), employee F, employee J (social worker), employee K (volunteer coordinator), and employee Z (bereavement coordinator), failed to evidence documentation of current drug regimen, or treatment(s) necessary to meet the needs of the patient, such as specialized dietary requirements, wound care, or respiratory treatments as identified by the skilled nurse on the comprehensive assessment dated 8/10/2020. 6. Clinical record review for patient #5 was completed on 9/29/2020, with hospice election date of 2/3/2020, benefit period 2/3 - 5/2/2020, and primary diagnosis of COPD (chronic obstructive pulmonary/lung disease). Record review evidenced an agency document dated and signed on 2/3/2020 by employee L (registered nurse), titled "Comprehensive Assessment" This document stated "... patient/family's current chief complaint: dyspnea [difficulty breathing], coccyx [tailbone area] wound ... risk of aspiration per hospital records, patient choosing not to downgrade diet ... wound ... Stage II [2] coccyx wound [pressure ulcer] ... patient uses oxygen ... nebulizer [breathing] treatments ... immediate needs for problem/symptom management ... [boxes checked for] ... dyspnea ... skin breakdown ...." Review of an agency document titled "Initial Plan of Care" dated and signed 2/4/2020 by the medical		met, the Director of Clinical Services or designee will conduct a clinical record review of 10% of active patient records monthly to ensure evidence of timely plan of care updates. The threshold for compliance is 100% for three months. · If the threshold for compliance is not met the Director of Clinical Services will continue to conduct clinical record reviews and provide continuing education to individual employees, counseling, and disciplinary action in accordance with agency policy if needed. · Once the threshold is met this review item will be incorporated into the agency's quarterly clinical record review; a minimum of 10% of all live charts will be audited quarterly. · Results of the above audits and analysis of trends will be included in the agency's Quarterly Quality review data and reported to the Administrator and Governing Body. **Person Responsible:** Administrator **Completion Date:** November 20, 2020	

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	director, employee D, employee M (registered nurse), employee J, employee G, employee K, and employee Z, failed to evidence documentation of current drug regimen, or treatment(s) necessary to meet the needs of the patient, such as specialized dietary requirements due to risk of aspiration, wound care, or respiratory treatments as identified by the skilled nurse on the comprehensive assessment dated 2/3/2020. 7. Clinical record review for patient #6 was completed on 9/29/2020 with hospice election date of 6/1/2018, benefit period 7/20 - 9/17/2020, and primary diagnosis of Muscular Dystrophy evidenced a document dated and signed on 9/8/2020 by the director of clinical services titled "Nurse Recertification" stated "... Oxygen liters per minute: 3 ... unable to tolerate oral diet ... enteral feedings ... sunken temples, sunken cheeks, protruding clavicles [collar bones] and scapula [shoulder blades], exposed hip bones ... constipation ... suprapubic catheter [surgically inserted drain tube for urine] ... changed monthly by patient's mother ... Stage II pressure ulcer to right buttock ... oxygen per: trach collar [tracheostomy] ... ventilator support to breathe ... suction ... significant fecal retention ... breathing is more shallow despite ventilator support ...." Review of a document titled "IDG [interdisciplinary group] Update" (updated plan of care) dated and signed 9/9/2020 by the medical director, employee N (physician designee), director of clinical services, employee E, and employee G, failed to evidence documentation of current drug regimen, or treatment(s) necessary to meet the needs of the patient such as enteral feedings, oxygen, wound, catheter, or ventilator orders based on the comprehensive re-assessment dated 9/8/2020.			

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	8. Clinical record review for patient #7 was completed on 9/29/2020, with hospice election date of 8/21/2020, benefit period 8/21 - 11/18/2020, and primary diagnosis of Multiple Sclerosis. Record review of an agency document dated and signed on 8/21/2020 by employee O (registered nurse), titled "Comprehensive Assessment" stated "... patient/family's current chief complaint: 'I need help taking care of him [patient's caregiver]' ... enteral feedings ... patient cannot feed himself ... excessive efforts required to maintain dietary intake ... patient is on Isosource 1.5 1 can 4x day ... paralysis ... tremors ... muscle cramps ... texas catheter [condom type catheter for urinary drainage] ... wounds ... DtI [deep tissue injury] to right plantar [bottom] aspect of foot ... left foot DTI patient uses oxygen ... trach collar ... suction ... tracheostomy ... Fall risk ... High risk ... immediate needs for problem/symptom management ... [boxes checked for] ... dyspnea ... skin breakdown ...." Review of an agency document titled "Initial Plan of Care" dated and signed 8/21/2020 by the medical director, employee D, employee I, employee K, employee J, employee Z, employee O, and employee F failed to evidence documentation of current drug regimen, or treatment(s) necessary to meet the needs of the patient, such as specialized dietary requirements, wound care, tracheostomy treatment/care, or respiratory treatments, as identified by the skilled nurse on the comprehensive assessment dated 8/21/2020. 9. During an interview on 9/25/2020 at 2:20 p.m., when queried if the plans of care were individualized with patient specific interventions, goals, and outcomes, employee B (corporate			

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	director of compliance) indicated the agency had a systemic problem with plans of care, and interventions and measurable outcomes were not evidenced on all patients' plans of care reviewed.10. Clinical record review for patient #8 was completed on 9/29/2020, with hospice election date of 9/19/20, hospice benefit period 9/19/20 to 12/17/20, and primary diagnosis of Cancer of upper lobe, right bronchus or lung. Review of an agency document signed and dated 9/19/2020 by employee FF, titled "Comprehensive Assessment" stated "... Patient family's goals: POA [family member name], wishes for hospice to assist in the care of his sister as her condition continues to progress. His wish is for pain free management of her care and comfort for the pt [patient] Pain/Comfort assessment: verbal scale current: 10 Best: 0 Acceptable: 5 Worst: 10 Pain duration: Intermittent What other symptoms associated with pain? Decreased mobility, increased sleeping, irritability/agitation, decreased appetite. Blood pressure 95/41 [normal blood pressure120/80] Nutritional status current weight: 130 on 9/19/2020 previous weight: 209 12/19/2019 ... Respiratory status Patient uses oxygen 4L per nasal cannula ....Pt becomes SOB with minimal exertion and will quickly desat below 90% [normal range 90-100%] and require 4-5 minutes to get O2 sats back above 90%. Cool/cold extermities[sic] Describe: Pts hands and feet bilaterally were cool to the touch Breath sounds Rhonchi ... Breathing pattern Irregular, Shallow ...Current Respiratory Medications and Treatments Nebulizer treatments describe: duo nebs PRN Q6h [every 6 hours], Oxygen saturation less than 88% on room air ... Other pertinent information related to respiratory status: Pt unable to string together more than 4-5 sentences without having to stop and catch her breath. Pt will stop and take a 5-6 breaths and then continue on with the conversation ...."			

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	Clinical record review evidenced an agency document titled "Initial Plan of Care" signed and dated 9/19/2020 by the medical director, employee D, employee H, employee J, and employee F. This plan of care failed to evidence documentation of current drug regimen, or treatment(s) necessary to meet the needs of the patient; such as specialized drug treatments for pain, fall precautions or respiratory treatments. 11. Clinical record review for patient #9 was completed on 9/29/20, with hospice election date 5/22/19, hospice benefit period 5/22/19 to 8/19/19 and primary diagnosis of COPD (chronic obstructive pulmonary disease). Review of an agency document signed and dated 5/22/2019 by employee X (registered nurse), titled "Comprehensive Assessment" stated " ... Patients family goals: Desires patient to be comfortable ... Patient heavy smoker ... Patients behavior: agitation/restlessness ... Patients Emotions: Anxiety ... Patient on home oxygen nasal cannula 2 liters ... Home safety assessment: No safety problems identified . ..." Review of an agency document signed and dated 8/16/2019 by employee O (registered nurse), titled "Nurse Recertification" failed to evidence documentation of current drug regimen, or treatment(s) necessary to meet the needs of the patient such as specialized dietary requirements, wound care, fall precautions or respiratory treatments. Clinical record review evidenced an agency document titled "Initial Plan of Care" signed and dated 5/22/2019 by the medical director, employee E, employee X, employee BB, employee Z, employee AA. This plan of care failed to evidence			

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	documentation of current drug regimen, or treatment(s) necessary to meet the needs of the patient; such as fall precautions or respiratory treatments. 12. Clinical record review for patient #10 was completed on 9/29/20, with hospice election 6/23/2018, hospice benefit period 8/11/20 to 10/9/20, and primary diagnosis of Alzheimer's disease. Review of an agency document signed and dated 6/23/2018 by employee CC (registered nurse), titled "Comprehensive Assessment" stated " ... Patients family goals: Comfortable and pain free passing ... Patient comfort assessment: Verbal scale current 0/10 ... Patient/Family's view of the origin and meaning of pain : patient is unable to describe pain, able to point to left knee as source of pain with movement ...Pain character, other words used to describe pain, pain to left knee with movement, then stops. Patient unable to describe or rate. Patient is unable to describe character of pain ... Patient wounds DTI (deep tissue injury) left heel, pressure-coccyx ...Patient/Family's goals of hospice: We just want him to be comfortable..." There was no evidence of a document for the initial plan of care, or concurrent plans of care for this patient. 13. Clinical record review for patient #11 was completed on 9/29/20, with hospice election 2/8/2018, hospice benefit period 2/8/18 to 5/8/18 and primary diagnosis of Pancreatic cancer. Review of an agency document signed and dated 2/8/2018 by employee BB (registered nurse), titled "Comprehensive Assessment" stated " ... Pt had a 20lb weight loss with mental and physical decline noted during respite stay at NH [nursing home] ...			

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	Patient/family's current chief complaint: decline ... Patient not eating due to loss of appetite ... Patient/Comfort assessment non-verbal scale: current 2/10. Symptoms associated with the pain: decreased mobility, decreased ADLs(activities of daily living), poor concentration, decreased socialization, increased sleeping, withdrawal, irritability/agitation, decreased appetite ... Respiratory rate 22 on room air ...Heart rate 103... Blood pressure 150/76 ... Behavior: agitated/restlessness ... Bowel constipation ... Urinary incontinence ...." Clinical record review evidenced an agency document titled "Initial Plan of Care" signed and dated 2/8/2018 by the medical director, employee DD, employee EE, and employee Z. This plan of care failed to evidence documentation of current drug regimen, or treatment(s) necessary to meet the needs of the patient; such as specialized dietary requirements, fall precautions or respiratory treatments. 14. Clinical record review of patient #12 was completed on 9/29/20, with hospice election date 8/26/2020, hospice benefit period 8/26/20 to 11/23/20, and primary diagnosis of Malignant Neoplasm of Tongue. Review of an agency document signed and dated 8/26/2020 by employee I (registered nurse), titled "Comprehensive Assessment" stated " ... Patient was admitted at ... for suicidal ideation and major depression. Was also admitted 8/09/2020 for multiple falls. HX of cataracts, glaucoma, hypertensive, anorexia, and AKI [acute kidney injury]. Patient alert and oriented X 1-2, incontinent of bowel and bladder, ambulates with unsteady gaits, verbal, chronic pain to left jaw ... Family is concerned about patient rapid decline in status. Refusing to eat because he wants to starve			

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	himself to death ... Patients family goals: Patient to remain at the nursing facility and have a peaceful passing ... Pain/Comfort assessment current: 5 ... acceptable: 4. Pain location: mouth ... Symptoms associated with pain decreased mobility, decreased ADLs, irritability/agitation, decreased appetite, suicide ideation(Notify MD) ... Pain preventing patient from eating ... Patient scheduled opioid Hydrocodone 5-325 mg q 6 hours as needed ... Bowel regimen Colace 100mg by mouth daily as needed ... Patient/family pain management goals: Maximum pain control with minimal symptoms ... Diet orders pureed with thickened liquids ... Excessive efforts required to maintain dietary intake: Takes nutritional supplements three times a day ... History of a fall within last 6 months: More than 2 falls ... Immediate needs for problem/symptom management: dysphagia, pain . ..." Review of an agency document titled "Initial Plan of Care" signed and dated 8/26/2020 by medical director, employee O, employee Z, employee E, employee I, failed to evidence documentation of current drug regimen, or treatment(s) necessary to meet the needs of the patient such as specialized dietary requirements, wound care, or fall precautions as identified on the comprehensive assessment dated 8/26/2020. Review of a document titled "IDG Update" (updated plan of care) dated and signed 9/9/2020 by the medical director, employee D, employee E, employee F, employee AA, employee Z, failed to evidence any patient or family-specific care, treatment(s), or services identified in the comprehensive assessment dated 9/9/2020. 15. Clinical record review for patient #13 was completed on 9/29/2020, with hospice election			

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	date of 1/29/18, hospice benefit period 1/29/18 to 4/28/18, and primary diagnosis of Lung Cancer. Review of an agency document signed and dated 1/29/18 by employee BB (registered nurse), titled "Comprehensive Assessment" stated "... Pt[patient] has had notable wt[weight] loss, generalized weakness, generalized pain and needs assist for ADLs. Cachexic in appearance. OU [both eyes] sunken and dark. Ribs structure visible. Treatment no longer effective ... Pt went to SLMH [hospital] d/t [due to] multiple discharge of defibrillator on 1/28/18 and 3 wks [weeks], prior for same issue ....Patient/family's current chief complaint: pain. Describe patient/family's goals: be comfortable ... Current treatments of pain: dilaudid, oxycontin, norco ... Temporal temperature: 97.7 ...Respiratory rate: 20 ... Diet orders: general as tolerated, anorexia/not eating, describe: unable to tolerate, evidence of chachexia, describe: skeletal system visible ...Behavior agitation/restlessness. Consciousness alert ... Oriented to person, place, time. Emotions anxiety, cooperative ... Muscle tone muscle wasting ... Gastrointestinal status: constipation, nausea/vomiting Describe: thick grey phlegm ... Integumentary status skin, swollen lymph glands describe: L [left] axillary ... Mobility has a gait and/or balance problem ... Comorbidities: cancer, angina ... Immediate needs for problem/symptom management anxiety/agitation, constipation, pain ...." Review of a document titled "Initial Plan of Care" signed and dated 1/29/2018 by medical director, employee BB, employee E, and employee G failed to evidence documentation of current drug regimen, or treatment(s) necessary to meet the needs of the patient such as specialized dietary requirements, bowel regimen or fall precautions as identified on the comprehensive assessment			

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	dated 1/29/18. Review of an agency document titled "IDG Update" (updated plan of care) dated and signed 1/31/2018 by the medical director, employee BB, employee E, employee G, failed to evidence any patient or family-specific care, treatment(s), or services identified in the comprehensive assessment dated 1/29/18. 16. Clinical record review of patient #14 was completed on 9/29/20, with hospice election date 2/8/2020, hospice benefit period from 2/8/20 to 5/7/20, and primary diagnosis of Chronic obstructive pulmonary disease. Review of an agency document signed and dated 2/8/2020 by employee A (registered nurse), titled "Comprehensive Assessment" stated " ... Patient illness respiratory distress ... Patient family goal: to keep patient comfortable ... Patient/Comfort assessment verbal scale current 5/10, acceptable 3/10 ... Symptoms related to pain: decreased mobility, decreased ADLs, increased sleeping, decreased appetite ... Patient on scheduled opioid ... Bowel regimen medication Bisacodyl ... Respirations 24 per minute ... Patient on oxygen 15 liters nasal cannula ... Diet general as tolerated ... Genitourinary status: decreasing urine output, oliguria (less than 400ml/24hrs) ... Patient had stage 1 wound to left buttock with ecchymosis. Immediate needs for problem/symptom management: decline in ADL/self care deficit, dyspnea, skin breakdown ... Breathing pattern irregular, labored(use of accessory muscles) ...." Review of an agency document titled "Initial Plan of Care" signed and dated 2/9/2020 by medical director, employee A, employee E, employee G			

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	failed to evidence documentation of current drug regimen, or treatment(s) necessary to meet the needs of the patient; such as specialized dietary requirements, fall precautions or respiratory treatments as identified on the comprehensive assessment dated 2/8/2020.			
L 0550 Bldg. 00	418.56(c)(5) CONTENT OF PLAN OF CARE [The plan of care must include all services necessary for the palliation and management of the terminal illness and related conditions, including the following:] (5) Medical supplies and appliances necessary to meet the needs of the patient. Based on observation, record review and interview, the hospice failed to ensure it developed individualized plans of care, which included medical supplies and appliances necessary to meet the needs of the patients for 13 of 14 clinical records reviewed (#1, 2, 3, 4, 5, 6, 7, 8, 9, 11, 12, 13, and 14). Findings include: 1. Review of an agency policy last updated 01/2014, titled "Patient Plan of Care" stated "... The Plan of Care will include ... Medical supplies and appliances necessary to meet the needs of the patient ...." 2. Clinical record review for patient #1 was completed on 9/29/2020, with hospice election date of 8/26/2020, benefit period 8/26 - 11/23/2020, and primary diagnosis of Parkinson's disease. Record review evidenced an agency document dated and signed on 8/26/2020 by employee A (registered nurse), titled "Comprehensive Assessment" This document indicated patient had grab bars and non-slip strips in the shower,	L 0550	**CMS Tag L550 Hospice-CoP Standard: 418.56 (c)(5) Content of the Plan of Care** **Findings:** The hospice failed to ensure it developed individualized plans of care which included medical supplies and appliances necessary to meet the needs of the patients for 14 of 14 clinical records reviewed. · The Director of Clinical Services and Interdisciplinary Group will review the current patient caseload on 11/18/2020 to ensure that each patient's individualized plan of care includes a medical supplies and appliances necessary to meet the needs of the patient per agency's Patient Plan of Care Policy. · Note that the agency's process for documenting the plan of care and updates is through the	11/20/2020

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	grab bars and elevated toilet seat, wore briefs, and had a bedside commode. During a home visit on 9/25/2020 at 8:00 a.m., with patient #1, equipment and supplies observed in the home for the patient included, (but may not be limited to), a hospital bed, low flow air loss mattress, wheelchair, oxygen concentrator, and dressing supplies. These items failed to be evidenced on the plan of care dated 8/26/2020. Review of a document titled "DME [durable medical equipment] Delivery" dated 9/3/2020, indicated an oxygen condenser was delivered to the patient's residence. Review of an agency document titled "Initial Plan of Care" dated and signed 8/26/2020 by the medical director, the director of clinical services (employee D), employee A, employee E (social worker), and employee F (spiritual counselor) failed to evidence documentation of any medical supplies, equipment, or appliances to meet the patient's needs or equipment / supplies observed while in the patient's home. 3. Clinical record review for patient #2 was completed on 9/29/2020, with hospice election date of 9/15/2020, benefit period 9/15 - 12/13/2020, and primary diagnosis of Ovarian Cancer. Record review evidenced an agency document dated and signed on 9/15/2020 by employee A, titled "Comprehensive Assessment" This document indicated the patient had a bedside commode, and was non-ambulatory. Review of a document titled "DME Delivery" dated 9/15/2020, indicated a hospital bed, floor mat, wheelchair, bedside commode, and over bed table was delivered to the patient's residence.		Plan of Care documentation, which is an addendum to the Initial Plan of Care. This process was in place at the time of the survey. Effective 11/18/2020, the agency will reference the Plan of Care document on the Initial Plan of Care, and the individualized Plan of Care, including the current medical supplies and appliances will be established based on the comprehensive assessment and updated as appropriate to reflect the patient's status and are reflective of the patient/family's needs. **Measures/Systematic Changes that will be put into place to ensure that the deficiency does not recur:** · The Director of Clinical Services will educate RN case managers and IDG team members by 11/18/2020 regarding the Plan of Care Policy and the requirement for the patient's individualized care plan which includes medical supplies and appliances utilized by the patient based on the comprehensive assessment and updated as appropriate to reflect the patient's status and that are reflective of the patient/family needs. Examples of medical supplies and appliances include, but are not limited to hospital beds, low flow air loss mattress, wheelchair, oxygen concentrator,	

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	Review of an agency document titled "Initial Plan of Care" dated and signed 9/15/2020 by the medical director, the director of clinical services, employee A, employee E, and employee F, failed to evidence documentation of any medical supplies, equipment, or appliances to meet the patient's needs. 4. Clinical record review for patient #3 was completed on 9/29/2020, with hospice election date of 5/21/2020, benefit period 5/21 - 8/18/2020, and primary diagnosis of Severe Caloric Malnutrition. Record review evidenced an agency document dated and signed on 5/21/2020 by employee A, titled "Comprehensive Assessment" This document stated "...enteral [a tube that goes directly to the stomach for nutrition] feedings ... wound ... pressure ulcer Stage III [3] right gluteal fold ... surgical incision wound right posterior thigh ... surgical wound right anterior thigh ...." and indicated the patient tub/shower grab bars, non-slip strips/mat, and elevated toilet seat with grab bars. During a home visit on 9/28/2020 at 10:30a.m., with patient #3, equipment and supplies observed in the home for the patient included, (but may not be limited to), a wheelchair and wound dressing supplies. These items failed to be evidenced on the plan of care dated 5/21/2020. Review of a document titled "DME Delivery" dated 5/22/2020, indicated a wheelchair cushion was delivered to the patient's residence. Review of an agency document titled "Initial Plan of Care" dated and signed 5/21/2020 by the medical director, employee A, employee G (spiritual counselor), and employee E, failed to		and dressing supplies. · The Director of Clinical Services will educate RN case managers on the requirement to review the patient's medical supplies and appliances during each home visits to ensure the care plan is consistent with the medical supplies and appliances the patient is using, and to ensure the provision of such medical supplies and appliances as appropriate based on the patient's needs and in accordance with physician orders and the plan of care. · Evidence of training will be noted in attendance logs. The Director of Clinical Services will review inservice attendance logs to ensure all staff receive this training. · This training will be incorporated into the agency's annual in-services by 1/30/21 and the new-employee orientation by 11/20/2020. · The Director of Clinical Services and Interdisciplinary Group will review each patient's record presented during each IDG to ensure that the individualized patient's care plan includes medical supplies and appliances utilized by the patient based on the comprehensive assessment and updated as appropriate to reflect the patient's status and that are reflective of the patient/family needs.	

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	evidence documentation of any medical supplies such as wound care dressings, medical equipment, or appliances to meet the patient's needs. 5. Clinical record review for patient #4 was completed on 9/29/2020, with hospice election date of 2/26/2019, benefit period 8/19 - 10/17/2020, and primary diagnosis of Cerebral Vascular Accident [CVA- stroke]. Record review evidenced an agency document titled "Hospice Aide Care Plan" dated and signed 8/6/2020 by employee H (registered nurse). This document indicated the patient wore briefs for incontinence, had enteral feedings, and used a hoyer lift [mechanical device used to transfer a patient] for transfers. During a home visit on 9/28/2020 at 12:00 p.m., with patient #4, equipment and supplies observed in the home for the patient included, (but may not be limited to), a broda [shower] chair, hospital bed, low flow air loss mattress, Feeding pump/machine, and dressing supplies. These supplies failed to be evidenced on the plan of care dated 8/12/2020. Review of an agency document dated and signed on 8/10/2020 by employee H, titled "Nurse Recertification" stated "... GT [enteral tube for nutrition] ... nebulizer treatments ... suction prn [as needed] ... fall risk assessment ... high risk ....", and had a broda chair. Review of an agency document titled "IDG [interdisciplinary group] Update" (updated plan of care) dated and signed 8/12/2020 by the medical director, director of clinical services, employee I (registered nurse), employee F, employee J (social worker), employee K (volunteer coordinator), and		**How the agency will monitor its quality assessment/performance improvement functions to ensure that the corrective measure or systemic change is sustained:** · The Director of Clinical Services or designee will ensure 100% of all clinical charts are audited to ensure the individualized patient's care plan includes medical supplies and appliances utilized by the patient based on the comprehensive assessment and updated as appropriate to reflect the patient's status and that are reflective of the patient/family needs for 4 weeks starting 11/18/2020. The threshold for compliance is 100%. · Once the initial threshold is met, the Director of Clinical Services or designee will conduct a clinical record review of 10% of active patient records monthly to ensure evidence of timely plan of care updates. The threshold for compliance is 100% for three months. · If the threshold for compliance is not met the Director of Clinical Services will continue to conduct clinical record reviews and provide continuing education to individual employees, counseling, and disciplinary action in accordance with agency policy if needed. · Once the threshold is met	

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	employee Z (bereavement coordinator), failed to evidence documentation of any medical supplies, equipment, or appliances to meet the patient's needs. 6. Clinical record review for patient #5 was completed on 9/29/2020, with hospice election date of 2/3/2020, benefit period 2/3 - 5/2/2020, and primary diagnosis of COPD (chronic obstructive pulmonary/lung disease). Record review evidenced an agency document dated and signed on 2/3/2020 by employee L (registered nurse), titled "Comprehensive Assessment" This document stated "... coccyx [tailbone area] wound... patient uses oxygen ... nebulizer [breathing] treatments ...." and indicated the patient had tub/shower grab bars, non-slip strips/mat, and elevated toilet seat with grab bars. Review of an agency document titled "Initial Plan of Care" dated and signed 2/4/2020 by the medical director, director of clinical services, employee M (registered nurse), employee J, employee G, employee K, and employee Z, failed to evidence documentation of any medical supplies, such as wound dressings, medical equipment, or appliances to meet the patient's needs. 7. Clinical record review for patient #6 was completed on 9/29/2020, with hospice election date of 6/1/2018, benefit period 7/20 - 9/17/2020, and primary diagnosis of Muscular Dystrophy. Record review evidenced an agency document dated and signed on 9/8/2020 by the director of clinical services, titled "Nurse Recertification" This document stated "... Oxygen liters per minute: 3 ... suprapubic catheter [surgically inserted drain tube for urine] ... Stage II pressure ulcer to right buttock ... oxygen per: trach collar [tracheostomy] ... ventilator support to breathe ...		this review item will be incorporated into the agency's quarterly clinical record review; a minimum of 10% of all live charts will be audited quarterly. · Results of the above audits and analysis of trends will be included in the agency's Quarterly Quality review data and reported to the Administrator and Governing Body. **Person Responsible:** Administrator **Completion Date:** November 20, 2020	

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	suction ...." Review of an agency document titled "IDG Update" (updated plan of care) dated and signed 9/9/2020 by the medical director, employee N (physician designee), director of clinical services, employee E, and employee G, failed to evidence documentation of any medical supplies, equipment, or appliances such as, (but not limited to), oxygen and tubing, wound dressing supplies, ventilator and suctioning equipment, and urinary catheter supplies to meet the patient's needs. 8. Clinical record review for patient #7 was completed on 9/29/2020, with hospice election date of 8/21/2020, benefit period 8/21 - 11/18/2020, and primary diagnosis of Multiple Sclerosis. Record review evidenced an agency document dated and signed on 8/21/2020 by employee O (registered nurse), titled "Comprehensive Assessment" This document stated "...enteral feedings ... texas catheter [condom type catheter for urinary drainage] ... wounds to right plantar [bottom] aspect of foot ... left foot DTI [deep tissue injury] patient uses oxygen ... trach collar ... suction ... tracheostomy ...." Review of an agency document titled "Initial Plan of Care" dated and signed 8/21/2020 by the medical director, director of clinical services, employee I, employee K, employee J, employee Z, employee O, and employee F failed to evidence documentation of any medical supplies such as, (but not limited to), wound dressing supplies, tracheostomy size and supplies, suctioning equipment, and urinary catheter supplies to meet the patient's needs. 9. Clinical record review for patient #8 was completed on 9/29/2020, with hospice election date of 9/19/20, hospice benefit period 9/19/20 to			

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	12/17/20, and primary diagnosis of Cancer of upper lobe, right bronchus or lung. Review of an agency document signed and dated 9/19/2020 by employee FF, titled "Comprehensive Assessment" stated "... Decreased mobility ... Patient uses oxygen 4L per nasal cannula..... " Review of a document titled "DME Delivery" dated 9/24/2020, indicated a "bed lal half rails" [alternating pressure bed with side rails] was delivered to the patient's residence. Review of a document titled "DME Delivery dated 9/20/2020, indicated a "floor matts [sic]" was delivered to the patient's residence. Review of an agency document titled "Initial Plan of Care" dated and signed 9/19/2019 by the medical director, employee Y, employee BB, employee Z, employee AA, failed to evidence documentation of any medical supplies and equipment such as oxygen, or DME such as a walker or cane to meet the patient's needs. 10. Clinical record review for patient #9 was completed on 9/29/20, with hospice election date 5/22/2019, hospice benefit period 5/22/19 to 8/19/19 and primary diagnosis of COPD (chronic obstructive pulmonary disease). Review of an agency document signed and dated 5/22/2019 by employee X, titled "Comprehensive Assessment" stated " ... Patient on home oxygen nasal cannula 2 liters ...." Review of a document titled "DME Delivery" dated 7/22/2019, indicated a bed alarm was delivered to the patient's residence. Review of a document titled "DME Delivery" dated 8/13/2019, indicated a low bed full rails lal			

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	[alternating pressure bed] was delivered to the patient's residence. Review of an agency document titled "Initial Plan of Care" dated and signed 5/22/2019 by the medical director, employee Y, employee BB, employee Z, employee AA (volunteer coordinator), failed to evidence documentation of equipment such as oxygen or appliances [walker or cane, bed alarm] to meet the patient's needs. 11. Clinical record review for patient #11 was completed on 9/29/20, with hospice election date 2/8/2018, hospice benefit period 2/8/18 to 5/8/18, and primary diagnosis of Pancreatic cancer. Review of a document titled "DME Delivery" dated 2/8/2018, indicated a bed/commode/obt [over bedside table] was delivered to the patient's residence. Review of a document titled "DME Delivery" dated 2/8/2018, indicated a Full rails lal mattress[alternating pressure bed] bed, commode, and OBT [over bedside table] O2 [oxygen] tank, and cart was delivered to the patient's residence. Review of an agency document titled "Initial Plan of Care" signed and dated 2/8/2018 by medical director, employee DD, employee EE, and employee Z, failed to evidence documentation of equipment or appliances to meet the patient's needs. 12. Clinical record review of patient #12 was completed on 9/29/20, with hospice election date 8/26/2020, hospice benefit period 8/26/20 to 11/23/20, and primary diagnosis of Malignant Neoplasm of Tongue.			

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	Review of the document signed and dated 8/26/2020 by employee I (registered nurse), titled "Comprehensive Assessment" stated " ... Patient was admitted at ... Was also admitted 08/09.20 for multiple falls. .... incontinent of bowel and bladder, ambulates with unsteady gaits, ... Diet orders pureed with thickened liquids ... History of a fall within last 6 months: More than 2 falls...." Review of a document titled "DME Delivery" dated 8/27/2020, indicated "bed with 1 ½ rail, standard mattress, fall mat, OBT, wc, (define if not defined above) walker" was delivered to the patient's residence. Review of an agency document titled "Initial Plan of Care" signed and dated 8/26/2020 by medical director, employee O (registered nurse), employee Z (social worker), employee E (spiritual counselor), employee I (registered nurse), failed to evidence documentation of any medical supplies, equipment, or appliances to meet the patient's needs. 13. Clinical record review for patient #13 was completed on 9/29/2020, with hospice election date of 1/29/18, hospice benefit period 1/29/18 to 4/28/18, and primary diagnosis of Lung Cancer. Review of an agency document signed and dated 1/29/18 by employee BB (registered nurse) titled "Comprehensive Assessment" stated "... Pt[patient] has ... generalized weakness ... Muscle tone muscle wasting ... Mobility has a gait and/or balance problem...." Review of a document titled "DME Delivery" dated 1/29/2018, indicated a "bed/lal [low air loss]/obt [over bed table]/urinal/commode/transport chair/ shower chair/ o2 con [oxygen concentrator]/ e tank/ o2			

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	cart/ full rails" Review of a document titled "DME Delivery" dated 2/26/2018, indicated a "bed makin[sic] noise"was delivered to the patient's residence. Review of an agency document titled "Initial Plan of Care" signed and dated 1/29/2018 by medical director, employee BB (registered nurse), employee E (social worker), employee G (spiritual counselor), failed to evidence documentation of any medical supplies, equipment, or appliances to meet the patient's needs. 14. Clinical record review of patient #14 was completed on 9/29/20, with hospice election date 2/8/2020, hospice benefit period 2/8/20 to 5/7/20, and primary diagnosis of Chronic obstructive pulmonary disease. Review of an agency document signed and dated 2/8/2020 by employee A, titled "Comprehensive Assessment" stated " ... decreased mobility, decreased ADLs, ... Patient on oxygen 15 liters nasal cannula ... Patient had stage 1 wound to left buttock with ecchymosis. Immediate needs for problem/symptom management: decline in ADL/self care deficit, dyspnea, skin breakdown...." Review of a document titled "DME Delivery" dated 2/8/2020, indicated a "Bed/half rails/lal/commode/obt/2 10LC con" was delivered to the patient's residence. Review of an agency document titled "Initial Plan of Care" signed and dated 2/9/2020 by medical director, employee A, employee E, employee G, failed to evidence documentation of any medical supplies, equipment, or appliances to meet the patient's needs.			

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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 observation, record review and interview, the hospice IDG (interdisciplinary group) failed to review, revise and document the individualized plan of care as frequently as the patient's condition required, which was necessary to meet the needs of the patients for 2 of 14 clinical records reviewed. (#1, and 9). Findings include: 1. Review of an agency policy updated 01/2014, titled "Ongoing Assessment" stated "... the RN [registered nurse] Case Manager ... will re-evaluate the patient according to the problems identified during the initial visit and thereafter ... based on the re-assessments, the Plan of Care, including problems, needs, goals and outcomes, will be reviewed and revised accordingly ... in collaboration with all hospice Interdisciplinary Group members ...." 2. Clinical record review for patient #1 was completed on 9/29/2020, with hospice election date of 8/26/2020, benefit period 8/26 - 11/23/2020, and primary diagnosis of Parkinson's disease. The record evidenced the patient was discharged from the hospital on 9/12/2020 after having a toe amputated, had a non-removable surgical dressing, the aide performed visits for personal care on 9/16/20 and 9/17/2020 prior to the nurse re-assessing the patient after hospital discharge,	L 0552	**CMS Tag L552 Hospice-CoP Standard: 418.56(d) Review of the Plan of Care** **Findings:** The IDG failed to failed to review, revise and document the individualized plan of care as frequently as the patient's condition required, which was necessary to meet the needs of the patients for 2 of 14 clinical records reviewed. **Plan to correct specific deficiency cited:** · The Director of Clinical Services and Interdisciplinary Group will review the current patient caseload on 11/18/2020 to ensure that each patient's plan of care is updated based on the comprehensive assessment to reflect the patient's status per agency's Ongoing Assessment Policy and that referrals are made to other disciplines as appropriate to meet the patient's needs. **Measures/Systematic Changes that will be put into place to ensure that the deficiency does**	11/20/2020

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	the nurse saw the patient on 9/17/2020 after the aide visit, and the record failed to evidence the hospice IDG or physician were notified, failed to evidence the social worker assisted the patient's family to ensure he could get to his follow up appointment, failed to evidence the nurse reconciled the patient's medications, and failed to evidence the plan of care was updated to reflect the change in the patient's condition. During a home visit for patient #1 on 9/25/2020 at 8:00 a.m., a pharmacy prescription bottle was observed for Bactrim (antibiotic) that was picked up after the patient was discharged from the hospital, and he had taken all seven daily doses per family. A dressing was observed on the patient's left foot, employee W (hospice aide) indicated she washed around the dressing, she had not received report from the nurse about the wound, and she thought the nurse changed it twice weekly. The family indicated they were unable to get the patient to his follow up appointment (one week after hospital discharge on 9/12/2020) because they had no transportation, and a social worker had not visited or called since the patient came home from the hospital. Review of a document signed and dated 9/12/2020, by person K (a hospital physician), titled "Infectious Disease Progress Note" indicated the patient was hospitalized and had his left 2nd toe amputated on 9/8/2020. Review of a document titled "Discharge Service Communication" evidenced the patient was admitted to facility L on 9/3/2020 and was discharged on 9/12/2020. Review of a document dated 9/14/2020, ordered by physician N, titled "IP [inpatient] Consult to		**not recur:** · The Director of Clinical Services will educate RN case managers and IDG team members by 11/18/2020 regarding the Ongoing Assessment Policy and the requirement for IDG team communication and timely follow up after a patient has a change in condition, change in location, hospitalization or any medical procedure, and referral to other disciplines as needed to meet the patient's needs. · The Director of Clinical Services will re-educate the nursing team that any patient that has a status change of any kind requires notification to the IDG team and clinical management and all care plans must be assessed and updated by 11/18/2020. · Evidence of training will be noted in attendance logs. The Director of Clinical Services will review in-service attendance logs to ensure all staff receive this training. · This training will be incorporated into the agency's annual in-services by 1/30/21 and the new-employee orientation by 11/20/2020. · The Director of Clinical Services will implement a new spread sheet tracking of patient change in location by 11/13/2020 to ensure proper follow up occurs	

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	Hospice" stated "... dressing to stay on unit seen by [physician M name] in 1 week; please make sure it gets arranged ...." Review of an agency document titled "Hospice Aide Visit Note" dated and signed on 9/16/2020 by employee W (hospice aide), evidenced an aide visit occurred on 9/16/2020 from 8:15 a.m. - 8:45 a.m., which failed to evidence instructions established by the nurse case manager for caring for the patient with a new surgical dressing. Review of an agency document titled "Hospice Aide Visit Note" and signed on 9/17/2020 by employee W, evidenced an aide visit occurred on 9/17/2020 from 7:30 a.m. - 8:00 a.m., which failed to evidence instructions established by the nurse case manager for caring for the patient with a new surgical dressing. Review of an agency document titled "Nursing Visit Note" signed and dated 9/17/2020 by employee A (registered nurse), evidenced a nursing visit occurred from 10:00 a.m. - 10:45 a.m., a non-removable surgical dressing was present on the patient's left foot, the aide care plan or patient's plan of care was not updated per a checked box on the document, failed to evidence if the nurse ensured the patient would be going to the follow up appointment with physician M, failed to evidence medication reconciliation to include patient's new prescription for Bactrim, and failed to evidence communication occurred with the hospice physician or IDG. Review of an agency document titled "Hospice Aide Care Plan" dated and signed on 8/26/2020 by employee A, and updated on 9/24/2020 by the director of clinical services, stated "... Notify [registered nurse] if dressing to left foot becomes		when the patient is hospitalized. · The Director of Clinical Services and Interdisciplinary Group will review the each patient's record presented during each IDG to ensure that the patient's care plan is updated minimally every 15 days or more frequently based on the comprehensive assessment to reflect the patient's status, including when there is a change in patient status or hospitalization and that referrals are made to other disciplines as appropriate to meet the patient's needs. **How the agency will monitor its quality assessment/performance improvement functions to ensure that the corrective measure or systemic change is sustained:** · The Director of Clinical Services will review the spreadsheet tracking of patient change in location monthly to ensure follow up and care plan updates for each applicable patient. This monitoring will continue monthly for 12 months. Compliance threshold is 100%. · The Director of Clinical Services or designee will ensure 100% of all clinical charts are audited for evidence of plan of care updates in accordance with comprehensive assessments	

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	saturated/soiled ...." The care plan failed to evidence it was updated or the aide was instructed on the dressing prior to 9/24/2020. Review of an agency document titled "IDG Update" (updated plan of care) dated and signed 9/9/2020 by the medical director, employee E (registered nurse), director of clinical services, employee Z (spiritual counselor), and employee K (volunteer coordinator), occurred prior to the patient's hospital discharge. Review of an agency document titled "IDG Update" (updated plan of care) dated and signed 9/23/2020 by the medical director, employee E, director of clinical services, employee Z, and employee K, occurred 11 days after the patient's hospital discharge. 3. During an interview on 9/23/2020 at 1:00 p.m., the director of clinical services indicated she did not know when the patient was admitted or discharged from the hospital. When informed the aide saw the patient on 9/16/2020 and 9/17/2020 prior to the nurse seeing the patient, she indicated that he likely came home on the 15th. When queried if it was typical to send an aide for visits prior to the registered nurse re-assessment, she stated, "Not always, but the nurse may have not been available that day." During an interview on 9/28/2020 at 10:57 a.m., employee O (registered nurse) indicated there were never unscheduled IDG meetings, and they were every other Wednesday. During an interview on 9/23/2020 at 10:15 a.m., the administrator indicated IDG meetings were every other Wednesday at 8:00 a.m.		minimally every 15 days, including when there is a change in patient status or hospitalization for 4 weeks starting 11/18/2020. The threshold for compliance is 100%. · Once the initial threshold is met, the Director of Clinical Services or designee will conduct a clinical record review of 10% of active patient records monthly to ensure evidence of timely plan of care updates. The threshold for compliance is 100% for three months. · If the threshold for compliance is not met the Director of Clinical Services will continue to conduct clinical record reviews and provide continuing education to individual employees, counseling, and disciplinary action in accordance with agency policy if needed. · Once the threshold is met this review item will be incorporated into the agency's quarterly clinical record review; a minimum of 10% of all live charts will be audited quarterly. · Results of the above audits and analysis of trends will be included in the agency's Quarterly Quality review data and reported to the Administrator and Governing Body. **Person Responsible:** Administrator **Completion Date:** November 20, 2020	

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	During an interview on 9/29/2020 at 3:14 p.m., when queried about the frequency of IDG meetings and if the agency held unscheduled IDG meetings for changes in a patient's condition, the administrator and director of clinical services indicated IDG meetings could occur more often than every two weeks, but they didn't, and they didn't when patients came out of the hospital and/or had significant changes. During an interview on 9/28/2020 at 12:40 p.m., a staff registered nurse at entity O (nursing home) who regularly cared for patient #4, indicated he never heard of an interdisciplinary group or that the hospice had IDG meetings with entity O. 4. Clinical record review for patient #9 was completed on 9/29/20, with hospice election date 5/22/2019, hospice benefit period 5/22/19 to 8/19/19, and primary diagnosis of COPD (chronic obstructive pulmonary disease). Review of a document signed and dated 5/22/2019 by employee X, titled "Comprehensive Assessment" stated " ... Patients family goals: Desires patient to be comfortable ... Patient heavy smoker ... Patients behavior: agitation/restlessness ... Patients Emotions: Anxiety ... Patient on home oxygen nasal cannula 2 liters ... Home safety assessment: No safety problems identified ...." Record review for patient #9 of an agency document dated 8/2/2019, titled "Nursing Visit Note" signed by employee O, stated " ... Current mental status: alert, disoriented, confused, forgetful, lethargic, impaired judgement ... Current behavioral status: appropriate, cooperative, angry/irritable ... Speech status: clear, appropriate, nonsensical ... Additional information/comments: Patient is drowsy today. Confused, disoriented. Wants to "go home'[sic] even though she is home. Lungs are diminished today, saturation is			

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	89% but patient refuses to wear oxygen. ... Patient is now hiding objects including cigarettes... Instructed PCG [patient caregiver] to monitor this as smoking is a safety issue. Patient must be monitored while smoking as she drops lit cigarettes ...." Record review of an agency document dated 8/3/2019, titled "Nurse Progress Note", signed by employee O, stated "RN [registered nurse] called to come by patient's one[sic] [family member name]. Patient ah[sic] suffered a fall and hit her face on an end table. Upon arrive[sic], ice has been applied to face. Swelling from forehead down to upper lip is present. Bruising to both eyes, under both eyes, and down cheeks. Patient states her face hurts rating a 4 with morphine given. Nose is crooked, off center to face and most likely broken. Educated family that nothing can be done to set nose. Ice to be applied for 10 minutes every 3 hours. Neosporin [medication not listed on medication list] to cuts to nose and lip. No evidence of a concussion, pupils equal, round, reactive, no nausea. Patient is alert. In her usual state of disorientation. Fall precautions discussed and remain in place." The agency failed to notify the physician of the patients changes in medical status. Due to the patients change of condition, the clinical record failed to evidence an IDG meeting to revise the individualized patients plan of care. Clinical record review on 9/29/20, evidenced an agency document titled "Nursing Visit Note (Abridged)" dated 8/7/2019 and signed by employee O. This document stated " ...Received patient in chair. Per family, gait remains unsteady and she is a high fall risk. Familyreports[sic] diarrhea with patient now requiring loperamide [antidiarrheal] 3 x day. Lungs are diminished and			

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	there is a nonproductive cough present. Patient continues to have bruising to her face with a laceration to the bridge of nose and upper lip from fall earlier last weekend. Remains conbative[sic] at times, and easily agitated. Sleeping 4-5 hours per day. Family reports that they have hired a private caregiver to come into the home 7 days a week to assist PCG [patient caregiver] Family is also requesting a low bed to be delivered sometime next week." Due to a change in the patients change of condition, the clinical record failed to evidence an IDG meeting to revise the individualized patients plan of care. Review of an agency document titled "IDG Update" (updated plan of care) dated and signed 8/14/2019 by the medical director, employee Y, employee O, employee J, employee Z (spiritual counselor & bereavement counselor), and employee K (volunteer coordinator), occurred 11 days after patient had a fall. The agency failed to conduct an IDG meeting to review and revise the patients individualized plan of care as frequently as the patient's condition required. Review of an agency document titled "IDG Update" (updated plan of care), dated and signed 9/11/2019 by the medical director, employee Y, employee O, employee J, employee Z, and employee K, occurred 6 days after patient passed away. The agency failed to conduct an IDG meeting to review and revise the patients individualized plan of care as frequently as the patient's condition required.			
L 0648 Bldg. 00	Based on observation, record review and	L 0648	**L648 Organization and**	11/20/2020

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UNITY HOSPICE OF NORTHWEST INDIANA LLC	3313 EAST 83RD PLACE MERRILLVILLE, IN 46410

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	interview, the governing body failed to ensure the hospice provided hospice care that optimized comfort and dignity, and was consistent with patient and family needs and goals, with patient needs and goals as priority (L650); failed to ensure the agency provided routine nursing services on a 24-hour basis, 7 days per week (L653); failed to ensure the agency maintained oversight of staff and services for all arranged services with entity O (nursing home), all services were authorized by the hospice, and care was delivered in accordance with the patient's plan of care (L655); and failed to ensure the agency hospice provided orientation about the hospice philosophy to all contracted staff who had patient and family contact (L661). The cumulative effect of these systemic problems resulted in the hospice's inability to be in compliance with the Condition of Participation 42 CFR 418.100 Organization / Administration of services.		**Administration Hospice CoPs-418.100 CONDITION** **Finding:** The Governing Body failed to ensure the hospice provided hospice care that optimized comfort and dignity, and was consistent with patient and family needs and goals, with patient needs and goals as priority (L650); failed to ensure the agency provided routine nursing services on a 24-hour basis, 7 days per week (L653); failed to ensure the agency maintained oversight of staff and services for all arranged services with entity O (nursing home), all services were authorized by the hospice, and care was delivered in accordance with the patient's plan of care (L655); and failed to ensure the agency hospice provided orientation about the hospice philosophy to all contracted staff who had patient and family contact (L661). Unity Hospice of Northwest Indiana is presenting a credible allegation of compliance with this CONDITION based on the implementation of the plan of correction stated in CMS Tags L650, L653, L655, and L661. Unity Hospice of Northwest Indiana has a history of having maintained a commitment of compliance as evidenced by prior survey	

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			experience and commitment to follow up and correction. Unity Hospice of Northwest Indiana will ensure that the plan of correction submitted for CMS Tags L650, L653, L655, and L661are realistic and will be accomplished between the date of the last survey and November 20, 2020 and will demonstrate resolution of the problem by this date.. Refer to the plans of correction for L650, L653, L655, and L661.	
L 0650 Bldg. 00	418.100(a) SERVING THE HOSPICE PATIENT AND FAMILY The hospice must provide hospice care that- (1) Optimizes comfort and dignity; and (2) Is consistent with patient and family needs and goals, with patient needs and goals as priority. Based on record review and interview, the agency failed to ensure it provided care to all patients that was consistent with patient and family needs and goals as a priority for 14 of 14 clinical records reviewed (#1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, and 14). Findings include: 1. Review of an agency policy last updated 01/2014, titled "Patient Plan of Care" stated "... The Plan of Care will reflect patient and family goals and interventions...." 2. Clinical record review for patient #1 was completed on 9/29/2020, with hospice election date of 8/26/2020, benefit period 8/26/20 -	L 0650	**L650 Hospice CoPs-Standard 418.100(a) Serving the Hospice Patient and Family** The Agency failed to ensure it provided care to all patients that was consistent with patient and family needs and goals as a priority for 14 of 14 clinical records reviewed. **Plan to correct specific deficiency cited:** · The Director of Clinical Services and Interdisciplinary Group will review the current patient caseload on 11/18/2020 to ensure the agency is providing	11/20/2020

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	11/23/2020, and primary diagnosis of Parkinson's disease. evidenced an agency document titled "Initial Plan of Care" dated and signed 8/26/2020 by the medical director, the director of clinical services, employee A, employee E (social worker), and employee F (spiritual counselor) failed to evidence any patient and family needs or goals. 3. Clinical record review for patient #2 was completed on 9/29/2020, with hospice election date of 9/15/2020, benefit period 9/15/20 - 12/13/2020, and primary diagnosis of Ovarian Cancer evidenced an agency document titled "Initial Plan of Care" dated and signed 9/15/2020 by the medical director, the director of clinical services, employee A, employee E, and employee F, failed to evidence any patient and family needs or goals. 4. Clinical record review for patient #3 was completed on 9/29/2020, with hospice election date of 5/21/2020, benefit period 5/21 - 8/18/2020, and primary diagnosis of Severe Caloric Malnutrition evidenced an agency document titled "Initial Plan of Care" dated and signed 5/21/2020 by the medical director, employee A, employee G (spiritual counselor), and employee E, failed to evidence any patient and family needs or goals. 5. Clinical record review for patient #4 was completed on 9/29/2020, with hospice election date of 2/26/2019, benefit period 8/19/20 - 10/17/2020, and primary diagnosis of Cerebral Vascular Accident [CVA- stroke] evidenced an agency document titled "IDG [interdisciplinary group] Update" (updated plan of care) dated and signed 8/12/2020 by the medical director, director of clinical services, employee I (registered nurse), employee F, employee J (social worker), employee		care to each patient that is consistent with patient and family needs and goals. This includes but is not limited to including patient/family goals and progress toward patient goals in IDG narratives. · The agency's process for documenting the plan of care and updates which specify care and services necessary to meet the patient and family specific needs as identified in Comprehensive Assessment (as properly and timely updated) is through the Plan of Care documentation part of each patient's unique medical record, which is an addendum to the Initial Plan of Care. This process and structure of each medical record was in place at the time of the survey. Effective 11/18/2020, the agency will reference the Plan of Care document on the Initial Plan of Care, and the Plan of Care will be established based on the comprehensive assessment and updated as appropriate to reflect changes in the patient's status, and ensure referral to additional disciplines as appropriate to meet patient and family needs. **Measures/Systematic Changes that will be put into place to ensure that the deficiency does not recur:** · Governing Body Review:	

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	K (volunteer coordinator), and employee Z (bereavement coordinator), failed to evidence any patient and family needs or goals. 6. Clinical record review for patient #5 was completed on 9/29/2020, with hospice election date of 2/3/2020, benefit period 2/3 - 5/2/2020, and primary diagnosis of COPD (chronic obstructive pulmonary/lung disease) evidenced an agency document titled "Initial Plan of Care" dated and signed 2/4/2020 by the medical director, director of clinical services, employee M (registered nurse), employee J, employee G, employee K, and employee Z, failed to evidence any patient and family needs or goals. 7. Clinical record review for patient #6 was completed on 9/29/2020, with hospice election date of 6/1/2018, benefit period 7/20 - 9/17/2020, and primary diagnosis of Muscular Dystrophy evidenced an agency document titled "IDG Update" (updated plan of care) dated and signed 9/9/2020 by the medical director, employee N (physician designee), director of clinical services, employee E, and employee G, failed to evidence any patient and family needs or goals. 8. Clinical record review for patient #7 was completed on 9/29/2020, with hospice election date of 8/21/2020, benefit period 8/21 - 11/18/2020, and primary diagnosis of Multiple Sclerosis evidenced an agency document titled "Initial Plan of Care" dated and signed 8/21/2020 by the medical director, director of clinical services, employee I, employee K, employee J, employee Z, employee O, and employee F failed to evidence any patient and family needs or goals. 9. During an interview on 9/25/2020 at 2:20 p.m., employee B (corporate director of compliance)		· The Governing Body will ensure the hospice provides care that optimizes comfort and dignity, is consistent with patient and family needs and goals, prioritizing patient needs and goals. · The Governing Body will monitor compliance by review of Quality review reports referenced below and data reflecting the Agency's level of compliance. · Evidence of such review will be made through signature on submitted Reports and or official memo or minutes. · The Director of Clinical Services will educate RN case managers and IDG team members by 11/18/2020 regarding the need to ensure the agency provides care to all patients that is consistent with patient and family needs and goals. This includes, but is not limited to, including patient/family goals and progress toward patient goals in IDG narratives. · Evidence of training will be noted in attendance logs. The Director of Clinical Services will review in-service attendance logs to ensure all staff receive this training. · This training will be incorporated into the agency's annual in-services by 1/30/21 and the new-employee orientation by 11/20/2020. · The Director of Clinical Services and Interdisciplinary	

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	indicated the agency had a systemic problem with plans of care, and interventions and measurable goals/outcomes were not evidenced on all patients' plans of care reviewed. 10. Clinical record review for patient #8 was completed on 9/29/2020, with hospice election date of 9/19/20, hospice benefit period 9/19/20 to 12/17/20, and primary diagnosis of Cancer of upper lobe, right bronchus or lung. Review of an agency document titled "IDG Update" (updated plan of care) dated and signed 9/23/20 by the medical director, employee D, employee J, employee H, employee G, failed to evidence any patient and family needs or goals. 11. Clinical record review for patient #9 was completed on 9/29/20, with hospice election date 5/22/19, hospice benefit period 5/22/19 to 8/19/19, and primary diagnosis of COPD (chronic obstructive pulmonary disease). Review of an agency document titled "IDG Update" (updated plan of care) dated and signed 7/17/19 by the medical director, person Y, employee Z, failed to evidence any patient and family needs or goals. 12. Clinical record review for patient #10 was completed on 9/29/20, with hospice election 6/23/2018, hospice benefit period 8/11/20 to 10/9/20, and primary diagnosis of Alzheimer's disease. Review of an agency document titled "IDG Update" (updated plan of care) dated and signed 7/29/20 by the medical director, director of clinical services, and social worker, failed to evidence any patient and family needs or goals. 13. Clinical record review for patient #11 was completed on 9/29/20, with hospice election 2/8/2018, benefit period 2/8/18 to 5/8/18, and primary diagnosis of Pancreatic cancer. Review of		Group will review each patient's record presented during each IDG to ensure the agency is providing care to each patient that is consistent with patient and family needs and goals. This includes, but is not limited to, including patient/family goals and progress toward patient goals in IDG narratives. **How the agency will monitor its quality assessment/performance improvement functions to ensure that the corrective measure or systemic change is sustained:** · The Director of Clinical Services or designee will ensure 100% of all clinical charts are audited for evidence the agency is providing care to each patient that is consistent with patient and family needs and goals. This includes but is not limited to including patient/family goals and progress toward patient goals in IDG narratives for 4 weeks starting 11/18/2020. The threshold for compliance is 100%. · Once the initial threshold is met, the Director of Clinical Services or designee will conduct a clinical record review of 10% of active patient records monthly to ensure evidence the agency is providing care to each patient that	

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	an agency document signs and dated 2/8/2018 by employee BB, titled "Comprehensive Assessment" stated " ... Patient/family's current chief complaint: decline ... Patient not eating due to loss of appetite ... Patient/Comfort assessment non-verbal scale 2/10. Symptoms associated with the pain: decreased mobility, decreased ADLs (activities of daily living), poor concentration, decreased socialization, increased sleeping, withdrawal, irritability/agitation, decreased appetite ... Respiratory rate 22 on room air ... Heart rate 103 ... Blood pressure 150/76 ... Behavior: agitated/restlessness ... Bowel constipation ... Urinary incontinence ...." The clinical record failed to evidence individualized needs and goals as priority to service the patient and family's needs. Clinical record review evidenced an agency document titled "Initial Plan of Care" signed and dated 2/8/2018 by employee DD (registered nurse), employee BB, employee EE, employee Z, and the medical director. This plan of care document failed to evidence they met the patient's / families' needs and goals. 14. Clinical record review of patient #12 was completed on 9/29/20, with hospice election date 8/26/2020, benefit period 8/26/20 to 11/23/20 and primary diagnosis of Malignant Neoplasm of Tongue. Review of an agency document titled "Initial Plan of Care" signed and dated 8/26/2020 by medical director, employee O, employee Z, employee E, employee I failed to evidence care that optimizes comfort and dignity, and is consistent with patient and family needs and goals. Review of an agency document titled "IDG Update" (updated plan of care) dated and signed		is consistent with patient and family needs and goals. This includes but is not limited to including patient/family goals and progress toward patient goals in IDG narratives. The threshold for compliance is 100% for three months. · If the threshold for compliance is not met the Director of Clinical Services will continue to conduct clinical record reviews and provide continuing education to individual employees, counseling, and disciplinary action in accordance with agency policy if needed. · Once the threshold is met this review item will be incorporated into the agency's quarterly clinical record review; a minimum of 10% of all live charts will be audited quarterly. · Results of the above audits and analysis of trends will be included in the agency's Quarterly Quality review data and reported to the Administrator and Governing Body. **Person Responsible:** Administrator **Completion Date:** November 20, 2020	

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	9/9/2020 by the medical director, employee D, employee E, employee F, employee AA, employee Z. The agency failed to provide documentation of care that was consistent with patient and family needs and goals, with patient needs and goals as priority. 15. Clinical record review for patient #13 was completed on 9/29/2020, with hospice election date of 1/29/18, hospice benefit period 1/29/18 to 4/28/18, and primary diagnosis of Lung Cancer. Review of an agency document titled "IDG Update" (updated plan of care) dated and signed 1/31/2018 by the medical director, employee BB, employee E, employee G, failed to evidence any patient and family needs or goals. 16. Clinical record review of patient #14 was completed on 9/29/20, with hospice election date 2/8/2020, benefit period 2/8/20 to 5/7/20, and primary diagnosis of Chronic obstructive pulmonary disease. Review of an agency document "IDG Update" (updated plan of care) signed and dated 2/12/2020 by medical director, employee D, employee E, employee G, and employee Z, failed to evidence any patient and family needs or goals. Review of an agency document titled "Initial Plan of Care" signed and dated 2/9/2020 by medical director, employee A, employee E, employee G failed to evidence documentation of current drug regimen, or treatment(s) necessary to meet the needs of the patient such as specialized dietary requirements, fall precautions or respiratory treatments.			
L 0653	418.100(c)(2) SERVICES			

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Bldg. 00	(2) Nursing services, physician services, and drugs and biologicals (as specified in §418.106) must be made routinely available on a 24-hour basis 7 days a week. Other covered services must be available on a 24-hour basis when reasonable and necessary to meet the needs of the patient and family. Based on record review and interview, the agency failed to provide routine nursing services on a 24-hour basis, 7 days per week for 3 of 3 (#1, 4, 5) records of patients which required or requested a skilled nursing visit by the patient or caregiver in a total sample of 14. Findings include: 1. Review of an agency policy last updated 01/2014, titled "On-Call Services" stated "... patients have the access to hospice services twenty-four hours per day ... assure appropriate follow-up at all times to hospice patients ...." 2. Review of an agency policy last updated 01/2014, titled "Nursing Services" stated "... Nursing services shall be directed and staffed to assure the unique nursing needs of each patient are met ...." 3. Review of agency complaint log was completed on 9/29/2020, this evidenced individual complaint statements including (but not limited to) "... Very disappointed ... would not recommend them to anyone ... She waited 5 hours to get morphine ... nurse never checked on her catheter (Person T) ... At 8:45 A.M., I called [nursing home where patient resided] to see how my dad's night went. The [entity] nurse stated 'Oh, honey! Didn't they [agency] call you? Your father passed away at 4:30 [a.m.] this morning ... The nurse said hospice	L 0653	**CMS Tag L653 Hospice-CoP Standard: 418.100(c)(2) Services** **Findings:** The Agency failed to provide routine nursing services on a 24-hour basis, 7 days per week for 3 of 3 (#1, 4, 5) records of patients which required or requested a skilled nursing visit by the patient or caregiver in a total sample of 14. **Plan to correct specific deficiency cited:** · The Director of Clinical Services will review the schedule each day to ensure appropriate staffing to address nursing needs in a timely manner. · The Director of Clinical Services will review each call that after-hours triage team receives each day to ensure timely response and appropriate handling of concerns or questions in accordance with the On-Call Services and Access to Services policies beginning on 11/12/2020. · The Administrator or designee will review the Complaint Log on 11/12/2020 and all complaints received on a daily	11/20/2020

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	should have called me (person U) ... I feel they didn't have nurse support (person X) ... The last few days of her life were left alone by the hospice team! Would never use them again (person W) ... There is no care on weekends! (person T) ... extremely upset nurse did not visit (person Y) ... [nurse] admitted she did not visit today (employee D) ...." 4. Clinical record review for patient #1 was completed on 9/29/2020, with hospice election date of 8/26/2020, benefit period 8/26/2020 - 11/23/2020, and primary diagnosis of Parkinson's disease. The record evidenced the patient was discharged from the hospital on 9/12/2020, after having toe amputated, the aide saw the patient on 9/16/2020 and 9/17/2020, and the nurse saw the patient after the aide visit on 9/17/2020. The agency failed to ensure a nurse was available on a 24 hour basis. This practice had the potential to affect all agency hospice patients. During an interview on 9/24/2020 at 1:15 p.m., when queried why the nurse didn't see the patient until 9/17/2020, the director of clinical services indicated the nurse may not have been available that day, and on-call services were for at night and after hours. 5. Clinical record review for patient #4 was completed on 9/29/2020, with hospice election date of 2/26/2019, benefit period 8/19 - 10/17/2020, and primary diagnosis of Cerebral Vascular Accident [CVA- stroke]. The record evidenced entity O contacted the agency on Sunday, 9/20/2020, requested a nursing visit due to patient had a persistent productive cough, more than normal oral secretions, and no nursing visit was made. This practice had the potential to affect all agency hospice patients.		basis going forward to ensure that any patient/family concerns regarding pain and symptom management issues or timeliness of visits are addressed immediately. **Measures/Systematic Changes that will be put into place to ensure that the deficiency does not recur:** · The Director of Clinical Services will educate RN case managers and IDG team members by 11/18/2020 regarding the On-Call Services and Access to Services policies and the on-call purpose and responsibilities including visiting each patient or family who calls with concerns, changes in condition, or symptom management issues. · The Director of Clinical Services will educate all field staff by 11/18/2020 regarding handling of death visits and ensure thorough understanding of all contacts required at the time of patient's death and proper documentation of this contact. · Evidence of training will be noted in attendance logs. The Director of Clinical Services will review in-service attendance logs to ensure all staff receive this training. · This training will be incorporated into the agency's	

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	During an interview on 9/25/2020 at 1:30 p.m., the corporate director of compliance, administrator, and director of clinical services indicated no nursing visit was performed when requested by entity O on 9/20/2020. 6. Clinical record review for patient #5 was completed on 9/29/2020, with hospice election date of 2/3/2020, benefit period 2/3/2020 - 5/2/2020, and primary diagnosis of COPD (chronic obstructive pulmonary/lung disease). The record indicated an on-call call was placed on Saturday, 2/8/2020, which indicated the patient was declining, and things were changing quickly, and Saturday 2/29/2020, which indicated the patient was hallucinating and had aggressive behaviors. No nursing visits were performed on those dates, and the documents indicated the family declined a visit. However, on the nursing visit on 2/14/2020, the nurse documented the family's perception of the call. Review of an agency document dated and signed by employee M (registered nurse) on 2/14/2020, titled "Nursing Visit Note (Abridged)" evidenced documentation by the nurse for the patient's daughter's complaint, which stated "... Daughter ... expresses concerns ... [daughter stated] 'I'm afraid that when the time comes, I will be all alone' ... the nurse didn't return the on call request in a timely manner and said 'Do you want to visit or what?'... considering switching to another agency ...." 7. During an interview on 9/23/2020 at 3:32 p.m., the director of clinical services indicated there were no routine visits on weekends, but would perform on-call visits if needed.		annual in-services by 1/30/21 and the new-employee orientation by 11/20/2020. · The Director of Clinical Services will review the schedule each day to ensure appropriate staffing to address nursing needs in a timely manner. · The Director of Clinical Services will review each call that after-hours triage team receives each day to ensure timely response and appropriate handling of concerns or questions in accordance with the On-Call Services and Access to Services policies beginning on 11/12/2020. · The Administrator or designee will review all complaints received on a daily basis going forward to ensure that any patient/family concerns regarding pain and symptom management issues or timeliness of visits are addressed immediately. **How the agency will monitor its quality assessment/performance improvement functions to ensure that the corrective measure or systemic change is sustained:** · The Administrator will verify on a weekly basis that all complaints related to patient/family concerns regarding pain and symptom management	

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	8. During a phone interview on 9/29/2020 at 9:50 a.m., person P indicated she was present when the nursing home nurse called Unity to inform the agency of her father's [the patient's] labored breathing, Unity nurse did not perform a visit, Unity nurse refused to talk to person P, and family switched to a different hospice agency. 9. Review of an agency document titled "Client Concern/Grievance Report" signed and dated 12/10/19 by person Z (former administrator), evidenced the complaint made by person P, and stated "... Findings and Interventions: a lack of communication ... Did re-education with nurses ...."		issues or timeliness of visits are addressed immediately. This monitoring will continue for 12 months. Compliance threshold is 100%. · The Director of Clinical Services or designee will ensure 100% of all clinical charts are audited for evidence of timely provision of care, including visiting each patient or family who calls with concerns, changes in condition, or symptom management issues for 4 weeks starting 11/18/2020. The threshold for compliance is 100%. · The Director of Clinical Services will ensure 100% of death reports are reviewed to ensure appropriate contacts were made for 4 weeks starting 11/18/2020. The threshold for compliance is 100%. · Once the initial threshold is met, the Director of Clinical Services or designee will conduct a clinical record review of 10% of active patient records monthly to ensure evidence of timely plan of care updates. The threshold for compliance is 100% for three months. · If the threshold for compliance is not met the Director of Clinical Services will continue to conduct clinical record reviews and provide continuing education to individual employees, counseling, and disciplinary action in accordance with agency policy	

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	151583	A. BUILDING 00 B. WING	09/29/2020

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			if needed. · Once the threshold is met this review item will be incorporated into the agency's quarterly clinical record review; a minimum of 10% of all live charts will be audited quarterly. · Results of the above audits and analysis of trends will be included in the agency's Quarterly Quality review data and reported to the Administrator and Governing Body. **Person Responsible:** Administrator **Completion Date:** November 20, 2020	
L 0655 Bldg. 00	418.100(e) PROFESSIONAL MANAGEMENT RESPONSIBILITY A hospice that has a written agreement with another agency, individual, or organization to furnish any services under arrangement must retain administrative and financial management, and oversight of staff and services for all arranged services, to ensure the provision of quality care. Arranged services must be supported by written agreements that require that all services be-- (1) Authorized by the hospice; (2) Furnished in a safe and effective manner by qualified personnel; and (3) Delivered in accordance with the patient's plan of care. Based on observation, record review and interview, the hospice agency failed to ensure the governing body maintained oversight of staff and services for all arranged services, all services were	L 0655	**CMS Tag L655 Hospice-CoP Standard: 418.100(e) Professional Management Responsibility**	11/20/2020

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	authorized by the hospice, and care was delivered in accordance with the patient's plan of care in 1 of 1 clinical record reviewed for a patient who resided in a nursing home, out of a total of 14 clinical records reviewed. (#4) Findings include: Review of an agency policy last updated 1/2014, titled "Facility [entity] Residents" stated "... there will be an agreed upon plan of care that reflects coordination and input from both the Hospice care team and the [entity] ... [agency] will provide the [entity] ... most recent plan of care ... names and contact information of hospice personnel involved in the care of the patient ... orders specific to the patient ...." Review of an agency document titled "Hospice Service Agreement" between entity O and agency, dated and signed with an effective date of 3/5/2010, by the agency governing body president and entity O's administrator stated "... [agency] shall maintain professional ... and administrative responsibility for the services rendered ... fully responsible for managing the hospice services provided ... Participate with [entity O] in the establishment of the Plan of Care ... Periodically review and update the Plan of Care in coordination with [entity O] ... Provide and supervise the provision of hospice services ... [agency] and [entity O] shall jointly develop a Plan of Care ... [agency] shall also furnish [entity O] with a copy of such Plan of Care ... also furnish ... any modifications to such Plan of Care ...."		**Findings:** The Agency failed to ensure the Governing Body maintained oversight of staff and services for all arranged services, all services were authorized by the hospice, and care was delivered in accordance with the patient's plan of care in 1 of 1 clinical record reviewed for a patient who resided in a nursing home, out of a total of 14 clinical records reviewed. **Plan to correct specific deficiency cited:** · The Director of Clinical Services will ensure that all patients who reside in nursing facilities have a current service agreement, hospice plan of care, and a Hospice/LTC Coordinated Task Plan of Care signed by both the hospice nurse and facility nurse specifying tasks/services to be performed by the hospice and by the facility, and evidence of communication with the facility that reflects professional management by the hospice related to hospice services, in accordance with the Facility Residents and Professional Management and Services under Arrangement policies by 11/18/2020. · The Administrator or designee will review records to ensure contracts for each facility where hospice patients currently reside by 11/13/2020. · The Administrator will	

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	Clinical record review for patient #4 was completed on 9/29/2020, with hospice election date of 2/26/2019, benefit period 8/19 - 10/17/2020, and primary diagnosis of Cerebral Vascular Accident [CVA- stroke]. Record review evidenced an agency document titled "IDG [interdisciplinary group] Update" (updated plan of care) dated and signed 8/12/2020 by the medical director, director of clinical services, employee I (registered nurse), employee F, employee J (social worker), employee K (volunteer coordinator), and employee Z (bereavement coordinator). This document failed to evidence the patient resided at entity O, any involvement from entity O in the development on the updated plan of care, or G-tube, oral suction and other patient specific orders. This practice had the potential to affect all agency hospice patients who resided in a facility. During a home visit for patient #4 on 9/28/2020 at 12:00 p.m., at entity O, an oral suction machine was observed at the patient's bedside, and a G-tube (surgically inserted tube into the stomach for nutritional feeding) was observed on the patient. Entity O documentation failed to evidence any (agency) plans of care for the patient, in the patient's medical record. Entity O staff contacted families for changes needed to patient treatment, and entity O would call "911" for an emergency, then family, followed by hospice agency. At 12:55 p.m., a copy of the service agreement between the hospice and entity O was requested from the entity's director of nursing, who indicated the entity did not have a copy. During an interview on 9/28/20 at 12:00 p.m., when queried, employee H (registered nurse) indicated entity O managed the G-tube and orders for feeding, not the agency		ensure education will be offered to all facility partners regarding emergency management for hospice patients and communication/coordination processes for facilities with patients on current census by 11/13/2020. **Measures/Systematic Changes that will be put into place to ensure that the deficiency does not recur:** · Administrator/DCS Training: · The Administrator and Director of Clinical Services reviewed the Organization and Administration responsibilities in accordance with the Medicare CoPs, including ensuring that there are current service agreements with all facilities where hospice patients reside, and the requirement for professional management, coordination and communication, and oversight by hospice staff for patients who reside in facilities, on 11/13/2020. · The Governing Body will monitor compliance by reviewing reports from Agency Administrator ensuring compliance with this requirement. · The Director of Clinical Services will educate RN case managers and IDG staff by 11/13/2020 with follow-up training on 11/18/2020 regarding the need	

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	During an interview on 9/28/2020 at 12:00 p.m., person Q (registered nurse), an employee of entity O, indicated he frequently took care of patient #4 and he did not know what an IDG meeting was. During an interview on 9/25/2020 at 1:30 p.m., when queried about the G-tube feeding prescription, rate, and frequency, employee B (corporate director of compliance) stated "The nursing home is in charge." When queried how frequently the patient was supposed to be suctioned, employee B indicated it would be nursing judgement. During an interview on 9/25/2020 at 2:20 p.m., employee B indicated the agency followed nursing home recommendations, and the agency was responsible for patients' plans of care.		to ensure hospice responsibility for professional management and maintaining oversight of staff and services provided to hospice patients via all arranged services. This includes but is not limited to a current hospice plan of care and the Hospice/LTC Coordinated Task Plan of Care specifying tasks/services to be performed by the hospice and by the facility, and evidence of communication with the facility that reflects professional management by the hospice related to hospice services, in accordance with the Facility Residents and Professional Management and Services under Arrangement policies. · Evidence of training will be noted in attendance logs. The Director of Clinical Services will review inservice attendance logs to ensure all staff receive this training. · This training will be incorporated into the agency's annual in-services by 1/30/21 and the new-employee orientation by 11/20/2020. · The Director of Clinical Services and Interdisciplinary Group will review each patient's record presented during each IDG to ensure the agency is documenting coordination of care and professional management between the hospice and facility for patients who reside in facilities.	

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			· The Administrator or designee will establish a contract tracking log by 11/13/2020 to ensure that all contracts are current, contains all requirements, and that Hospice 101 and emergency procedures training is provided to the facility. **How the agency will monitor its quality assessment/performance improvement functions to ensure that the corrective measure or systemic change is sustained:** · The Administrator or designee will review all hospice contracts quarterly to ensure all contracts are current and implemented for all facilities where hospice patients reside, and that required hospice training has been provided to facility staff caring for the agency's hospice patients. · The Director of Clinical Services or designee will make an onsite visit quarterly to each facility actively serving hospice patients to validate evidence of hospice responsibility for professional management and maintaining oversight of staff and services provided to hospice patients via all arranged services. This includes, but is not limited to, a current hospice plan of care,	

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			NOE, and Hospice/LTC Coordinated Task Plan of Care to be performed by the hospice and by the facility, and evidence of communication with the facility that reflects professional management by the hospice related to hospice services. This quarterly onsite visit will be documented as a component of the agency's QAPI program. Any issues or missing information identified during the visit will be immediately addressed with the facility DON/Supervisor and the hospice RN case manager. · The Director of Clinical Services or designee will ensure 100% of all clinical charts are audited for evidence of hospice responsibility for professional management and maintaining oversight of staff and services provided to hospice patients via all arranged services. This includes, but is not limited to, a current hospice plan of care and the Hospice/LTC Coordinated Task Plan of Care specifying tasks/services to be performed by the hospice and by the facility, and evidence of communication with the facility that reflects professional management by the hospice related to hospice services, for 4 weeks starting 11/18/2020. The threshold for compliance is 100%. · Once the initial threshold is met, the Director of Clinical	

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			Services or designee will conduct a clinical record review of 10% of active patient records monthly to ensure evidence the agency is providing care to each patient that is consistent with patient and family needs and goals. This includes, but is not limited to, including patient/family goals and progress toward patient goals in IDG narratives. The threshold for compliance is 100% for three months. · If the threshold for compliance is not met the Director of Clinical Services will continue to conduct clinical record reviews and provide continuing education to individual employees, counseling, and disciplinary action in accordance with agency policy if needed. · Once the threshold is met this review item will be incorporated into the agency's quarterly clinical record review; a minimum of 10% of all live charts will be audited quarterly. · Results of the above audits and analysis of trends will be included in the agency's Quarterly Quality review data and reported to the Administrator and Governing Body. **Person Responsible:** Administrator **Completion Date:** November 20, 2020	

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L 0661 Bldg. 00	418.100(g)(1) TRAINING (1) A hospice must provide orientation about the hospice philosophy to all employees and contracted staff who have patient and family contact. Based on record review and interview, the agency failed to ensure it provided orientation regarding hospice philosophy to all contracted staff that had direct patient and family contact for 1 of 1 clinical records reviewed where the patient lived in a nursing facility, in a total of 14 clinical records reviewed. (#4). Findings include: Review of an agency policy last updated 1/2014, titled "Facility Residents" stated "... [agency] will make available to [entity] staff information regarding hospice philosophy ... to ensure that [entity] staff furnishing care to hospice patients are oriented to hospice care." Review of an agency policy last updated 1/2014, titled "Orientation Content/Process" stated "... orientation process for contracted personnel will consist of the following ... oriented to Unity Hospice policies, procedures ...." Clinical record review for patient #4 was completed on 9/29/2020, with hospice election date of 2/26/2019, benefit period 8/19 - 10/17/2020, and primary diagnosis of Cerebral Vascular Accident [CVA- stroke]. Record review evidenced the patient resided at entity O (nursing facility).	L 0661	**CMS Tag L661 Hospice-CoP Standard: 418.100(g)(1) Training** **Findings:** The Agency failed to ensure it provided orientation regarding hospice philosophy to all contracted staff that had direct patient and family contact for 1 of 1 clinical record reviewed for a patient who resided in a nursing home, out of a total of 14 clinical records reviewed. **Plan to correct specific deficiency cited:** · The Director of Clinical Services will ensure that all contracted facility staff caring for current hospice patients receive Hospice 101 training in accordance with the Orientation Content/Process Policy by 11/13/2020. · The Administrator or designee will ensure that there is a service agreement in place for all facilities where hospice patients currently reside by 11/13/2020. · The Director of Clinical Services will ensure education will be delivered to appropriate staff of all facility partners regarding	11/20/2020

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	During an interview on 9/24/2020 at 10:40 a.m., the director of clinical services indicated the contractor would discuss hospice philosophy with its employees, employee B (corporate director of compliance) indicated it was up to the contracted entity to pass that information on to its employees, the agency offered the training, the entities have the right to refuse the training, and the entities may have already had training from another hospice so they would refuse training from Unity. This practice had the potential to affect all agency hospice patients that resided in a contracted facility. During an interview on 9/28/2020 at 12:20 p.m., a staff nurse at entity O, who regularly cared for agency patients, indicated he was not trained on hospice philosophy by Unity, and he wasn't sure if they did that.		Hospice 101, emergency management for hospice patients and communication/coordination processes to all facilities who have patient on our current census by 11/13/2020. **Measures/Systematic Changes that will be put into place to ensure that the deficiency does not recur:** · The Director of Clinical Services will educate RN case managers and IDG staff by 11/18/2020 regarding the need to ensure all facility staff caring for the Agency's hospice patients have received Hospice 101 training in accordance with agency policies. · Evidence of training will be noted in attendance logs. The Director of Clinical Services will review in-service attendance logs to ensure all staff receive this training. · This training will be incorporated into the agency's annual in-services by 1/30/21 and the new-employee orientation by 11/20/2020. · The Administrator or designee will establish a contract tracking log by 11/13/2020 to ensure that all contracts are current, contain all requirements, and that Hospice 101 and emergency procedures training is provided to the facility.	

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			How the agency will monitor its quality assessment/performance improvement functions to ensure that the corrective measure or systemic change is sustained: · The Administrator or designee will review all hospice contracts quarterly to ensure all contracts are current and implemented for all facilities where hospice patients reside, and that required hospice training has been provided to facility staff caring for the agency's hospice patients. · The Director of Clinical Services or designee will make an onsite visit quarterly to each facility actively serving hospice patients to validate evidence of hospice 101 training for facility staff serving the agency's hospice patients, documented evidence of responsibility for professional management and maintaining oversight of staff and services provided to hospice patients via all arranged services. This includes, but is not limited to, a current hospice plan of care, NOE, and the Hospice/LTC Coordinated Task Plan of Care to be performed by the hospice and by the facility, and evidence of communication with the facility that reflects professional management by the hospice related to hospice services. This quarterly onsite visit	

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			will be documented as a component of the agency's QAPI program. Any issues or missing information identified during the visit will be immediately addressed with the facility DON/Supervisor and the hospice RN case manager. Compliance threshold is 100%. · If the threshold for compliance is not met the Director of Clinical Services will continue to conduct onsite visits and provide continuing education to facility DON staff to coordinate facility staff training, counsel hospice individual employees and hospice staff disciplinary action in accordance with agency policy if needed. · Results of the above audits and analysis of trends will be included in the agency's Quarterly Quality review data and reported to the Administrator and Governing Body. **Person Responsible:** Administrator **Completion Date:** November 20, 2020	