STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	151582	A. BUILDING B. WING	09/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERNCARE SOUTH BEND	1626 E DAY RD, MISHAWAKA, IN, 46545

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
L0000	INITIAL COMMENTS At the direction of CMS, this was a federal complaint survey conducted at SouthernCare of South Bend, a deemed facility, by the Indiana Department of Health (IDOH). Complaint #: IN00383124: substantiated with findings. An Immediate Jeopardy related to 42 CFR §418.56 Interdisciplinary Group, Care Planning, and Coordination of Services was identified and announced on 9/26/22 at 12:46 PM. An Immediate Jeopardy related to 42 CFR §418.52 Patient's Rights was identified and announced on 9/27/22 at 1:51 PM. Due to the actions taken by the agency, the Immediate Jeopardy was abated prior to	L0000		2022-10-21

	Administrator was notified on 9/28/22 at 11:37 AM. Survey Dates: September 19, 20, 21, 22, 23, 26, 27, and 28 (2022). Facility ID: 003723 Current Census: 310 Quality Review Completed 10/11/2022			
L0500	PATIENTS' RIGHTS 418.52 An Immediate Jeopardy related to 42 CFR §418.52 Patient's Rights was identified and announced on 9/27/22 at 1:51 PM. The Immediate Jeopardy began on 9/21/22, when clinical record review evidenced Patient #9 (terminal Diagnosis cerebrovascular disease [an area of the brain is temporarily or permanently damaged by obstruction of blood flow or bleeding], other diagnosis Dementia) was oriented to self only, and was confused. On 9/06/22, The patient's in-home private duty caregiver (PDCG) informed the hospice agency of an incident of abuse that occurred on 9/05/22, and requested a nurse	L0500	· The Administrator reviewed the specific surveyfindings that lead to the Immediate Jeopardy concern with clinical staff on9/27/2022. · Patient #9 identified: o PRN IDG Meeting was held 9/27/2022 with Dr. Moore and the IDG team todiscuss the safety of the patient o Dr. Moore Hospice Medical Director called APS herself and spoke withBrenda the investigator o IDG action plan: § Daily SN visits § Weekly SW visits	2022-10-14

	visit. The PDCG witnessed a family member yell, physically grab and yank the patient, and told her to stop talking, to which the patient responded by hitting and kicking out toward the family member. The hospice nurse performed a visit on 9/06/22. She documented assessed bruising on the patient's right arm. On 9/15/22, a social worker visit was made, and the social worked documented the PDCG observed family member "being rough" with patient, and it upset the PDCG, patient was disoriented, family instructed PDCGs to have patient upstairs in her room before he/she got home from work at 4:00 PM, PDCG was concerned about patient's safety, as she "scooted" up and down the stairs, and the house smelled very strongly of cat urine. On 9/16/22, a nursing visit was made, which documented bruising noted to left lower back and left distal forearm, environmental issues included strong cat urine odor in home with fleas, patient fell on 9/11/22, and had difficulty going up/down the stairs. On 9/21/22 a clinical record document indicated the social worker received a call from the PDCG agency, who indicated they would no longer provide services to the patient due to the circumstances between the family member and the patient, PDCG felt it was unsafe for the patient, they were going to let Adult Protective Services (APS) know they were "backing out" of the case, and fleas remained in the home.		§ Offer PT evaluation for strengthening and stair safety. § Offer suggestion of installing chair lift for stair safety (ifdaughter desires this option) § Review LOC change option and use of respite services to be offered tothe daughter to allow break for daughterand to allow for home extermination of fleas if needed/desired § Suggest family meeting to include other daughters from out of state · For specific education, additional correctiveactions and monitoring see L511 and L517	

L0511	EXERCISE OF RIGHTS/RESPECT FOR PROPRTY/PERSON 418.52(b)(4)(iv) [The hospice must:] (iv) Ensure that verified violations are reported to State and local bodies having jurisdiction (including to the State survey and certification agency) within 5 working days of becoming aware of the violation. Based on record review and interview, the hospice agency failed to report a witnessed physical/verbal incident to the Indiana Department of Health (IDOH) and Adult Protective Services (APS) within 5 working days of becoming aware of the violation, for 1 of 1 clinical record reviewed where the patient experienced verbal/physical abuse by a family member (#9). Findings include: Review of an agency policy dated 11/2020, titled "Assessment of Possible Abuse/Neglect" stated, "... Hospice ... will report all suspected cases of abuse, neglect ... Report any verified violations to State ... within 5 working days ...." Review of an agency policy	L0511	· Action Statement: Clinical staff will beeducated on the requirement that verified violations are reported to the properauthorities within 5 working days of becoming aware of the violation. Educationwill include o Policy No. 2-002 Patient Bill of Rights. o SENTINEL EVENTS Policy No. 5-006 o COMPLAINT/GRIEVANCE PROCESS Policy No. 2-006 o ASSESSMENT OF POSSIBLE ABUSE/NEGLECT Policy No.2-035 o State of Indiana's definition of reportableevents o State of IN Paper Incident report if you cannotaccess the online system · Who is assigned: Administrator or Designee · Monitoring: Audit 25 records or 25% of the activecensus (whichever is greater) for each branch within the provider SSB, SKM,SMC, SLF, SVA, and SFT by 10-21-22	2022-10-21

	dated 5/22, titled "Patient Rights" stated, "... Hospice Has the Responsibility ... To ensure that all alleged violations ... are reported immediately ... to State and local bodies ... including ... [IDOH] ... within 5 working days of becoming aware ...." Review of the agency's incident/complaint log on 9/21/22, evidenced a document dated 9/06/22, titled "Client Occurrence Report", which indicated entity 3 (a non-medical provider for PDCG services) staff requested a hospice nurse visit because she witnessed a verbal/physical altercation between the patient and a family member on 9/05/22; family yelled, grabbed, and yanked the patient's right arm, and told the patient to be quiet and stop talking. In response, the patient hit and kicked out toward the family member. The documented stated "... [the nurse assessed] ... right posterior [back] forearm old bruising yellowish in color and round circular dime sized old purplish in color bruise to anterior [front] right forearm ...." The document also included an update added by Administrator #1 on 9/06/22, which indicated		are reported to the proper authorities in atimely manner, with corrections/amendments made as applicable. o Audit 10 patient records or 10% of the dailycensus (whichever is greater) for each branch within the provider SSB, SKM,SMC, SLF, SVA, and SFT weekly beginning10-23-22 until the Threshold has been met to ensure that verified violationsare reported to the proper authorities timely. o Target Threshold- 90% or greater o Audits will continue weekly until the resurvey. o Post resurvey: § When Threshold has been met for 4 consecutiveweeks, we may reduce audits to 10 records or 10% of the daily census (whicheveris greater) for each branch within the provider SSB, SKM, SMC, SLF, SVA, and SFT monthly § When Threshold has been met for 2 consecutivemonths, may reduce audits to 10 records or 10% of the daily census (whicheveris greater) for each	

	a call was placed to entity #3, the Administrator spoke with entity #3's manager (other person #5), who indicated he was going to place a call to APS to report the incident. The document failed to evidence the hospice agency reported the incident to IDOH or APS. During an interview on 9/21/22 at 5:18 PM, Administrator #1 indicated the agency collaborated with entity #3, entity #3 staff witnessed the incident, not the hospice agency, so they (entity #3) actually contacted APS to put in a complaint to do further investigation. When queried if the hospice agency followed up on the APS complaint, Administrator #1 stated "Yes, and there were no significant findings ... The caregiver is still in the home ...." During an interview on 9/26/22 at 12:23 PM, when queried about alleged abuse, entity #3's manager (other person #5) indicated he had concern with family/patient interaction, and he notified APS. When queried if there was any outcome, person #5 indicated he didn't		branch within the provider SSB, SKM, SMC, SLF, SVA, and SFT to quarterly.	

	agency to make them aware of the concern for abuse on 9/06/22, and APS was called again (by entity #3) on 9/12/22. During an interview on 9/26/22 at 1:05 PM, when queried if the hospice agency notified IDOH, Administrator #1 stated "No." When queried if there was any agency documentation about follow up with APS, or if it was confirmed that entity #3 contacted APS, Administrator #1 indicated there was not.			
L0517	RIGHTS OF THE PATIENT 418.52(c)(6) [The patient has a right to the following:] (6) Be free from mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property; Based on record review and interview, the hospice agency failed to ensure the patient was free from mistreatment, verbal, and/or physical abuse, which also included injuries of unknown source, for 1 of 1 clinical record reviewed where	L0517	· Action Statement: Clinical staff will beeducated on the requirement that patients have the right to be free frommistreatment, neglect, verbal, mental, sexual, and physical abuse, or misappropriationof patient property and that alleged violations will be reported immediately tothe administrator/executive director. Education will include o Policy No. 2-002 Patient Bill of Rights. o SENTINEL EVENTS Policy No. 5-006 o COMPLAINT/GRIEVANCE	2022-10-21

	the patient experienced verbal/physical abuse by a family member (#9). The findings include: Review of an agency policy dated 11/2020, titled "Assessment of Possible Abuse/Neglect" stated, "... Occurrences may include but are not limited to ... Physical Abuse ... [examples] ... bruise ... Neglect/Failure to Provide ... Acceptable environment ... Verbal Abuse ... Verbal humiliation ... Upon receiving a report of a potential patient violation [sic] the hospice must ... Ensure patient is protected from further potential violations during the investigational period ... [ensure] further potential abuse has been prevented ...." Review of an agency policy dated 5/22, titled "Patient Rights" stated, "... Patients Have the Right ... To be free from mistreatment, neglect, or verbal, mental ... emotional, and physical abuse, including injuries of unknown source ...." Review of the agency's incident/complaint log on 9/21/22, evidenced a document		PROCESS Policy No. 2-006 o ASSESSMENT OF POSSIBLE ABUSE/NEGLECT Policy No.2-035 o State of Indiana's definition of reportableevents o State of IN Paper Incident report if you cannotaccess the online system · Who is assigned: Administrator or Designee · Monitoring: Audit 25 records or 25% of the activecensus (whichever is greater) for each branch within the provider SSB, SKM,SMC, SLF, SVA, and SFT by 10-21-22 toensure that alleged violations were reported to the administrator/executivedirector, with corrections/amendments made as applicable. o Audit 10 patient records or 10% of the dailycensus (whichever is greater) for each branch within the provider SSB, SKM,SMC, SLF, SVA, and SFT weekly beginning 10-23-22until the Threshold has been met to ensure that alleged violations werereported to the administrator/executive	

	dated 9/06/22, titled "Client Occurrence Report", which indicated entity 3 (a non-medical provider for private duty caregiver services) staff requested a hospice nurse visit because entity #3 witnessed a verbal/physical altercation between the patient and a family member on 9/05/22; family yelled, grabbed, and yanked the patient's right arm, and told the patient to be quiet and stop talking. The documented stated "... [the nurse assessed] ... right posterior [back] forearm old bruising yellowish in color and round circular dime sized old purplish in color bruise to anterior [front] right forearm ...." The document failed to evidence the hospice agency conducted its own investigation, ensured the patient was safe, or attempted to determine the cause of the "old" bruises. Clinical record review on 9/21/22, for patient #9, election of benefit/hospice admission date 4/19/22, primary diagnosis cerebrovascular disease (an area of the brain is temporarily or permanently damaged by obstruction of blood flow or bleeding) and other diagnosis		director. o Target Threshold=90% or greater o Audits will continue weekly until resurvey. o Post resurvey: § When Threshold has been met for 4 consecutiveweeks, may reduce audits to 10 records or 10% of the daily census (whichever isgreater) for each branch within the provider SSB, SKM, SMC, SLF, SVA, and SFT monthly. § When Threshold has been met for 2 consecutivemonths, may reduce audits to 10 records or 10% of the daily census (whicheveris greater) for each branch within the provider SSB, SKM, SMC, SLF, SVA, and SFT to quarterly.	

	Dementia, evidenced a document dated 9/06/22, titled "Visit Note Report", which indicated a nursing visit was made due to allegations of abuse by family, and Administrator #1 "was made aware". Review of a document dated 9/15/22, titled "Visit Note Report", indicated a social worker visit was made, and documented entity #3 staff observed family member "being rough" with patient, it upset entity #3 staff, patient was disoriented, family instructed entity #3 staff to have patient upstairs in her room before he/she got home from work at 4:00 PM, entity #3 staff was concerned about patient's safety, as she "scooted" up and down the stairs, and the house smelled very strongly of cat urine. The document failed to evidence the hospice agency provided any intervention for the patient's safety/prevention of abuse, safety while using stairs, or to ensure an acceptable home environment. Review of a document dated 9/16/22, titled "Visit Note Report", indicated a nursing visit			

	was made, which documented bruising noted to left lower back and left distal forearm, environmental issues included strong cat urine odor in home with fleas, patient fell on 9/11/22, and had difficulty going up/down the stairs. The document failed to evidence the hospice agency provided any intervention for safety while using stairs, why/how the patient fell, or to ensure an acceptable home environment. A document dated 9/19/22, titled "Hospice IDG [interdisciplinary group] Comprehensive Assessment and Plan of Care Update Report", evidenced social worker #1 received phone calls from entity #3 with concerns that patient had bruises and witnessed family being rough with the patient. The document failed to indicate the hospice IDG took any immediate action to ensure the patient's safety or prevention of further abuse. Review of a document dated 9/21/22, titled "Client Coordination Note Report", indicated the social worker received a call from entity #3, who indicated they would no			

	longer provide services to the patient due to the circumstances between the family member and the patient, entity #3 felt it was unsafe for the patient, they were going to let Adult Protective Services (APS) know they were "backing out" of the case, and fleas remained in the home. During an interview on 9/26/22 at 12:23 PM, when queried about alleged abuse, entity #3's manager (person #5) indicated he/she had concern with family/patient interaction, and he/she notified APS. When queried if there was any outcome, person #5 indicated he/she didn't know, he/she informed the hospice agency to make them aware of the concern for abuse on 9/06/22, and APS was called again (by entity #3) on 9/12/22. During an interview on 9/26/22 at 1:05 PM, when queried what steps were taken when the agency was made aware of the witnessed verbal/physical abuse, Administrator #1 indicated a nurse went out to assess the patient, the social worker and chaplain always checked while they visited, and			

	family was rarely present during hospice agency visits. When queried if physical therapy (PT) was referred for the concern with the patient's ability to safely negotiate stairs, Administrator #1 indicated there was not a PT referral made.			
L0536	IDG, CARE PLANNING, COORDINATION OF SERVICES 418.56 An Immediate Jeopardy related to 42 CFR §418.56 Interdisciplinary Group, Care Planning, and Coordination of Services was identified and announced on 9/26/22 at 12:46 PM. The Immediate Jeopardy began on 9/21/22, when clinical record review evidenced Patient #8 (admitted 5/6/22, terminal diagnosis osteomyelitis [infection in bone], other diagnosis paraplegia [paralysis of legs and lower body]), had a Stage 4 pressure injury (PI) (wound caused by unrelieved pressure, with muscle, tendon, and/or bone exposed) to coccyx (tailbone area) identified 5/6/22, and Stage 4 PI's to left and right buttocks, also identified on 5/6/22. On 8/9/22, the EMR indicated the buttocks ulcers	L0536	· The Administrator reviewed the specific surveyfindings that lead to the Immediate Jeopardy concern with clinical staff on 9/26/2022 · Patient # 8 Identified: o Supervisory visit made 9-27-22 to ensure POC was corrected, orderswere corrected and followed, assessment and measurements completed. · Patient # 11 Identified: o Supervisory visit 9-27-22made to ensure POC was corrected,orders were corrected and followed, assessment and measurements completed. o Continue to Assess weekly	2022-09-28

	had "morphed into one bigger wound", to include area of gluteal cleft (vertical crease between buttocks) and rectal area, with "extensive" depth, and purulent (indicative of infection) drainage, tunneling (a wound that's progressed to form passageways underneath the surface of the skin). Antibiotics weren't ordered until 9/2/22 for wound infection, newly prescribed Morphine for increased pain, and also indicated extensive patient non-compliance with treatment orders and medications. Interdisciplinary Group (IDG)/plan of care (POC) documents failed to include the patient's ongoing non-compliance with treatment/medications; wound assessments, which would include all wounds, location(s), and measurements; or wound treatments. The EMR also indicated the wounds were not assessed by the hospice nurse(s) since 8/09/22. During a home visit on 9/23/22, surveyor observed presence of wounds not included in the EMR (greater than 2), and worsening of wound(s) as compared to most recent documentation reviewed in the EMR. Patient #11 was admitted to hospice 11/23/20, with terminal diagnosis hypertensive heart disease with heart failure (inability to effectively pump blood throughout the body, caused by high blood pressure). The EMR indicated a wound was present on		· Patient # 5Identified: o Supervisory visit 9-27-22made to ensure POC wascorrected, orders were corrected and followed, assessment and measurementscompleted. o Continue to Assess weekly	

	the left lower leg, and the last wound care order was 7/22/22. The EMR failed to evidence any assessment of the wound on or after 7/22/22. When interviewed, registered nurse (RN) #1 indicated she knew the patient had a wound, but couldn't remember which leg, she'd never assessed or seen the wound herself, she saw a picture of it "at least 3 or 4 weeks ago"; and Entity #1 (an extended care facility [ECF]) where the patient resided, had a wound care nurse, and they did the wound care. Review of Entity #1 documentation indicated the patient actually had 2 ongoing wounds to the left lower leg. Entity #1 staff interview revealed last picture taken of wound(s) was 4/28/22, and the hospice nurse(s) were aware the wound physician rounded (saw patients) on Tuesdays, and were always welcome to attend and participate in wound assessments. The hospice IDG meeting notes failed to evidence accurate number of wounds, location(s), measurements, or treatment; and failed to include care coordination between Entity #1 and the hospice agency. Patient #5 (admitted to hospice 7/11/22, revoked 8/08/22, terminal diagnosis chronic obstructive pulmonary disease [COPD] [long-term lung disease]). The RN admission document indicated the patient had abdominal surgery "2 days ago (7/9/22)" with presence of incisions. No assessments of			

	incisions were made during the visit. During this visit, the patient's oxygen saturation (O2 sat) was 88% (95-100% is normal range). No further indication O2 sat was checked at any subsequent nursing visit. Interview with the admitting RN indicated checking O2 saturation was "not part of hospice vital signs". A skilled nursing note dated 7/12/22 indicated the patient asked nurse to assess the surgical sites, as the dressings had not been removed since surgery (7/9/22), an incision had a large amount of drainage, but no documentation of an assessment made, or measurements taken. A nursing note dated 7/20/22, indicated the patient only had 1 lung, and stated she was unable to breathe. No O2 sat was assessed. The patient used oxygen 2LPM (2 liters per minute), and reported minor pain to abdomen. A skilled nursing visit note dated 8/05/22 indicated the patient complained of shortness of breath, and used oxygen 2 LPM. The note failed to evidence the nurse increased quantity of oxygen administration or assessed O2 sat. The patient's medication list indicated the patient could use O2 at 2-3 LPM. A patient coordination note dated 8/08/22 indicated the patient stated she felt like she was being smothered, and revoked services. IDG document dated 7/13/22 failed to evidence the presence of surgical incisions, assessment, or treatment. Due to the actions taken by the			

	agency, the Immediate Jeopardy was abated prior to the conclusion of the survey on 9/28/22, at 11:37 AM. The cumulative effect of these systemic problems resulted in the hospice agency's failure to ensure the provision of quality health care in a safe environment at 42 CFR §418.56 Interdisciplinary Group, Care Planning, and Coordination of Services. Other unrelated conditions of participation and findings will be cited. Additionally, the hospice agency failed to ensure the patient's plan of care included measurable outcomes (See tag L548); failed to ensure the patient's plan of care included all drugs and/or treatments (See tag L549); failed to review/revise, and document the patient's plan of care as often as needed (See tag L552); and failed to ensure it directed, supervised, and coordinated/shared information to meet the patient's needs (See tag L554). This practice had the potential to affect all agency patients. A standard level citation was evidenced as follows: Based on observation, record			

	review, and interview, the hospice agency failed to ensure all patients' plans of care contained patient-specific treatment/care needs, it supervised the care provided, ensured continuous assessments that met the patients' needs, or coordinated care to ensure needs were met, all which led to wound infection(s), emergent hospitalization, and/or likelihood of new/worsening wounds for 3 patients (#5, 8, 11). This practice had the potential to affect all agency patients. The findings include:			

	7. The clinical record of Patient #8 was reviewed on 09/22/2022 and 09/27/2022. The record included a skilled nursing visit completed on 08/09/2022 by RN #1. The visit note indicated Patient #8 had one extensive Stage 4 pressure ulcer to their left and right buttocks, gluteal cleft (groove between buttocks), and rectum. The nurse measured the wound to be 11 cm in length by 17.8 cm in width by 2.4 cm in depth with undermining of 2.1 cm from 12 – 3 o'clock, 2.8 cm from 3 -6 o'clock, 4.2 cm from 6 - 9 o'clock, and 4 cm from 9- 12 o'clock, and tunneling of 4.8 cm from 6 -9 o'clock. An interview was conducted on 09/23/2022 at 9:40 AM with LPN #1. During the interview, the LPN confirmed Patient #8 refused any wound care or treatment to their Stage 4 bilateral (both right and left sides of the body) gluteal cleft wound. The nurse indicated the patient would typically allow her to assess the wound but refused wound care treatment. LPN #1 reported she felt the patient was depressed and had "given up."			

	A home visit observation with Patient #8 occurred on 09/23/2022 at 10:00 AM with RN #1 and LPN #1. Upon entry to the home, Patient #8 was noted to be lying on a hospital bed however no specialty mattress was observed. During the home visit, RN #1 assessed Patient #8's right leg and foot. The patient had two closed wounds on their right anterior toes, one to the 3rd toe and one to the 5th toe. The patient also had pencil-sized dark purple bruising to their anterior right 4th toe. The patient reported the wounds had been present for "a few" weeks. RN #1 indicated she had completed the assessment of the patient's right leg and foot and began to put the patient's clothing back on their foot but had failed to assess or measure the right toe wounds. After prompting from the surveyor, the nurse assessed and measured the right toe wounds. RN #1 then moved to assessing the patient's Stage 4 bilateral gluteal cleft wound. The surveyor observed a Stage 2 pressure ulcer to the patient's midline lower back above the Stage 4 bilateral gluteal cleft wound. After the nurse assessed and measured the Stage 4			

	gluteal cleft wound, she indicated the patient could reposition back onto their back despite the nurse failing to assess the midline Stage 3 coccyx wound. The surveyor asked RN #1 if wound to coccyx was new and the nurse reported she had not seen the wound prior to it being pointed out by the surveyor. The nurse then assessed and measured wound but failed to offer wound care for the midline coccyx wound. Later in the visit, the nurse confirmed she had completed her assessment of the patient but had failed to assess the patient's left leg and foot. After prompting by the surveyor, the nurse assessed the left leg and foot. A closed wound to the 2nd left anterior toe was noted. An interview was conducted on 09/23/2022 at 10:53 AM with Patient #8. The patient confirmed they routinely declined wound care to their extensive coccyx/gluteal wound due to the wound having copious amounts of drainage and the wound dressing would get saturated and fall off within 1 hour of applying. Patient #8 indicated they had been declining a wound dressing to			

	the extensive coccyx/gluteal wound for several years. The patient stated they preferred no dressing to be applied to the area and only have reusable pads placed underneath them. An interview was conducted on 09/23/2022 at 11:00 AM with RN #1. During the interview, the nurse confirmed they were the nurse case manager for Patient #8 and attended the patients' IDG meetings. The nurse reported the patient's primary concern discussed during IDG was pain control. RN #1 reported the visit completed on 09/23/2022 was the first visit "in a long time" where the patient allowed her to measure their wounds. The nurse indicated the patient typically allowed her during visits to assess the wound but declined wound measurements. RN #1 could not remember the last time the wound was measured. RN #1 indicated Patient #8 had refused wound care or treatment since she began caring for the patient. The clinical note from the visit completed on 09/23/2022 was reviewed on 09/27/2022. RN #1			

	"unstageable" wounds to the patient's right 5th toe, the first measuring 1 cm in length by 1 cm in width with no depth and the second measuring 1 cm in length by 1.5 cm in width with no depth. The visit note documentation indicated one new "unstageable" wound to the left 5th toe measuring 1 cm in length by 0.75 cm in width with no depth and one new Stage 3 pressure ulcer to the midline lower back measuring 3 cm in length by 2 cm in width by 0.25 cm in depth. The visit note documentation also indicated the Stage 4 pressure ulcer wound to the left and right gluteal clefts measured 23 cm in length by 18 cm in width by 2 cm in depth with undermining of 1.75 cm from 12 – 3 o'clock, 2.5 cm from 3-6 o'clock, 2.5 cm from 6 -9 o'clock, and 2 cm from 9 -12 o'clock. No tunneling was noted. The documentation indicated there was no change in the wound despite the increase of 5.2 cm in length compared to the 08/09/2022 assessment. The assessment failed to reflect the wounds observed on Patient #8's right 3rd toe and left 2nd toe.			

	1. A Joint Commission web-based reference reviewed 9/21/22, https://www.jointcommission.org/standards/standard-faqs/home-care/provision-of-care-treatment-and-services-pc/000001744/?p=1, titled "Topic: Pulse Oximetry [O2 sat] - Order by Physician/Licensed Independent Practitioner ... Is a Physician/Licensed Independent Practitioner's order required for the use of a pulse oximeter?" stated, "... CMS does not have any requirements which prohibit the use of pulse oximetry without a physician's order ... The use of pulse oximetry on a PRN [as needed] basis may be viewed as a part of vital signs [temperature, heartbeats per minute, breaths per minute, blood pressure] ...." 2. Review of an agency policy dated 11/2020, titled "Ongoing Assessment" stated, "... During each home visit, the Case Manager [nurse] ... will evaluate the patient according to the problems ... assess each patient on each visit for ... Vital signs appropriate to the patient's condition ... skin integrity ...." 3. Review of an agency policy dated 8/05/22, titled "Wound Assessment, Documentation			

	and Clinical Oversight" stated, "... Physician orders will be obtained for all wound treatments ... Wound assessments will be performed ... no less than once weekly ... will include wound measurements ... Location ... Wound bed characteristics ... Condition of surrounding skin ... Patients Who Reside in Facilities ... information applies to all patients, including those who reside in a facility ... If facility staff are performing wounds care, the hospice nurse must assess the wound at least once per week, documenting a full assessment. This is not optional ... The patient/caregiver has the right to refuse treatment ... When a patient/caregiver refuses wound assessment or wound care, the following must be completed ... Educate patient ... on importance of wound assessment and wound care ... potential consequences ... Notify the attending physician ... Report refusals to the ... members of the IDG ... include specifics regarding the refusal ... Document the report, the plan to address refusals, and collaboration in the IDG note ...."			

	4. Review of an agency policy dated 6/27/22, titled "Hospice Nursing Care" stated, "... The hospice nurse will ... Initiate appropriate preventative ... nursing procedures ... Assure communication ... between the hospice and other non-hospice health care providers ...." 5. Review of an agency policy dated 1/2022, titled "Interdisciplinary Group Membership and Responsibilities" stated, "... responsibilities include but are not limited to ... establishment of the plan of care ... periodic review and updating of the plan of care ... to evidence specific treatments, goals and outcomes ... Coordination of care ... to include ... non-hospice care providers ...." 6. Clinical record review on 9/21/22, for patient #8, election of benefit/hospice admission date 5/6/22, terminal diagnosis osteomyelitis [infection in bone], other diagnosis paraplegia [paralysis of legs and lower body]), evidenced a document titled "Visit Note Report" (skilled nurse home visit), dated 8/04/22. The			

	a stage 4 PI on the patient's coccyx, with onset date 5/06/22; a stage 4 PI on the patient's right buttock; and a stage 4 PI on the patient's right buttock; and the patient refused wound assessment or treatment. A document titled "Visit Note Report" (skilled nurse home visit), dated 8/09/22, indicated the patient was non-compliant with taking medications, following treatment orders on the plan of care, and this was reported to the RN Case Manager, and IDG team coordination was needed; and the stage 4 PIs to the left and right buttocks became 1 large wound, which now included both buttocks, gluteal cleft, and rectal area, with purulent drainage, extensive wound depth, and signs of infection present. A document titled "Hospice IDG Comprehensive Assessment and Plan of Care Update Report", dated 8/10/22, indicated skilled nurse visits were ordered 2 times weekly, wound care was ordered daily, wounds continued to get worse, and patient was non-compliant with			

	and listed diagnoses included only 1 wound- "pressure ulcer [injury] of unspecified site, unspecified stage". The document failed to include who did wound care on days the hospice nurse was not present, or a plan to improve compliance with medications and wound care; an actual number of, locations, assessments, or measurements of all wounds the patient had. Documents titled "Visit Note Report" (skilled nurse home visit), dated 8/04/22, 8/16/22, 8/18/22, 8/23/22, 8/30/22, and 9/13/22, all indicated the patient refused wound assessment/treatment. Documents titled "Visit Note Report", dated 8/18/22, 8/30/22, 9/01/22, 9/08/22, 9/13/22, and 9/15/22, all indicated wound care was already completed, and no wound care/assessment was performed by the hospice nurse. A document titled "Visit Note Report", dated 09/02/22, indicated the visit occurred at the request of family, due to the patient's complaint of pain level			

	10 (0= no pain at all, with 10= worst pain ever, unbearable) to tailbone area, hips, and lower back and family report of change in wound appearance. Review evidenced the nurse failed to assess wounds or provide wound care. A new antibiotic and morphine was ordered. No further nursing visit was made until 9/08/22. A document titled "Hospice IDG Comprehensive Assessment and Plan of Care Update Report", dated 9/07/22, indicated skilled nurse visits were ordered 2 times weekly, antibiotics were ordered 9/02/22 (daily for 10 days) for wound infection, morphine was ordered 9/02/22 for pain, presence of "multiple wounds", wounds have increased in size, and problems to be addressed over the next 2 weeks included the primary caregiver (family, who patient resided with) had failing health, the patient experienced depression, and need for facility placement. The document failed to include wound care orders, efficacy of antibiotic treatment, level of pain relief from morphine, or an actual number of, locations, assessments, or measurements of all wounds			

	the patient had; the failure of hospice nurses to assess wounds since 8/09/22 with a plan for immediate completion of wound assessment/treatment plan; or a plan to prevent further deterioration of wounds. A document titled "Visit Note Report", dated 09/08/22, failed to evidence the nurse assessed or provided wound treatment for efficacy of antibiotic treatment, or assessed compliance with taking all antibiotics as ordered. A document titled "Hospice IDG Comprehensive Assessment and Plan of Care Update Report", dated 9/21/22, indicated the patient had multiple wounds which were getting larger, recently prescribed morphine, and new infection in wound and placed on antibiotics. The document failed to include update on caregiver's failing health, the patient's depression, or current need for facility placement; wound care orders, efficacy of antibiotic treatment, level of pain relief from morphine, or an actual number of, locations, assessments, or measurements of all wounds			

	hospice nurses to assess wounds since 8/09/22 with a plan for immediate completion of wound assessment/treatment plan; or a plan to prevent further deterioration of wounds. A document titled "Visit Note Report", dated 09/08/22, indicated 4 new wounds were identified, the wound to the buttocks, gluteal cleft, and rectum area was significantly worse/larger; and no wound care was being performed per the patient, as the patient wanted the incontinence pads to absorb wound drainage. During an interview on 9/21/22 at 3:57 PM, Administrator #1 indicated the patient's clinical record didn't show any wound measurements after 8/09/22. During an interview on 9/23/22 at 4:18 PM, Administrator #1 indicated the patient had the right to refuse (treatments), but IDG should be discussing it, and the first goal was to keep the patient comfortable, and she would expect to see that included on IDG meeting notes. When queried if a full head to toe assessment was appropriate			

	Director of Education #5 stated "Yes we would expect a full head to toe assessment." Area Director of Education #5 also indicated the patient's depression and non-compliance should be discussed and documented in IDG meeting notes. 7. Clinical record review on 9/21/22, for Patient #11, election of benefit/hospice admission date 11/23/20, terminal diagnosis of hypertensive heart disease with heart failure (inability to effectively pump blood throughout the body, caused by high blood pressure), evidenced an undated (cumulative report) document received on 9/22/22, titled "Wound Record Report". The document evidenced the patient had one stage 2 (partial thickness, involving no more than the layers of the skin) PI to the left lower leg, with onset date 7/20/2020, a nurse visit date 7/22/22, and an order for wound care to be performed by the hospice nurse each visit. The document failed to evidence the wound was assessed, measured, or wound care was performed on or any time after 7/22/22.			

	A document titled "Visit Note Report", dated and signed by RN #1 on 09/12/22, indicated the patient had "wound(s)". The document failed include assessment of the wound, or wound care was performed. A document titled "Hospice IDG Comprehensive Assessment and Plan of Care Update Report", dated 9/14/22, indicated the patient resided at an extended care facility (ECF) (no further information provided), and had wounds on leg (not further specified). The document failed to specify the type, location, assessment, or measurements of the wound(s), wound treatment orders, what ECF the patient resided at, or who performed wound care for the patient; and failed to include care coordination between Entity #1 and the hospice agency. During an interview on 9/22/22 at 2:21 PM, RN #1 indicated she knew the patient had a wound, but couldn't remember which leg, she'd never assessed or seen the wound herself, she saw a picture of it "at least 3 or 4 weeks ago"; and Entity #1 (ECF) (where the patient resided) had			

	a wound care nurse, and they did the wound care. When queried if the patient had more than 1 wound, RN #1 stated, "No." During an interview on 9/22/22 at 1:35 PM, the Administrative RN #4 (Area Vice President of Operations) indicated she was the agency's Clinical Supervisor, the patient resided at a facility, and "they" typically had a wound care nurse. When queried where the wound was documented in the clinical record, Administrator #1 indicated she didn't see anything. Administrative RN #4 indicated she saw an order for wound care on 5/18/22. When queried if all wound assessments performed during visits would be included on the "Wound Record Report", Administrative RN #4 indicated the report showed a wound to the left lower leg on the report, and she assumed all wound assessments would be on the report. At 1:44 PM, Administrator #1 indicated there were no wound care orders after 7/22/22, or wounds assessments on or after 7/22/22.			

	Review of Entity #1 documentation received on 9/23/22, dated 9/16/22 and 9/20/22, both titled "Wound Evaluation and Management Summary" indicated the patient had 2 current, chronic/ongoing wounds greater than 1 year old to the left lower leg, and wound care was ordered 3 times weekly. During an interview on 9/23/22 at 11:50 AM, Staff #2 (at Entity #1) indicated the last picture taken of wound(s) was 4/28/22, they didn't do that anymore, the hospice nurse(s) were aware that the wound physician rounded (saw patients) on Tuesdays, and were always welcome to attend and participate in wound assessments. 8. Clinical record review on 9/21/22, for Patient #5, election of benefit/hospice admission 7/11/22, revoked 8/08/22, terminal diagnosis chronic obstructive pulmonary disease (COPD) (long-term lung disease), evidenced a document dated 7/11/22, titled "Hospice RN Start of Care". The document indicated the patient			

	used continuous supplemental oxygen at 2 LPM, had abdominal surgery "2 days ago (7/9/22)" with presence of incisions. No assessments of incisions were made during the visit. Also during this visit, the patient's oxygen saturation (O2 sat) was 88% (95-100% is normal range). No further indication O2 sat was re-checked, or checked during any subsequent nursing visit. A document titled "Visit Note Report", dated 7/12/22, indicated the patient asked the nurse to assess the surgical sites, as the dressings had not been removed since surgery (7/9/22), an incision had a large amount of drainage, and wound care was performed with a dressing change; and failed to evidence documentation that an assessment was made, or measurements taken. A document titled "Visit Note Report", dated 7/20/22, indicated the patient only had 1 lung, stated she was unable to breathe, and reported minor pain to her abdomen. The nurse failed to assess O2 sat or abdominal incision(s).			

	A document titled "Visit Note Report", dated 8/05/22, indicated the patient complained of shortness of breath, and used oxygen 2 LPM. The note failed to evidence the nurse increased quantity of oxygen administration or assessed O2 sat. A document received 9/20/22, titled "Client Medication Report" indicated the patient could use O2 at 2-3 LPM, with an effective date of 7/11/22. A document dated 8/08/22, titled "Client Coordination Note Report", indicated the patient stated she felt like she was being smothered, and revoked services to seek aggressive treatment. A document titled "Hospice IDG Comprehensive Assessment and Plan of Care Update Report", dated 7/13/22 failed to evidence the presence of surgical incisions, assessments made, or wound/incision care orders. A document titled "Hospice IDG Comprehensive Assessment and Plan of Care Update Report", dated 7/27/22, failed to evidence the presence of			

surgical incisions, assessments made, wound/incision care orders, plan to mitigate shortness of breath, or abdominal pain.

During an interview on 9/20/22 at 2:39 PM, Administrator #1 indicated she was unaware there was no regulation which required a physician's order to obtain O2 sat, the clinical record failed to include incision/wound care orders, or detailed assessment of incision(s), wounds and treatment; orders should be on the plan of care; and the "Hospice IDG Comprehensive Assessment and Plan of Care Update Report" was the plan of care and comprehensive assessment.

During an interview on 9/21/22 at 10:20 AM, RN #2 indicated she performed the start of care visit for patient #5. When queried the procedure for charting on incisions/wounds, RN #2 stated, "You would assess upon admission ... [the patient] had the dressing on it [incision(s)] ... and they [patient/family] had said it was just put on in the hospital ... and I didn't have supplies because I

	... I called the doctor on admission, to make sure he didn't want to change the orders for treatment ... The patient and [family] wanted it changed the next day ....” When queried if that information was documented in the start of care visit note, RN #2 stated “I probably didn't ... I'm trying to enter a late note ... I did not get those details in there appropriately ....” When queried how often the incision(s) should be assessed, RN #2 stated “They [no further specific identifier] instructed daily dressing change, so I added that [late visit note] ... I want to say we would check it 2 or 3 times a week ....” When queried about O2 sats, RN #2 stated “... It looks like I have 88% in the note ... But the patient said my O2 sat was wrong, and she never runs that low ....” When queried if she checked the patient’s O2 sat every visit, RN #2 stated “... Usually just a baseline ... I usually check each visit ... I know it’s not a vital sign for hospice ....”			
L0548	CONTENT OF PLAN OF CARE	L0548	· Action Statement: Clinical staff will beeducated on the requirement that the plan of	2022-10-21

	418.56(c)(3) [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 observation, record review, and interview, the hospice agency failed to ensure the patient's plan of care included measurable outcomes for 6 of 6 active clinical records reviewed (#1, 3, 8, 9, 10, 11). The findings include: 1. Review of an agency policy dated 01/22, titled "Interdisciplinary Group [IDG] Membership and Responsibilities" stated "... responsibilities include ... updating of the plan of care for each patient ... to evidence specific ... outcomes ...." 2. Review of an agency policy received 9/26/22, dated "February" (no year identified), titled "The Plan of Care", stated "... The individualized plan of care will be reviewed by the		care must include measurableoutcomes anticipated from implementing and coordinating the plan of care.Education will include o Policy 4-027 Plan of Care · Who is assigned: Administrator or Designee · Monitoring: o Audit 25 records or 25% of the active census(whichever is greater) for each branch within the provider SSB, SKM, SMC, SLF,SVA, and SFT 10-21-22 to ensure there isevidence in the patient record that the plan of care includes measurableoutcomes, with corrections/amendments made as applicable o Audit 10 patient records or 10% of the dailycensus (whichever is greater) for each branch within the provider SSB, SKM,SMC, SLF, SVA, and SFT weekly beginning10-23-22 until the Threshold has been met to ensure there is evidence in thepatient record that the plan of care includes measurable outcomes o Target Threshold 90% or	

	patient will be monitored for ... response to care or services provided against ... goals ... and patient outcomes to evaluate progress ... written plan of care will contain ... Measurable outcomes ...." 3. Review of an agency policy dated 11/2020, titled "Ongoing Assessments", stated, "... the plan of care-including ... goals, and outcomes ... will be reviewed and updated by the interdisciplinary group [IDG] members ...." 4. A home visit was observed with patient #1 and registered nurse (RN) #3 on 9/22/22 at 3:00 PM. The patient indicated she decreased use of acetaminophen (non-narcotic pain relief) to twice daily, and family indicated she only took 1 today so far. Clinical record review on 9/21/22, for patient #1, election of benefit/hospice admission date 6/14/22, evidenced a document dated 9/12/22, titled "Hospice IDG Comprehensive Assessment and Plan of Care Update Report". The document stated "... Current Problem List ...		greater o Audits will continue weekly until resurvey o Post resurvey: § When Threshold has been met for 4 consecutiveweeks, may reduce audits to 10 records or 10% of the daily census (whichever isgreater) for each branch within the provider SSB, SKM, SMC, SLF, SVA, and SFT monthly. § When Threshold has been met for 2 consecutivemonths, may reduce audits to 10 records or 10% of the daily census (whicheveris greater) for each branch within the provider SSB, SKM, SMC, SLF, SVA, and SFT to quarterly	

	Comfort ... The patient is now using [acetaminophen] for pain and norco [a narcotic pain reliever] at times ... has had increased fatigue and will often sleep 12-16 hours at a time ....” The plan of care failed to include measurable outcomes for pain to include the patient’s acceptable pain level, previous pain level, current pain level, or specific amount of medication used to attain/maintain desired pain relief; or previous hours slept to determine the patient’s increased fatigue. During an interview on 9/23/22 at 3:35, Administrator #1 indicated the plan of care did not include measurable outcomes. 5. Clinical record review on 9/21/22, for patient #3, election of benefit/hospice admission date 5/25/22, evidenced a document dated 9/19/22, titled “Hospice IDG Comprehensive Assessment and Plan of Care Update Report”. The document indicated progress toward goals included “skin condition worsened”. During an interview on 9/23/22 at 10:10 AM, RN #4 indicated			

	she didn't read "Hospice IDG Comprehensive Assessment and Plan of Care Update Report[s]" very often. When queried if "wound worsened" was a measurable outcome, RN #4 indicated it should be explained in more detail, and it was not a measurable outcome. During an interview on 9/23/22 at 3:29 PM, Administrator #1 indicated wound measurements would be specific and measurable outcomes on the plan of care. 6. Clinical record review on 9/21/22, for patient #8, election of benefit/hospice admission date 5/6/22, evidenced a document dated 8/10/22, titled "Hospice IDG Comprehensive Assessment and Plan of Care Update Report". The document indicated the patient was bedbound, his wounds continued to get worse, was non-compliant with wound care, and stated "... what has occurred in the past 2 weeks to include progress toward goals ... [wounds] on lower buttocks have become 1 large wound ... [skilled nurse] plan, goals ... for next 2 weeks ... goals to be			

	...." The document failed to include any wound measurements to determine a measurable outcome, measurable outcome for non-compliance with wound care, or any measurable and patient specific skilled nursing goals for the next 2 weeks to determine outcome.			

	Review of a document dated 9/21/22, titled "Hospice IDG Comprehensive Assessment and Plan of Care Update Report", indicated the patient had "multiple wounds" which were getting larger, increased pain and recently prescribed morphine (a narcotic medication for severe pain), had new wound infection, and was prescribed antibiotics. The document stated "... Progress to goals ... NA [not applicable] ...." The document failed to include the number of wounds, or any wound measurements to determine a measurable outcome; and failed to include measurable outcomes for pain to include the patient's acceptable pain level, previous pain level, current pain level, or specific amount of medication used to attain/maintain desired pain relief. During an interview on 9/23/22 at 4:18 PM, Administrator #1 indicated the patient had the right to refuse treatment, but IDG should be discussing it, the first goal was to keep the patient comfortable, and she expected to see this documented on the plan of			

	IDG plan of care dated 9/21/22, which indicated the wound was bigger, Area Director of Education #5 indicated the plan of care should include the wound assessment measurements. 7. Clinical record review on 9/21/22, for patient #9, election of benefit/hospice admission date 4/19/22, primary diagnosis cerebrovascular disease (an area of the brain is temporarily or permanently damaged by obstruction of blood flow or bleeding) and other diagnosis Dementia, evidenced a document dated 9/06/22, titled "Visit Note Report", which indicated a nursing visit was made due to allegations of abuse from family, and Administrator #1 "was made aware". Review of a document dated 9/15/22, titled "Visit Note Report", indicated a social worker visit was made, and documented entity #3 (non-medical private duty caregiver agency) staff observed family member "being rough" with patient, it upset the entity #3 staff, patient was disoriented, family instructed			

	entity #3 staff to have patient upstairs in her room before he/she got home from work at 4:00 PM, entity #3 staff was concerned about patient's safety, as she "scooted" up and down the stairs, and the house smelled very strongly of cat urine. Review of a document dated 9/16/22, titled "Visit Note Report", indicated a nursing visit was made, which documented bruising noted to left lower back and left distal forearm, environmental issues included strong cat urine odor in home with fleas, patient fell on 9/11/22, and had difficulty going up/down the stairs. Review of a document dated 9/19/22, titled "Hospice IDG Comprehensive Assessment and Plan of Care Update Report", evidenced social worker #1 received phone calls from entity #3 with concerns that patient had bruises and witnessed family being rough with the patient. The document failed to include development of measurable goals/outcomes for home safety related to patient ability to go up/downstairs, home environment related to			

	cat urine odor and fleas, falls, or alleged abuse. During an interview on 9/21/22 at 5:18 PM, when queried if there was evidence the IDG addressed abuse, home safety, inadequate home environment, falls, and inability to safely negotiate stairs in the clinical record, Regional Director of Clinical Operation #2 indicated there was documentation, but it wasn't part of the clinical record. During an interview on 9/26/22 at 1:05 PM, when queried if the clinical record evidenced the IDG or plan of care addressed home safety related to patient ability to go up/downstairs, home environment related to cat urine odor and fleas, falls, or alleged abuse, Administrator #1 indicated they did not. 8. Clinical record review on 9/21/22, for patient #10, election of benefit/hospice admission date 3/2/22, evidenced a document dated 9/07/22, titled "Hospice IDG Comprehensive Assessment and Plan of Care Update Report", which stated "... Any new problems identified: wound to			

	heel ....” The document failed to include development of measurable outcomes for the new wound. Review of a document dated 9/21/22, titled “Hospice IDG Comprehensive Assessment and Plan of Care Update Report”, failed to include any documentation of presence or status of a wound. During an interview on 9/28/22 at 12:04 PM, when queried if there were any wound treatment orders on the plan of care, measurements, or outcomes addressed on the plan of care, Administrator #1 stated “No.” During this time, Regional Director of Clinical Operation #2 indicated this patient was on the list to be audited as part of the Immediate Jeopardy plan for removal, the audits were due to be completed by 5:00 PM on 9/30/22, and this record was not yet audited. 9. Clinical record review on 9/22/22, for patient #11, election of benefit/hospice admission date 11/23/2020, evidenced a document dated 9/14/22, titled “Hospice IDG			

	Comprehensive Assessment and Plan of Care Update Report", which indicated the patient had wounds on her leg, and new problems included increased fatigue. The document failed to include development of measurable outcomes for the increased fatigue, or measurable outcomes for the wounds. During an interview on 9/23/22 at 3:43 PM, Administrator #1 indicated she would expect basic wound information to be in the plan of care, they didn't usually include a lot of specific information, and that would be included in the wound care report. During this time, Area Director of Education #5 indicated wound review of better or worse should be in IDG (plan of care document), and should be described as far as progress, and include new interventions if worse. 10. During an interview on 9/22/22 at 1:44 PM, when queried what the agency has implemented to protect patients from negative outcomes, Administrator #1 indicated they developed a			

	project (PIP) on 9/01/22, and Area Vice President of Operations #4 indicated this problem was identified in July and August (2022), but no immediate action was taken yet to protect patients from negative outcomes.			
L0549	CONTENT OF PLAN OF CARE 418.56(c)(4) [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 observation, record review, and interview, the hospice agency failed to ensure the patient's plan of care included all drugs and/or treatments for 4 of 6 active clinical records reviewed (#1, 3, 10, 11). The findings include: 1. Review of an agency policy received 9/26/22, dated "February" (no year identified), titled "The Plan of Care", stated	L0549	· Action Statement: Clinical staff will beeducated on the requirement that the plan of care must include measurableoutcomes anticipated from implementing and coordinating the plan of care.Education will include o Policy 4-027 Plan of Care. · Who is assigned: Administrator or designee · Monitoring: Audit 25 records or 25% of the activecensus (whichever is greater) for each branch within the provider SSB, SKM,SMC, SLF, SVA, and SFT 10-21-22 toensure there is evidence in the patient record that the plan of care includesmeasurable outcomes, with corrections/amendments made as applicable. o Audit 10 patient records or	2022-10-21

	"... written plan of care will contain ... Medications and treatments ... including drugs and treatments necessary to meet the needs of the patient ...." 2. Review of an agency policy dated 11/2020, titled "Ongoing Assessments", stated, "... change/verbal orders will be generated ... and incorporated into the plan of care ... The physician will be notified to verify any changes in medications, including drugs and treatments to meet the needs of the patient, over-the-counter medications ... will be included in the plan of care by the interdisciplinary group ...." 3. A home visit was observed with patient #1 and registered nurse (RN) #3 on 9/22/22 at 3:00 PM. Observed the patient had an indwelling urinary catheter (a tube inserted into the bladder to drain urine), RN #3 indicated she just changed it about a week ago, and it was changed every 30 days. Observed the patient's buttocks were reddened/inflamed, and RN #3 applied "Coloplast Hydrophilic Wound Dressing		10% of the dailycensus (whichever is greater) for each branch within the provider SSB, SKM,SMC, SLF, SVA, and SFT weekly beginning10-23-22 until the Threshold has been met to ensure there is evidence in thepatient record that the plan of care includes measurable outcomes. o Target Threshold=90% Greater o Audits will continue weekly until resurvey. o Post resurvey: § When Threshold has been met for 4 consecutiveweeks, may reduce audits to 10 records or 10% of the daily census (whichever isgreater) for each branch within the provider SSB, SKM, SMC, SLF, SVA, and SFT monthly. § When Threshold has been met for 2 consecutive months,may reduce audits to 10 records or 10% of the daily census (whichever isgreater) for each branch within the provider SSB, SKM, SMC, SLF, SVA, and SFT to quarterly.	

	Paste" (wound/skin treatment to provide a protective seal over the skin, while absorbing excess fluid, to reduce inflammation/skin redness) to the buttocks after personal care was provided (due to incontinence of bowel). RN #3 indicated the patient had previous open wounds on the buttocks, which were now healed, and the paste was routinely used for prevention of skin breakdown due to bowel incontinence and bedbound status. Clinical record review on 9/21/22, for patient #1, election of benefit/hospice admission date 6/14/22, evidenced a document dated 9/12/22, titled "Hospice IDG Comprehensive Assessment and Plan of Care Update Report". The plan of care failed to include Coloplast Hydrophilic Wound Dressing Paste was used as a routine treatment (per RN #3 statement), or was listed as an over-the-counter (OTC) remedy on the medication list; and failed to include treatment orders for the care/maintenance of the indwelling urinary catheter.			

	An agency document received and reviewed on 9/23/22, dated 9/22/22, titled "Visit Note Report" indicated the patient had a stage 1 (a wound without skin breaks or tears, appears reddened and does not blanch [lose color briefly when you press your finger on it and then remove your finger]) pressure injury (injury caused by unrelieved pressure) to the left buttock, and barrier cream was applied. . During an interview on 9/23/22 at 3:35, Administrator #1 indicated no order was needed for barrier cream if it wasn't an actual treatment, but just used as a preventative. 4. A home visit was observed with patient #3 and registered nurse (RN) #4 on 9/22/22 at 3:00 PM, at entity #6 (an assisted living facility [ALF]). Observed RN #4, who applied hydrocolloid dressings to both buttocks, and applied lotion to a reddened area on the patient's spine, just below the shoulder blades, where pressure was consistent while the patient sat in the recliner. RN #4			

	indicated the area on the spine was an old pressure injury, she kept lotion on the area to keep the skin supple, and she wasn't "doing anything official" with it. Clinical record review on 9/21/22, for patient #3, election of benefit/hospice admission date 5/25/22, evidenced a document dated 8/26/22, titled "Visit Note Report", which indicated a nursing visit was made, the nurse re-applied a hydrocolloid dressing (provides a moist and insulating healing environment which protects uninfected wounds while allowing the body's own enzymes to help heal wounds) to the patient's buttocks, and applied lotion to a reddened area on the patient's spine. The clinical record failed to evidence an order for the use of hydrocolloid, or use of lotion to treat the reddened area on the patient's spine on 8/26/22. Review of a document dated 8/29/22, titled "Visit Note Report", indicated a nursing visit was made, and the nurse applied a hydrocolloid dressing to the buttocks. The clinical record failed to evidence an			

	hydrocolloid on 8/29/22. Review of a document dated 9/02/22, titled "Visit Note Report", indicated a nursing visit was made, the nurse applied antifungal cream (location not specified). The clinical record failed to evidence an order for the use of antifungal cream on 8/29/22. Review of a document dated 9/12/22, titled "Visit Note Report", indicated a nursing visit was made, the nurse applied antifungal cream (location not specified), and indicated staff at entity #6 (an assisted living facility [ALF]) was aware hydrocolloid dressings were available if patient had increased discomfort or skin worsened. The clinical record failed to evidence an order for the use of hydrocolloid to be used if needed. Review of a document dated 9/16/22, titled "Visit Note Report", indicated a nursing visit was made, the patient had a new shearing (caused by friction) wound to the left buttock, and an order was received to apply hydrocolloid			

visits.

Review of a document dated 9/06/22, titled "Hospice IDG Comprehensive Assessment and Plan of Care Update Report". The document stated "... Buttocks remain red and chaffed. We are now using antifungal barrier cream ...." The section of the document for inclusion of orders received since last IDG meeting failed to evidence an order for the antifungal cream, or frequency of use.

Review of a document dated 9/16/22, titled "Hospice Physician Order", indicated wound orders to apply hydrocolloid dressing to the left buttock. The order failed to indicate hydrocolloid was ordered to be applied to the right buttock.

During an interview on 9/28/22 at 11:42 AM, Administrator #1 indicated she would expect to see a treatment order for the antifungal, but wouldn't expect to see an order for barrier cream. When queried if there should be an order, and should it be on the plan of care, for the

	skilled nurse note dated 9/12/22, which stated, "... Staff aware hydrocolloid available if patient has increased to discomfort or skin condition worsens ....", Administrator #1 stated, "... Well I think it wasn't being used yet ... she [hospice nurse] was just letting them [entity #6 staff] know it was available if it was needed ...." When queried if there was an order to apply hydrocolloid to both buttocks, Administrator #1 stated, "... maybe she [hospice nurse] was being proactive with the hydrocolloid ....", and indicated there should be an order for the hydrocolloid, and it should be on the plan of care. 5. Clinical record review on 9/21/22, for patient #10, election of benefit/hospice admission date 3/2/22, evidenced a document dated 9/07/22, titled "Hospice IDG Comprehensive Assessment and Plan of Care Update Report", which stated "... Any new problems identified: wound to heel ...." The document failed to include wound treatment orders. Review of a document dated 9/21/22, titled "Hospice IDG			

	Comprehensive Assessment and Plan of Care Update Report", failed to include any documentation of presence or status of a wound. During an interview on 9/28/22 at 12:04 PM, when queried if there were any wound treatment orders on the plan of care, Administrator #1 stated "No." During this time, Regional Director of Clinical Operation #2 indicated this patient was on the list to be audited as part of the Immediate Jeopardy plan for removal, the audits were due to be completed by 5:00 PM on 9/30/22, and this record was not yet audited. 6. Clinical record review on 9/22/22, for patient #11, election of benefit/hospice admission date 11/23/2020, evidenced a document dated 9/14/22, titled "Hospice IDG Comprehensive Assessment and Plan of Care Update Report", which indicated the patient had wounds on her leg, and failed to include any wound treatment orders. During an interview on 9/22/22 at 2:21 PM, RN #1 indicated she knew the patient had a wound,			

	but couldn't remember which leg, she'd never assessed or seen the wound herself, she saw a picture of it "at least 3 or 4 weeks ago"; entity #1 (an extended care facility [ECF]) (where the patient resided) had a wound care nurse, and they did the wound care. When queried if the patient had more than 1 wound, RN #1 stated, "No." During an interview on 9/22/22 at 1:35 PM, Administrative RN #4 (Area Vice President of Operations) indicated she was the agency's Clinical Supervisor, the patient resided at a facility, and "they" typically had a wound care nurse. Administrative RN #4 indicated she saw an order for wound care on 5/18/22. At 1:44 PM, Administrator #1 indicated there were no wound care orders after 7/22/22. Review of a document dated 7/22/22, titled "Hospice Physician Order", stated, "... Wound care leg ... clean with wound cleaners ... rinse with NS [sterile salt water] ... apply silver alginate [dressing made of natural fibers derived from seaweed, with silver as an			

	antimicrobial property] ... cover with dressing ... wound care to be performed ... [during hospice nurse visits] ....” Review of Entity #1 documentation received on 9/23/22, dated 7/28/22, 8/4/22, 8/11/22, 8/15/22, 8/23/22, 8/30/22, 9/16/22 and 9/20/22, all titled “Wound Evaluation and Management Summary” indicated the patient had 2 current, chronic/ongoing wounds greater than 1 year old to the left lower leg; and wound care was ordered 3 times weekly to both wounds: apply iodosorb (iodine impregnated gauze), cover with Vaseline impregnated gauze, and wrap leg with rolled gauze.			
L0552	REVIEW OF THE PLAN OF CARE 418.56(d) 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 record review and	L0552	· Action Statement: Clinical staff will beeducated on the requirement that the IDG is to collaborate with the attendingphysician, if any, and review, revise and document toward the plan of care asfrequently as the patient's condition requires but no less than every 15 days.Education will include o Policy No. 4-032	2022-10-21

	interview, the hospice interdisciplinary group (IDG) failed to review/revise, and document the patient's plan of care as often as needed, for 1 of 1 clinical record reviewed for a patient who required immediate intervention (#9). The findings include: Review of an agency policy dated 01/22, titled "Interdisciplinary Group [IDG] Membership and Responsibilities" stated "... responsibilities include ... Review of any ... caregiver complaints ... and takes remedial action as appropriate ...." Review of an agency policy received 9/26/22, dated "February" (no year identified), titled "The Plan of Care", stated "... The plan of care will be reviewed and revised as often as frequently as deemed necessary ... Review of the plan of care will be documented in the clinical record. Revision dates will be noted on the plan of care ... Any change in the patient's condition must result in a change in the plan of care, prior to the implementation of		Interdisciplinary GroupMeeting. · Who is assigned: Administrator or designee · Monitoring: Audit 25 records or 25% of the activecensus (whichever is greater) for each branch within the provider SSB, SKM,SMC, SLF, SVA, and SFT 10-21-22 toensure a documented IDG discussion and revised plan of care, if needed, atleast every 15 days as required., with corrections/amendments made asapplicable. o Audit 10 patient records or 10% of the dailycensus (whichever is greater) for each branch within the provider SSB, SKM,SMC, SLF, SVA, and SFT weekly beginning10-23-22 until the Threshold has been met to ensure a documented IDG discussionand revised plan of care, if needed, at least every 15 days as required. o Target Threshold=90% greater o Audits will continue weekly until resurvey. o Post resurvey:	

	the new service …." Review of the agency's incident/complaint log on 9/21/22, evidenced a document dated 9/06/22, titled "Client Occurrence Report", which indicated entity #3 (a non-medical provider for private duty caregiver services) staff requested a hospice nurse visit because its staff member (other person #4) witnessed a verbal/physical encounter between the patient and a family member on 9/05/22; family yelled, grabbed, and yanked the patient's right arm, and told the patient to be quiet and stop talking. Clinical record review on 9/21/22, for patient #9, election of benefit/hospice admission date 4/19/22, primary diagnosis cerebrovascular disease (an area of the brain is temporarily or permanently damaged by obstruction of blood flow or bleeding) and other diagnosis Dementia, evidenced a document dated 9/06/22, titled "Visit Note Report", which indicated a nursing visit was made due to allegations of abuse by family, bruising was		§ When Threshold has been met for 4 consecutiveweeks, may reduce audits to 10 records or 10% of the daily census (whichever isgreater) for each branch within the provider SSB, SKM, SMC, SLF, SVA, and SFT monthly. § When Threshold has been met for 2 consecutivemonths, may reduce audits to 10 records or 10% of the daily census (whicheveris greater) for each branch within the provider SSB, SKM, SMC, SLF, SVA, and SFT to quarterly.	

	"was made aware". A document dated 9/06/22, titled "Hospice IDG [interdisciplinary group] Comprehensive Assessment and Plan of Care Update Report" failed to include information related to allegations of abuse. The clinical record failed to evidence another IDG meeting was conducted "as needed" to revise/update the plan of care due to the need for immediate hospice agency intervention(s) for alleged patient abuse. A document dated 9/19/22, titled "Hospice IDG Comprehensive Assessment and Plan of Care Update Report", evidenced social worker #1 received phone calls from entity #3 on 9/15/22 with concerns that patient had bruises and witnessed family being rough with the patient. The document failed to indicate the hospice IDG conducted a meeting to update the plan of care prior to 9/19/22. During an interview on 9/21/22 at 5:18 PM, Administrator #1 indicated the agency did send a nurse out (after being notified of alleged abuse).			

	During an interview on 9/26/22 at 12:23 PM, when queried about alleged abuse, entity #3's manager (other person #5) indicated he had concern with family/patient interaction, and he informed the hospice agency on 9/06/22, to make them aware of the concern for abuse. During an interview on 9/26/22 at 1:05 PM, when queried what steps were taken when the agency was made aware of the witnessed verbal/physical abuse, Administrator #1 indicated a nurse went out to assess the patient, the social worker and chaplain always checked while they visited, and family was rarely present during hospice agency visits.			
L0554	COORDINATION OF SERVICES 418.56(e)(1) The hospice must develop and maintain a system of communication and integration, in accordance with the hospice's own policies and procedures, to- (1) Ensure that the interdisciplinary group maintains responsibility for directing, coordinating, and supervising the care and services provided.	L0554	· Action Statement: Clinical staff will be educatedon the requirement that there is to be communication and integration betweenIDG members to maintain responsibility for directing, coordinating, andsupervising the care and services provided. Education will include o Policy No. 4-001	2022-10-21

	Based on record review and interview, the interdisciplinary group (IDG) failed to ensure it directed, supervised, and coordinated/shared information to meet the patient's needs, for 6 of 6 active clinical records reviewed (#1, 3, 8, 9, 10, 11). The findings include: 1. Review of an agency policy dated 01/22, titled "Interdisciplinary Group [IDG] Membership and Responsibilities" stated "... responsibilities include ... supervision of hospice care and services ... Coordination of care and sharing of information among IDG members and non-hospice care providers ...." 2. A home visit was observed with patient #1 and registered nurse (RN) #3 on 9/22/22 at 3:00 PM. The patient indicated she wanted to receive a COVID-19 booster shot and a seasonal flu shot, and she previously asked hospice staff about this. RN #3 indicated she previously talked to the social worker about it, and the social worker was looking into who		Membership and Responsibilities. o Policy 4-002 Hospice Nursing Care o Policy 4-027 o Policy The Plan of Care 4-042 ComprehensiveAssessment o Policy4-043 Ongoing Assessments o Policy 4-099 Care/Service Coordination · Who is Assigned: Administrator or designee · Monitoring: Audit 25 records or 25% of the activecensus (whichever is greater) for each branch within the provider SSB, SKM,SMC, SLF, SVA, and SFT 10-21-22 toensure there is evidence in the patient record of communication and integrationbetween IDG members to maintain that care and services provided are directed,coordinated, and supervised by the IDG, and follow-up by the appropriatedisciplines for identified needs, with corrections/amendments made	

	home to administer the vaccines. Clinical record review on 9/21/22, for patient #1, election of benefit/hospice admission date 6/14/22, evidenced a document dated 9/22/22, titled "Visit Note Report", failed to evidence care coordination/sharing of information to the IDG about the patient's request to receive vaccinations. Review of a document dated 9/12/22, titled "Hospice IDG Comprehensive Assessment and Plan of Care Update Report", failed to evidence care coordination/sharing of information to the IDG about the patient's request to receive vaccinations. During an interview on 9/23/22 at 3:35 PM, Administrator #1 indicated they (the agency) just needed an order from the physician, and then they could administer the vaccines. When queried if the clinical record contained information about the patient's request for vaccines, no further information was provided or submitted. 3. A home visit was observed		asapplicable. o Audit 10 patient records or 10% of the dailycensus (whichever is greater) for each branch within the provider SSB, SKM,SMC, SLF, SVA, and SFT weekly beginning10-23-22 until the Threshold has been met to ensure there is evidence in thepatient record of communication and integration between IDG members to maintainthat care and services provided are directed, coordinated and supervised by theIDG, and follow-up by the appropriate disciplines for identified needs. o Target Threshold=90% or greater o Audits will continue weekly until resurvey. o Post resurvey: § When Threshold has been met for 4 consecutiveweeks, may reduce audits to 10 records or 10% of the daily census (whichever isgreater) for each branch within the provider SSB, SKM, SMC, SLF, SVA, and SFT monthly. § When Threshold has been met	

	with patient #3 and registered nurse (RN) #4 on 9/22/22 at 3:00 PM, at entity #6 (an assisted living facility [ALF]). The patient did not have a wound dressing in place on the buttocks upon removal of clothing. Observed RN #4, who applied hydrocolloid dressings to both buttocks. When queried why there was no dressing on the patient's buttocks, RN #3 stated, "... It must have fallen off ...." At 10:10 AM, person #7 (staff at entity #6) indicated they (staff at entity #6) did not do wound care for this patient, they weren't allowed, and the hospice did it. Clinical record review on 9/21/22, for patient #3, election of benefit/hospice admission date 5/25/22, evidenced a document dated 9/19/22, titled "Hospice IDG Comprehensive Assessment and Plan of Care Update Report". The document included wound care orders, which indicated the "facility" (entity #6) nurse would change the dressing as needed if soiled or loosened. During an interview on 9/28/22 at 11:47 AM, Administrator #1 indicated she was unaware		for 2 consecutivemonths, may reduce audits to 10 records or 10% of the daily census (whicheveris greater) for each branch within the provider SSB, SKM, SMC, SLF, SVA, and SFT to quarterly.	

entity #6 staff did not perform wound care, and she would have to get clarification. No further information was provided.

4. Clinical record review on 9/21/22, for patient #8, election of benefit/hospice admission date 5/6/22, evidenced a document titled "Hospice IDG Comprehensive Assessment and Plan of Care Update Report", dated 8/10/22, indicated skilled nurse visits were ordered 2 times weekly, wound care was ordered daily, wounds continued to get worse, and patient was non-compliant with medications and wound care; and listed diagnoses included only 1 wound- "pressure ulcer [injury] of unspecified site, unspecified stage". The document failed to include who did wound care on days the hospice nurse was not present, or a plan to improve compliance with medications and wound care.

Review of documents titled "Visit Note Report" (skilled nurse home visit), dated 8/04/22, 8/16/22, 8/18/22, 8/23/22, 8/30/22, and 9/13/22, all indicated the patient refused

wound assessment/treatment.

Review of documents titled "Visit Note Report", dated 8/18/22, 8/30/22, 9/01/22, 9/08/22, 9/13/22, and 9/15/22, all indicated wound care was already completed, and no wound care/assessment was performed by the hospice nurse.

Review of a document dated 9/21/22, titled "Hospice IDG Comprehensive Assessment and Plan of Care Update Report", indicated the patient had "multiple wounds" which were getting larger, increased pain and recently prescribed morphine (a narcotic medication for severe pain), had new wound infection, and was prescribed antibiotics. The document failed to evidence the IDG supervised the care provided and was aware no wound care or assessments were made since 8/09/22.

During an interview on 9/23/22 at 4:18 PM, Administrator #1 indicated the patient had the right to refuse treatment, but IDG should be discussing it, the first goal was to keep the patient comfortable, and she

expected to see this documented on the plan of care. When queried about the IDG plan of care dated 9/21/22, which indicated the wound was bigger, Area Director of Education #5 indicated the plan of care should include wound assessment/measurements.

5. Clinical record review on 9/21/22, for patient #9, election of benefit/hospice admission date 4/19/22, primary diagnosis cerebrovascular disease (an area of the brain is temporarily or permanently damaged by obstruction of blood flow or bleeding) and other diagnosis Dementia, evidenced a document dated 9/06/22, titled "Visit Note Report", which indicated a nursing visit was made due to allegations of abuse by family, and Administrator #1 "was made aware".

Review of the agency's incident/complaint log on 9/21/22, evidenced a document dated 9/06/22, titled "Client Occurrence Report", which indicated entity #3 (a non-medical provider for private duty caregiver services) staff requested a hospice nurse

visit because its staff member (other person #4) witnessed a verbal/physical encounter between the patient and a family member on 9/05/22; family yelled, grabbed, and yanked the patient's right arm, and told the patient to be quiet and stop talking. The documented stated "... [the nurse assessed] ... right posterior [back] forearm old bruising yellowish in color and round circular dime sized old purplish in color bruise to anterior [front] right forearm ...." The document also included an update added by Administrator #1 on 9/06/22, which indicated a call was placed to entity #3, Administrator #1 spoke with entity #3's manager (other person #5), who indicated he was going to place a call to APS to report the incident. The document failed to evidence the hospice IDG conducted its own investigation, contacted/coordinated with Adult Protective Services (APS) or Indiana Department of Health (IDOH), or immediately took action to ensure the patient's safety.

Review of a document dated

Coordination Note Report" indicated the hospice agency was unsuccessful with attempt to contact family, and a voicemail was left. The clinical record failed to evidence any further attempt to coordinate with family.

Review of a document dated 9/19/22, titled "Hospice IDG [interdisciplinary group] Comprehensive Assessment and Plan of Care Update Report", evidenced social worker #1 received phone calls from entity #3 with concerns that patient had bruises and witnessed family being rough with the patient. The document failed to indicate the hospice IDG conducted its own investigation or took any immediate action to ensure the patient's safety.

During an interview on 9/21/22 at 5:18 PM, Administrator #1 indicated the agency did send a nurse out (after being notified of alleged abuse), collaborated with entity #3, entity #3 witnessed the incident, not the hospice agency, so they (entity #3) actually contacted APS to put in a complaint to do further investigation.

During an interview on 9/26/22 at 12:23 PM, when queried about alleged abuse, entity #3's manager (other person #5) indicated he had concern with family/patient interaction, and he informed the hospice agency to make them aware of the concern for abuse on 9/06/22.

During an interview on 9/26/22 at 1:05 PM, when queried what steps were taken when the agency was made aware of the witnessed verbal/physical abuse, Administrator #1 indicated a nurse went out to assess the patient, the social worker and chaplain always checked while they visited, and family was rarely present during hospice agency visits.

6. Clinical record review on 9/21/22, for patient #10, election of benefit/hospice admission date 3/2/22, evidenced a document dated 9/07/22, titled "Hospice IDG Comprehensive Assessment and Plan of Care Update Report", which indicated the patient resided at entity #8, a long-term care facility, and had a new wound to the heel. The document failed to evidence

which heel the wound was located, or who performed wound care.

Review of a document dated 9/21/22, titled "Hospice IDG Comprehensive Assessment and Plan of Care Update Report", failed to include any documentation of presence or status of a wound.

During an interview on 9/28/22 at 12:04 PM, Administrator #1 indicated the IDG meeting note/plan of care dated 9/07/22, failed to include the wound was addressed by the IDG. During this time, Regional Director of Clinical Operation #2 indicated this patient was on the list to be audited as part of the Immediate Jeopardy plan for removal, the audits were due to be completed by 5:00 PM on 9/30/22, and this record was not yet audited.

7. Clinical record review on 9/22/22, for patient #11, election of benefit/hospice admission date 11/23/2020, evidenced a document dated 9/14/22, titled "Hospice IDG Comprehensive Assessment and Plan of Care Update Report", which indicated the patient had

wounds on her leg, and failed to include the IDG addressed the wound(s), or coordinated care with entity #1(an extended care facility [ECF]) (where the patient resided).

During an interview on 9/22/22 at 2:21 PM, RN #1 indicated she knew the patient had a wound, couldn't remember which leg, she'd never assessed or seen the wound herself, she saw a picture of it "at least 3 or 4 weeks ago"; and entity #1 had a wound care nurse, who did the wound care. When queried if the patient had more than 1 wound, RN #1 stated, "No."

During an interview on 9/22/22 at 1:35 PM, Administrative RN #4 (Area Vice President of Operations) indicated she was the agency's Clinical Supervisor, the patient resided at a facility, and "they" typically had a wound care nurse. Administrative RN #4 indicated she saw an order for wound care on 5/18/22. At 1:44 PM, Administrator #1 indicated there were no wound care orders after 7/22/22.

During an interview on 9/23/22

entity #1) indicated the hospice was aware the facility wound physician saw wound patients every Tuesday, and they were welcome to attend.

Review of a document dated 7/22/22, titled "Hospice Physician Order", stated, "... Wound care leg ... clean with wound cleaners ... rinse with NS [sterile salt water] ... apply silver alginate [dressing made of natural fibers derived from seaweed, with silver as an antimicrobial property] ... cover with dressing ... wound care to be performed ... [during hospice nurse visits] ...." No further wound treatment orders were evidenced in the clinical record.

Review of Entity #1 documentation received on 9/23/22, dated 7/28/22, 8/4/22, 8/11/22, 8/15/22, 8/23/22, 8/30/22, 9/16/22 and 9/20/22, all titled "Wound Evaluation and Management Summary" indicated the patient had 2 current, chronic/ongoing wounds greater than 1 year old to the left lower leg; and wound care was ordered 3 times weekly to both wounds: apply iodosorb (iodine impregnated gauze), cover with Vaseline

	impregnated gauze, and wrap leg with rolled gauze. The clinical record failed to evidence coordination with entity #1 for current wound care orders. During an interview on 9/23/22 at 3:43 PM, Administrator #1 indicated she would expect weekly coordination with the facility to schedule a time to attend while the facility performed wound care/assessments. 8. During an interview on 9/23/22 at 4:02 PM, Administrator #1 indicated whatever was included on the IDG/plan of care document was what was discussed during the meeting.			

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided.For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility.If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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