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	12/03/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. 00	At the initial visit dated 9/29/20 the 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		
L 0000 Bldg. 00	This was a re-visit for a federal hospice recertification survey with one complaint conducted 9/23/2020 - 9/29/2020. Facility ID: 002379 Provider # 151583 Dates of Survey: 11/30/2020 - 12/2/2020 Active Home Patient Census: 28 Active General Inpatient (GIP) Census: 0 Active Continuous Care (CC) Patient Census: 0 Active Assisted Living Facility (ALF) Patient Census: 0 Active Skilled Nursing Facility (SNF) Patient Census: 30 Active Respite Patient Census: 0 Unduplicated census: 389 Sample Selection: Record review for 4 patients with 0 home visits During this survey, 4 of 4 Conditions were corrected, 13 standards were corrected, and 4	L 0000		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	standards were re-cited. No new standards were cited.			
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 record review and interview, the hospice failed to ensure all patients had an initial and/or updated 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 2 of 4 records reviewed (#2 and 3). 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 ... 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 ...."	L 0538	INITIAL COMMENTS 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. **CMS Tag L538 Hospice-CoP Standard: 418.56 IDG, Care Planning, Coordination of Services** **Findings:** The hospice failed to ensure all patients had an initial and/or updated 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 2 of 4 records reviewed (#2 and #3). **Plan to correct specific deficiency cited:**	12/18/2020

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	2. Clinical record review for patient #2 was completed on 12/2/2020, with hospice election date of 11/25/2020, benefit period 11/25/2020 - 2/22/2021, and primary diagnosis of COPD (chronic obstructive pulmonary/lung disease). Record review evidenced a document dated and signed on 11/28/2020 by employee I (spiritual counselor), titled "Spiritual Assessment" which stated "... and he [patient] is fatiguing more quickly thus wife requests a homemaker which chaplain notified team of ...." Review of an agency document titled "Homemaker Visit Note" dated and signed 12/1/2020 by employee P (homemaker) evidenced a homemaker visit occurred on 12/1/2020 from 1:00 p.m. - 3:20 p.m. The record failed to evidence a homemaker care plan. Review of an agency document titled "IDG [interdisciplinary group] Update [updated plan of care]" dated and signed 12/2/2020 by employee O (bereavement coordinator), employee C (registered nurse), employee K, and employee I failed to evidence homemaker services were ordered for the patient. 3. Clinical record review for patient #3 was completed on 12/2/2020, with hospice election date of 11/30/2020, benefit period 11/30/2020 - 2/27/2021, and primary diagnosis of COPD. Record review evidenced an unsigned document dated 11/30/2020 titled "Comprehensive Assessment" which stated "... Patient/Family Goals ... [box checked] Patient and family will receive physical, spiritual, and emotional support ...." The record failed to evidence the patient received services from the spiritual counselor. Review of an agency document titled "Initial Plan		· Patient #2: o An order was written for homemaker services on 12/03/2020 and a homemaker plan of care was created on 12/03/2020. · Patient #3: o Hospice has 5 calendar days to complete the comprehensive, which includes the spiritual assessment. The patient's spiritual assessment was completed on 12/02/2020 at 7:07pm CST, within 5 days from admission on 11/30/2020. Physical, emotional and spiritual support is being provided on an on-going basis by caregiving staff and the chaplain as documented in the patient's individualized medical record. **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 12/16/2020 regarding the Patient Plan of Care Policy. RN Case Managers will receive education regarding the requirement that the Plan of Care must be established and maintained based on the comprehensive assessment and updated as appropriate to reflect changes in the patient's status,	

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	of Care" dated and signed 11/30/2020 by employee O, employee C, employee F (registered nurse), employee H (spiritual counselor), employee L (registered nurse), employee E (medical director), and employee I failed to evidence orders for spiritual counseling visits. Review of an agency document titled "IDG Update" dated and signed 12/2/2020 by employee F, and employee I failed to evidence orders for spiritual counseling visits. 4. During an interview on 12/2/2020 at 3:30 p.m., while discussing current plans of care, employee C indicated she was aware some plans of care needed improvement, staff was engaged in ongoing training, and the management team continued to audit 100% of all new plans of care for all required elements.		services being provided according to required orders, 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 12/18/2020. **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 all clinical charts are audited for evidence 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, services are added, and that referrals are made to other disciplines with required orders as appropriate to meet the patient/family's needs for 4 weeks starting 12/18/2020. The threshold	

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			for compliance is 90%. · 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 90% 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:** December 18, 2020	
L 0545 Bldg. 00	418.56(c) CONTENT OF PLAN OF CARE The hospice must develop an individualized			

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	written plan of care for each patient. The plan of care must reflect patient and family goals and interventions based on the problems identified in the initial, comprehensive, and updated comprehensive assessments. The plan of care must include all services necessary for the palliation and management of the terminal illness and related conditions, including the following: Based on record review and interview, the hospice failed to ensure it developed individualized plans of care which included individualized patient interventions based on the problems identified in the initial comprehensive assessment for 1 of 4 clinical records reviewed (#2). Findings include: 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 ...." Clinical record review for patient #2 was completed on 12/2/2020, with hospice election date of 11/25/2020, benefit period 11/25/2020 - 2/22/2021, and primary diagnosis of COPD (chronic obstructive pulmonary/lung disease). Record review evidenced a document dated and signed on 11/25/2020 by employee J (registered nurse), titled "Comprehensive Assessment" stated "... smokes about a pack of cigarettes a day ... [patient's] primary concern is SOB [shortness of breath] ... patient lives alone ... depression ... other symptoms associated with the pain ... depression ... denies smoking in bedroom but there was an ashtray with cigarette butts in it ...."	L 0545	**CMS Tag L545 Hospice-CoP Standard: 418.56 (c) Content of the Plan of Care** **Findings:** The hospice failed to ensure it developed individualized plans of care which included individualized patient interventions based on the problems identified in the initial comprehensive assessment for 1 of 4 clinical records reviewed (#2). **Plan to correct specific deficiency cited:** · Patient #2: o A plan of care was completed for Depression, Safety (smoking in bed and around oxygen), and Pain and all interventions were added by 12/3/2020. o Smoking Cessation plan of care was not opened because this does not align with the patient's desired goals per specific discussions; this has been documented in Patient's individualized medical record. **Measures/Systematic Changes that will be put into place to ensure that the deficiency does**	12/18/2020

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	Review of an agency document titled "Initial Plan of Care" dated and signed 11/25/2020 by employee J, employee B (registered nurse), employee K (registered nurse), stated "... [patient] has a plan of care for dyspnea (difficulty breathing/shortness of breath) ...." The document failed to evidence reference to care plans for depression, not smoking with oxygen, or pain. Review of an agency document dated and signed 11/30/2020 by employee J titled "Care Plan" evidenced patient goals and interventions for dyspnea, but failed to include goals or interventions for smoking cessation. Review of 3 unsigned or dated agency documents titled "Care Plan" evidenced patient goals for depression, not smoking with oxygen, and pain. The documents failed to evidence any interventions (general nursing, or patient specific). During an interview on 12/1/2020 at 11:15 AM, employee C (registered nurse) indicated the plan of care included also documents titled "Care Plan", and "Safety Measures", and stated "They're all part of the [patient's] plan of care". During an interview on 12/2/2020 at 1:30 p.m., during review of the patient's clinical record, employee A (registered nurse, administrator) acknowledged the dyspnea care plan failed to address cigarette smoking, and the other 3 care plans were not completed with interventions.		**not recur:** · The Director of Clinical Services will educate RN case managers and IDG team members by 12/16/2020 regarding the Initial Plan of Care and Patient Plan of Care Policies. 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 to meet each patient's and family member's individualized 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 12/18/2020. **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 all clinical charts are audited for	

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			evidence 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, based on the comprehensive assessment and updated as appropriate to reflect changes in the patient's status and to meet each patient's and family member's individualized needs. The threshold for compliance is 90%. · 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 90% 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	

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			included in the agency's Quarterly Quality review data and reported to the Administrator and Governing Body. **Person Responsible:** Administrator **Completion Date:** December 18, 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 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 2 of 4 clinical records reviewed (#1, 2). 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 12/2/2020, with hospice election date of 11/24/2020, benefit period 11/24/2020 - 1/22/2021, and primary diagnosis of Parkinson's disease. Record review evidenced a document dated and signed on 11/24/2020 by employee F (registered nurse) titled "Nurse Progress Note" which stated "... plan of care opened for nutrition	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 2 of 4 clinical records reviewed (#1, #2). **Plan to correct specific deficiency cited:** · Patient #1: o Anxiety and Nutrition care plans were updated with specific, individualized interventions with measurable outcomes and goals for this patient on 12/8/2020. · Patient #2: o A plan of care was completed for Depression, Safety, and Pain and all interventions were specific	12/18/2020

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	with goals to maintain weight." Review of a document dated and signed on 11/24/2020 by employee H (spiritual care coordinator), employee G (social worker), employee C (registered nurse), employee F, and employee E (medical director), titled "Initial Plan of Care", stated "... The following Plan of Care(s) will be initiated based on the patient's and families' needs and goals. Please see the Plan of Care documents for specifics: Pt [patient] will be comfortable and his nutritional status will be monitored ...." This plan of care failed to evidence documentation of implementation of interventions to determine any measurable outcomes. Review of a document dated and signed on 11/25/2020, by employee F, titled "Care Plan" stated "... Problem being care planned: Agitiation ... Goals: pt will allow hospice and facility staff to get him out of bed daily ...." This care plan failed to evidence documentation of implementation of interventions to determine any measurable outcomes. Review of a document dated and signed on 12/2/2020, by employee F, titled "IDG [interdisciplinary group] Update", stated "... Plan of care opened for nutrition and anxiety/agitation. Family goals are for comfort and the use of broda [supportive, tilting, positioning chair] chair to be utilized ...." This plan of care failed to evidence documentation of implementation of interventions to determine any measurable outcomes. 3. Clinical record review for patient #2 was completed on 12/2/2020, with hospice election date of 11/25/2020, benefit period 11/25/2020 - 2/22/2021, and primary diagnosis of COPD (chronic obstructive pulmonary/lung disease).		with measurable outcomes and goals for this patient on 12/3/2020. **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 team members by 12/16/2020 regarding the Patient Plan of Care Policy. RN Case Managers will receive education regarding the requirement that the Plan of Care must have interventions with measurable outcomes to reflect the patient's and his/her family's individualized 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 12/18/2020. **How the agency will monitor its quality assessment/performance improvement functions to ensure that the corrective measure or systemic change is sustained:**	

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	Record review evidenced a document dated and signed on 11/25/2020 by employee J (registered nurse), titled "Comprehensive Assessment" stated "... smokes about a pack of cigarettes a day ... [patient's] primary concern is SOB [shortness of breath] ... patient lives alone ... depression ... other symptoms associated with the pain ... depression ... denies smoking in bedroom but there was an ashtray with cigarette butts in it ...." Review of an agency document titled "Initial Plan of Care" dated and signed 11/25/2020 by employee J, employee B (registered nurse), employee K (registered nurse), stated "... [patient] has a plan of care for dyspnea (difficulty breathing/shortness of breath) ...." This care plan failed to evidence documentation of implementation of interventions to determine any measurable outcomes. Review of an agency document dated and signed 11/30/2020 by employee J titled "Care Plan" failed to evidence documentation of implementation of interventions to determine any measurable outcomes. Review of 3 unsigned or dated agency documents titled "Care Plan" evidenced patient goals for depression, not smoking with oxygen, and pain, but failed to evidence documentation of implementation of interventions to determine any measurable outcomes. Review of a document dated and signed on 12/2/2020 by employee I, employee O (volunteer coordinator). employee K (registered nurse), and employee C, titled "IDG Update", stated "... Open care plans for depression/anxiety, dyspnea, and safety ...." This plan of care failed to evidence documentation of implementation of interventions		· The Director of Clinical Services or designee will ensure all clinical charts are audited for evidence that each Plan of Care has specific, measurable outcomes that reflect the patient and families' individualized goals starting 12/18/2020. The threshold for compliance is 90%. · 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 plan of care compliance. The threshold for compliance is 90% 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.	

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	to determine any measurable outcomes. 4. During an interview on 12/1/2020 at 11:15 a.m., employee C indicated the plan of care included also documents titled "Care Plan", and "Safety Measures", and stated "They're all part of the [patient's] plan of care". During an interview on 12/2/2020 at 3:30 p.m., employee C indicated the agency still had issues with plans of care, but were greatly improved, she was aware some plans of care needed improvement, staff was engaged in ongoing training, and the management team continued to audit 100% of all new plans of care for all required elements.		**Person Responsible:** Administrator **Completion Date:** December 18, 2020	
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 for 1 of 4 clinical records reviewed (#2), and treatment necessary to meet the needs of the patients for 1 of 4 clinical records reviewed (#4) Fndings 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 ...."	L 0549	**CMS Tag L549 Hospice-CoP Standard: 418.56 (c)(4) Content of the Plan of Care** **Findings:** the hospice failed to ensure it developed individualized plans of care which included drugs for 1 of 4 clinical records reviewed (#2), and treatment necessary to meet the needs of the patients for 1 of 4 clinical records reviewed (#4). **Plan to correct specific deficiency cited:** · Patient #2:	12/18/2020

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	12/03/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	2. Clinical record review for patient #2 was completed on 12/2/2020, with hospice election date of 11/25/2020, benefit period 11/25/2020 - 2/22/2021, and primary diagnosis of COPD (chronic obstructive pulmonary/lung disease). Record review of a document titled "Initial Plan of Care" dated and signed 11/25/2020 by employee J, employee B (registered nurse), employee K (registered nurse), failed to evidence documentation of current drug regimen. 3. Clinical record review for patient #4 was completed on 12/2/2020, with hospice election date of 11/27/2020, benefit period 11/27/2020 - 2/24/2021, and primary diagnosis of malignant neoplasm of unspecified part of unspecified bronchus or lung (lung cancer). Record review of a document signed and dated 11/27/2020 by employee N (registered nurse) evidenced the patient had an indwelling catheter [tube inserted directly into the bladder to drain urine). Review of a document dated and signed 11/27/2020 by employee N, and employee C (registered nurse) stated "... The following Plans of Care(s) will be initiated ... Dyspnea, Agitation ...." The document failed to evidence treatment necessary to meet the needs of the patient, specifically care and management of the indwelling urinary catheter. 4. During an interview on 12/1/2020 at 11:15 a.m., employee C indicated the plan of care also included documents titled "Care Plan", and "Safety Measures", and stated "They're all part of the [patient's] plan of care". During an interview on 12/2/2020 at 3:30 p.m., employee C indicated the agency still had issues with plans of care, but were greatly improved, she		o The patient's clinical record includes documentation of current drug regimen as of 12/03/2020. · Patient #4: o A Catheter Care plan of care was established for this patient on 12/3/2020. **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 team members by 12/16/2020 regarding the Patient Plan of Care Policy. RN Case Managers will specifically receive education regarding the requirement that the Plan of Care must have interventions that includes a regimen for all current medications and all treatments (including catheter care where relevant) necessary 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 12/18/2020.	

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	was aware some plans of care needed improvement, staff was engaged in ongoing training, and the management team continued to audit 100% of all new plans of care for all required elements.		**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 all clinical charts are audited for evidence that each patient's Plan of Care includes all current medications and necessary treatments listed as interventions starting 12/18/2020. The threshold for compliance is 90%. · 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 plan of care compliance. The threshold for compliance is 90% 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.	

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			· 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:** December 18, 2020	