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	151577	A. BUILDING _____ B. WING _____	C 05/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN ANGEL HOSPICE INC	513 W LINCOLN RD KOKOMO, IN 46902

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E 000	Initial Comments An Emergency Preparedness Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 418.113. Survey Date: 5/11/21 Facility Number: 003385 Provider Number: 151577 Census: 948 At this Emergency Preparedness survey, Guardian Angel Hospice was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 418.113.	E 000		
L 000	INITIAL COMMENTS This was a federal hospice recertification and state licensure survey. Survey Dates: 4/27/21, 4/28/21, 4/29/21, 5/3/21, 5/4/21, 5/5/21, 5/6/21, 5/7/21, 5/10/21, 5/11/21 Facility Number: 003385 Provider Number: 151577 Medicaid Number: 200406660 Unduplicated Census: 756 Home patient census: 83 Assisted living patient census: 22 Skilled nursing facility patient census: 87 Total Current Census: 948	L 000		
L 509	EXERCISE OF RIGHTS/RESPECT FOR PROPRTY/PERSON	L 509		

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

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L 509	Continued From page 1 CFR(s): 418.52(b)(4)(ii) [The hospice must:] (ii) Immediately investigate all alleged violations involving anyone furnishing services on behalf of the hospice and immediately take action to prevent further potential violations while the alleged violation is being verified. Investigations and/or documentation of all alleged violations must be conducted in accordance with established procedures; This STANDARD is not met as evidenced by: Based on record review and interview, the hospice failed to ensure all complaints were thoroughly investigated for 4 of 4 complaints reviewed. Findings include: A policy dated 3/30/2021, received from quality nurse C on 4/4/27/21 at 2:43 PM, titled "Complaint Resolution," stated "...Appropriate personnel conduct and document an investigation of all written or verbal complaints ... Complaints are tracked and regularly reviewed to identify patterns or trends and performance improvement opportunities ...." The agency failed to fully investigate each complaint, as no calls were made to any other patients/families LPN D cared for, to ensure other patients were not dissatisfied with care as evidenced by: During a review of the agency complaint log, a complaint dated 10/9/2020 was reviewed. The	L 509		

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L 509	Continued From page 2	L 509		

patient's daughter voiced concern over the care that Licensed Practical Nurse (LPN) D had provided to her father. She stated that she felt rushed, as she liked to help with his care. LPN D wasn't as gentle as she would have liked. The documented results of the complaint were " ...Investigator apologized to daughter ... asked if she would like a different nurse ... daughter requests [LPN D] not return ... informed registered nurse case manager of request ... coaching session with [LPN D] on 10/14/2020 ... [LPN D] voiced understanding ...."

A complaint dated 1/24/2021 was also reviewed. A nurse from Skilled Nursing Facility (SNF) A stated she requested a visit from LPN D, and was told she couldn't come now. The nurse from SNF A felt LPN D was rude. The documented results of the complaint were " ... [LPN D] was coached on making a visit any time requested ... [LPN D] voiced understanding ...."

A complaint dated 1/25/2021 was also reviewed. A nurse from SNF B stated the family of a patient requested a visit from LPN D for shortness of breath. When she spoke with LPN D, she felt she just didn't want to make the visit, but that she should have. The documented results of the complaint were " ...situation was discussed with [LPN D] ... coaching form was completed ...."

Lastly, a complaint dated 2/24/2021 was reviewed. The patient's daughter stated she felt LPN D was calloused when she informed the patient of tumor growth and requested that she not return to their home for visits, including on call visits. The documented results of the complaint were " ...Investigator discussed empathy during visits, with [LPN D] agreeing ...."

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L 509	Continued From page 3 During an interview on 5/11/2021 at 3pm, when asked how the agency ensured complaints were not a systemic problem, the alternate administrator, indicated through patient survey responses, patient advocate calls, tracking in quality assessment performance indicators, and feedback from field staff.	L 509		
L 522	INITIAL ASSESSMENT CFR(s): 418.54(a) The hospice registered nurse must complete an initial assessment within 48 hours after the election of hospice care in accordance with §418.24 is complete (unless the physician, patient, or representative requests that the initial assessment be completed in less than 48 hours.) This STANDARD is not met as evidenced by: Based on record review and interview, the Registered Nurse (RN) failed to assess the patient's immediate physical care needs regarding wound care physical status upon the initial assessment for 1 of 6 (#13) records reviewed of patients with wounds. Findings include: An undated policy titled "Assessment - Comprehensive Assessment of the Patient," stated " ...The hospice nurse makes an initial assessment visit to the patient/caregiver ... to determine the patient's immediate care and support needs ...." An undated policy titled "Assessment - Comprehensive Assessment - Content," stated " ...The comprehensive assessment identifies the	L 522		

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physical ... needs of the patient ... that must be addressed in order to promote the patient's well-being, comfort, and dignity throughout the dying process ...."

A policy titled "Registered Nurse - Case Manager," dated 6/6/2017, stated, "...Demonstrates competency in all skills required for the agency ... Evaluates ... nursing needs of the patient ...."

An undated policy titled "Coordination of Services," stated " ...An assigned hospice RN [Registered Nurse] coordinates ... and facilitates the ongoing sharing of information with ... contracted facilities ... furnishing services related to the terminal illness ...."

The clinical record of patient #13 was reviewed on 5/4/21 at 2:16 PM and indicated an initial election date of 11/22/2019. The patient's terminal illness was identified as "Alzheimer's Disease unspecified [brain disorder that causes problems with memory, thinking and behavior]."

The record included a document dated 11/22/2019, titled "Skilled Nursing Visit Note," stated " ...Description: RN/SOC [Start of Care] Visit ... Wound Assessment and Care: Right Posterior Buttocks/Decubitus/Pressure Ulcer ... Other: Wound care by facility ... Unable to assess wound ...."

The record also included an undated document titled "Wound Flowsheet," which stated "... [Patient #13] ... Bilateral Buttocks Coccyx/Decubitus/Pressure Ulcer Stage IV - Active ... 12/12/2019 ... Measurements: 0.5 x 0.5 ... Drainage Amount: None ... Drainage Odor:

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L 522	Continued From page 5 None ... Wound Bed: Clean ... Bed Color/%: Pink ... Wound Edges: WNL [within normal limits] ... Peri Wound Skin: WNL [within normal limits] ...." The record failed to evidence a thorough initial comprehensive assessment upon election of the hospice benefit. During an interview on 5/10/2021 at 4:45 PM, when asked if a facility is taking care of a hospice patient and managed their wound as well, how would the nurse obtain measurements upon an initial assessment. The Family Care Coordinator indicated they would request documentation from the facility.	L 522		
L 530	CONTENT OF COMPREHENSIVE ASSESSMENT CFR(s): 418.54(c)(6) [The comprehensive assessment must take into consideration the following factors:] (6) Drug profile. A review of all of the patient's prescription and over-the-counter drugs, herbal remedies and other alternative treatments that could affect drug therapy. This includes, but is not limited to, identification of the following: (i) Effectiveness of drug therapy (ii) Drug side effects (iii) Actual or potential drug interactions (iv) Duplicate drug therapy (v) Drug therapy currently associated with laboratory monitoring. This STANDARD is not met as evidenced by: Based on record review and interview, the hospice failed to ensure all medications were included on the patient's drug profile and included	L 530		

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clear instructions for use, in 10 of 17 active records reviewed (2, 3, 4, 5, 8, 11, 14, 16, 21, 24).

Findings include:

1. An undated policy titled "Plan of Care - Content," stated " ...The patient's plan of care includes all services necessary for the palliation and management of the terminal illness and its related conditions ... the plan of care includes ... interventions to manage pain and symptoms ... a detailed statement of the scope and frequency of services necessary to meet the specific patient and family needs ... drugs and treatments necessary to meet the needs of the patient ...."

2. An undated policy titled "Medications - Management," stated " ...A medication profile is maintained for every patient and includes a listing of the current medication orders for each patient ... the medication profile includes all prescriptions, medications ... and alternative supplements ...."

3. An undated policy titled "Medications - Administration," stated " ...The RN (Registered Nurse) or designee provides instructions on the proper administration of medications ... instruction includes ... when and how to administer medications included in the plan of care ... documents all instructions given regarding the safe administration of medication ...."

4. The clinical record of patient #2 was reviewed on 4/29/2021 at 9:00 AM and indicated a hospice election date of 4/1/2021 and a primary diagnosis of congestive heart failure (chronic condition in which the heart doesn't pump blood as well as it should). The record contained a plan of care, with benefit period of 4/1/2021 to 6/29/2021, which

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indicated an order for "oxygen 2l aerosol; Administer 2 liters per minute intranasally continuously for SOB [shortness of breath]." The plan of care failed to specify titration orders, a goal oxygen saturation percentage, or when to notify the physician.

5. The clinical record of patient #3 was reviewed on 5/3/2021 at 11:47 AM and indicated a hospice election date of 12/17/2018 and a primary diagnosis of syringomyelia (a fluid-filled cyst within the spinal cord). The record contains a plan of care, with benefit period of 2/1/21 to 4/1/21, that indicated an order for "ComfortPak." The medication list failed to specify what the ComfortPak was, what it contained, dosage information, instructions for use, possible side effects, and possible interactions with other medications.

6. The clinical record of patient #4 was reviewed on 4/28/2021 at 3:41 PM and indicated a hospice election date of 10/13/2017 with a primary diagnosis of congestive heart failure. The record contained a plan of care, with a benefit period of 1/25/21 to 3/25/21, that indicated orders for, but are not limited to, "Albuterol [prevent and treat difficulty breathing, wheezing, shortness of breath, coughing, and chest tightness caused by lung diseases such as asthma and chronic obstructive pulmonary disease] ... Aldactone [treats high blood pressure and heart failure] ... Carvedilol [treats high blood pressure and heart failure] ... Lantus [treats diabetes] ... Lasix [treats fluid retention] ... MiraLAX [treats constipation] ... Oxygen 2-6 liters per minute via nasal cannula; continuous as needed; For SOB [shortness of breath] may titration [sic] ... Pepcid [treats conditions that cause excess stomach

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acid] ... Potassium chloride [supplement] ... Reglan [treats gastroesophageal reflux disease] ... Spiriva [treats symptoms of chronic obstructive pulmonary disease] ... Symbicort [treats asthma and chronic obstructive pulmonary disease] ... Tamsulosin [treats the symptoms of an enlarged prostate] ... Trazodone [treats insomnia] ... Xarelto [treats and prevents blood clots] ...." The plan of care failed to specify when to titrate the oxygen being used or how much to increase the oxygen.

On 4/29/2021, during a home visit with patient #4, the medications that were reported to be taken by the patient were observed. The medications included Aldactone, Reglan, Spiriva, Symbicort, Xarelto, Aspirin, and Loratadine. Aspirin and Loratadine failed to be evidenced on the plan of care/medication list.

7. The clinical record of patient #5 was reviewed on 5/3/2021 at 1:25 PM and indicated a hospice election date of 7/6/2019 with a primary diagnosis of ischemic cardiomyopathy (narrowing of the coronary arteries). The record contained a plan of care, with a benefit period of 2/25/2021 to 4/25/2021, indicated an order for "ComfortPak". The medication list failed to specify what the ComfortPak was, what it contained, dosage information, instructions for use, possible side effects, and possible interactions with other medications.

8. The clinical record of patient #8 was reviewed on 5/3/21 at 2:45 PM and indicated a hospice election date of 3/6/2021 with a primary diagnosis of atherosclerotic heart disease of native coronary artery (progressive buildup of plaque that causes less blood flow to the heart muscle).

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The record contained a plan of care, with a benefit period of 3/6/2021 to 6/3/2021, which indicated an order for "ComfortPak." The medication list failed to specify what the ComfortPak is, what it contained, dosage information, instructions for use, possible side effects, and possible interactions with other medications. The plan of care also indicated an order for "oxygen 2-6 liters per minute via nasal cannula; as needed; may titrate for increased dyspnea [labored breathing]." The plan of care does not specify titration orders, a goal oxygen saturation percentage, or when to notify the physician.

9. The clinical record of patient #11 was reviewed on 5/4/21 at 10:30 AM and indicated a hospice election date of 7/1/2020 with a primary diagnosis of Alzheimer's Disease (brain disorder that causes problems with memory, thinking and behavior). The record contained a plan of care, with a benefit period of 12/28/2020 to 2/25/2021, indicated an order for "ComfortPak." The medication list failed to specify what the ComfortPak was, what it contained, dosage information, instructions for use, possible side effect, and possible interactions with other medications.

10. The clinical record of patient #14 was reviewed on 5/5/2021 at 9:48 AM and indicated a hospice election date of 12/9/2020 with a primary diagnosis of cauda equina syndrome (nerve roots are compressed and disrupt motor and sensory function to the lower extremities and bladder). The record contained a plan of care, with a benefit period of 12/9/2020 to 3/8/2021, indicated an order for "ComfortPak." The medication list failed to specify what the ComfortPak is, what it

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contained, dosage information, instructions for use, possible side effect, and possible interactions with other medications.

11. The clinical record of patient #16 was reviewed on 5/5/2021 at 4:40 PM and indicated a hospice election date of 4/23/2021 with a primary diagnosis of Alzheimer's Disease (brain disorder that causes problems with memory, thinking and behavior). The record contained a plan of care, with a benefit period of 4/23/2021 to 7/21/2021, indicating an order for "ComfortPak". The medication list failed to specify what the ComfortPak was, what it contained, dosage information, instructions for use, possible side effect, and possible interactions with other medications.

12. The clinical record of patient #21 was reviewed on 5/5/21 at 3:35 PM and indicated a hospice election date of 8/11/2020 with a primary diagnosis of atherosclerotic heart disease (progressive buildup of plaque that causes less blood flow to the heart muscle). The record contained a plan of care, with a benefit period of 4/8/3021 to 6/6/2021, which indicated orders for "Morphine 20 mg/ml [milligrams/milliliters] 10 mg/0.5 ml by mouth PRN [as needed] every 4 hours for pain or shortness of breath ... Morphine 20 mg/ml 5 mg/0.25 ml by mouth PRN [as needed] every 2 hours for pain of shortness of breath ... Morphine Sulfate 15 mg oral tablet; Take 7.5 - 15 milligrams oral 2 times a day as needed for pain; Take 0.5 to 1 tablet BID [twice daily] for pain ... Oxygen 2-6 liters per minute via nasal cannula; prn as needed; may titrate for increased dyspnea ...." The plan of care failed to evidence when to use the different morphine doses, failed to specify titration orders, a goal

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L 530	Continued From page 11 oxygen saturation percentage, or when to notify the physician. 13. The clinical record of patient #24 was reviewed on 5/6/2021 at 1:50 PM and indicated a hospice election date of 1/2/2021 with a primary diagnosis of atherosclerosis native arteries of extremities (narrowing and hardening of the arteries that supply the legs and feet). The record contained a plan of care, with a benefit period of 4/2/2021 to 6/30/2021, indicated an order for "ComfortPak." The medication list failed to specify what the ComfortPak was, what it contained, dosage information, instructions for use, possible side effect, and possible interactions with other medications. 14. During an interview on 5/10/2021 at 2:25 PM, when asked how the patient was educated on how to take pain medications when more than one dose, the Family Patient Care Coordinator indicated that it would "hopefully be on the label." Additionally, when asked if the ComfortPak should be detailed and specific on each medication list, she stated "yes."	L 530		
L 533	UPDATE OF COMPREHENSIVE ASSESSMENT CFR(s): 418.54(d) The update of the comprehensive assessment must be accomplished by the hospice interdisciplinary group (in collaboration with the individual's attending physician, if any) and must consider changes that have taken place since the initial assessment. It must include information on the patient's progress toward desired outcomes, as well as a reassessment of the patient's response to care. The assessment update must be accomplished as frequently as the condition of	L 533		

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the patient requires, but no less frequently than every 15 days.

This STANDARD is not met as evidenced by:
Based on record review and interview, the hospice's comprehensive assessment failed to include information on the patient's progress toward desired outcomes and failed to have a policy to direct the staff to do this for 13 of 25 clinical records reviewed (2, 3, 5, 6, 7, 11, 13, 14, 15, 17, 22, 23, 24).

Findings include:

1. The clinical record of patient #2 was reviewed on 4/29/2021 at 9:00 AM and indicated a hospice election date of 4/1/2021 and a primary diagnosis of congestive heart failure (chronic condition in which the heart doesn't pump blood as well as it should).

The record contained a document dated 4/20/2021, completed by Employee G Licensed Practical Nurse (LPN) G, titled "Skilled Nursing Visit Note," stated " ...Description ... LPN Routine Visit ... Care Plan Documentation ... Goal: Patient/caregiver can demonstrate safe and effective use of home oxygen including: safe storage, compliance and precautions ... Progress: 10% ... Goal: Patient/caregiver demonstrate knowledge of disease process including prognosis, symptoms, and complications ... Progress: 10% .... Goal: Patient/caregiver demonstrate proper administration of oxygen ... Progress: 10% ...Goal: Patient/caregiver will acknowledge support and understanding of communication

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needs ... Progress: 10% ... Patient/caregiver will acknowledge support and understanding of plan ... Progress: 10% ... Patient/caregiver able to identify s/s [signs/symptoms] to report to MD [medical doctor]; actions to take ... Progress: 10% ... Patient's symptoms will be consistent with stage of disease and problems managed as well as disease process will allow ... Progress: 10% ... Patient/caregiver will be able to verbalize/demonstrate appropriate level of assistance and cueing when the patient is using assistive device ... Progress: 10% ... Goal: Family will have needed support at time of death ... Progress: 10% ... Goal: Survivor will be knowledgeable of bereavement services and, when needed, will use available support to achieve a more positive grief outcome ... Progress: 10% ... Goal: Patient/caregiver will verbalize understanding of pain management regimen ... Progress 10% ... Goal: Patient/caregiver will verbalize understanding/demonstrate compliance and independence of medication regimen and s/s [signs/symptoms] adverse reactions to report ... Progress: 10% ... Goal: Healing of scabbed area on left medial inner leg/knee abrasion ... Progress: 10%...." The record failed to evidence objective measurement of patient-specific goals.

2. The clinical record of patient #3 was reviewed on 5/3/2021 at 11:47 AM and indicated a hospice election date of 12/17/2018 and a primary diagnosis of syringomyelia (a fluid-filled cyst within the spinal cord).

The record contained a document dated 4/20/2021, completed by LPN H titled "Skilled Nursing Visit Note," stated " ...Description ... LPN Routine Visit ... Care Plan Documentation ...

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Goal: Patient/caregiver will be independent with intermittent catheterization ... Progress: 70% ... Goal: Knowledge of use, side effects of medications ... Progress: 70% ... Goal: Patient will remain safe at home ... Goal: 70% ... Goal: Compliant with medications ... 60% ... Goal: Patient will see out education related to her rare disease ... Progress: 60% ... Goal: Anxiety level at optimal level for achievement of health and functioning ... Progress: 100% ... Goal: Management and control of anxiety level ... Progress: 100% ... Goal: Patient/caregiver can identify effective stress reduction strategies ... Goal: Patient/caregiver verbalize understanding regarding avoiding irritating foods/fluids that can affect condition ... Progress: 60% ... Goal: Patient/caregiver verbalizes understanding regarding signs/symptoms of urinary tract infections and what to report ... Progress: 60% ... Goal: Patient/caregiver will acknowledge support and understanding of communication needs ... Progress: 90% ... Goal: Continuity of care will be maintained as appropriate to patient/primary caregiver needs ... Progress: 60% ... Goal: Patient will verbalize decreased signs/symptoms depression/hopelessness ... Progress: 80% ... Goal: Patient will discuss her feelings with Guardian Angel Hospice Staff ... Progress: 80% ... Goal: Caregiver will identify coping strengths and resources for support ... Progress: 50% ... Goal: Patient will identify coping strengths and resources for support ... Progress: 50% ... Goal: Patient/caregiver can describe ways to deal with grief ... Progress: 70% ... Goal: Patient can identify achievable goals, alternative sources of action ... Progress: 70% ... Goal: Patient to allow blood pressure in unaffected arm only due to possibility of lymphoma ... Progress: 60%...." The record

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failed to evidence objective measurement of patient-specific goals.

3. The clinical record of patient #5 was reviewed on 5/3/2021 at 1:25 PM and indicated a hospice election date of 7/6/2019 with a primary diagnosis of ischemic cardiomyopathy (narrowing of the coronary arteries). The record contained a document dated 4/22/2021, completed by Registered Nurse (RN) I, titled "Skilled Nursing Visit Note," stated " ...Description ... RN Aide Supervision with RN Visit ... Care Plan Documentation ... Goal: Patient/caregiver will acknowledge support and understanding of communication needs ... Progress: 100% ... Goal: Patient/caregiver will acknowledge support and understanding of plan ... Progress: 100% ... Goal: Patient will maintain optimal coping through hospice care ... Progress: 100% ... Goal: Patient/caregiver will verbalize understanding of treatment/prevention of diarrhea ... Progress: 100% ... Goal: Caregiver will be able to verbalize/demonstrate appropriate level of assistance and cueing when the patient is using assistive device ... Progress: 100% ... Patient will be able to demonstrate safely sitting in swivel chair ... Progress: 100% ... Goal: Family will have needed support at time of death ... Progress: 100% ... Goal: Survivor will be knowledgeable of bereavement services and, when needed, will use available support to achieve a more positive grief outcome ... Progress: 100% ... Goal: Patient able to identify physical and mental stressors and avoids them when possible ... Progress: 100% ... Goal: patient's symptoms will be consistent with stage of disease process and problems managed as well as disease process will allow ... Progress: 100% ... Goal: Family/caregiver will demonstrate

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ability to care for dependent patient ... Progress: 20%...." The record failed to evidence objective measurement of patient-specific goals.

4. The clinical record of patient #6 was reviewed on 5/3/2021 at 2:30 PM and indicated a hospice election date of 3/10/2021 with a primary diagnosis of congestive heart failure (chronic condition in which the heart doesn't pump blood as well as it should). The record contained a document dated 4/25/2021, completed by RN I, titled "Skilled Nursing Visit Note," stated " ...Description ... RN Aide Supervision with RN Visit ... Care Plan Documentation ... Goal: Patient passes soft, formed stool at frequency that is normal for the patient ... Progress: 10% ... Goal: Patient/caregiver will demonstrate understanding of measures to manage episodes of constipation ... Progress: 10% ... Goal: Caregiver will be able to verbalize/demonstrate appropriate level of assistance and cueing when the patient is using assistive device ... Progress: 10% ... Goal: Patient/caregiver will verbalize understanding of falls/injury prevention and home safety measures ... Progress: 10% ... Goal: Patient/caregiver will demonstrate necessary behaviors to maintain good safety awareness and minimize the risk of falls and/or injury ... Progress: 10% ... Goal: Family will have needed support at time of death ... Progress: 20% ... Goal: Survivor will be knowledgeable of bereavement services and, when needed, will use available support to achieve a more positive grief outcome ... Progress: 20% ... Goal: patient's symptoms will be consistent with stage of disease process and problems managed as well as disease process will allow ... Progress: 10% ... Goal: Patient/caregiver verbalize understanding of disease process including

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prognosis, signs/symptoms, complications, effect of disease on body systems and what to report ... Progress: 10% ... Goal: Patient/caregiver will demonstrate compliance with treatment regimen ...." The record failed to evidence objective measurement of patient-specific goals.

5. The clinical record of patient #7 was reviewed on 5/3/2021 at 2:45 PM and indicated a hospice election date of 7/2/2018 with a primary diagnosis of malignant neoplasm of right female breast (abnormal cells divide uncontrollably and destroy body tissue). The record contained a document dated 7/18/2018, completed by RN J, titled "Skilled Nursing Visit Note," stated " ...Description ... RN Routine Visit ... Care Plan Documentation ... Goal: Patient/caregiver can describe measures-maintain [sic] adequate nutrition/hydration ... Progress: 80% ... Goal: Patient/caregiver will demonstrate understanding of appropriate use of medications for pain and symptom management ... Progress: 10% ... Goal: Patient will be pain free or verbalize acceptable pain level with current pain management regimen ... Progress: 0% ... Patient/caregiver will verbalize understanding of pain management regimen ... Progress: 20% ... Goal: Patient/caregiver will demonstrate correct procedure for dressing changes ... Progress: 100%...." The record failed to evidence objective measurement of patient-specific goals.

6. The clinical record of patient #11 was reviewed on 5/4/21 at 10:30 AM and indicated a hospice election date of 7/1/2020 with a primary diagnosis of Alzheimer's Disease (brain disorder that causes problems with memory, thinking and behavior). The record contained a document dated 1/4/2021, completed by RN K, titled "Skilled

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Nursing Visit Note," stated " ...Description ... RN Aide Supervision with RN Visit ... Care Plan Documentation ... Goal: Anxiety level at optimal level for achievement of health and functioning ... Progress: 30% ... Goal: Patient/caregiver will demonstrate understanding of measures to reduce anxiety ... Progress: 30% ... Goal: Patient/caregiver will acknowledge support and understanding of communication needs ... Progress: 30% ... Goal: Patient/caregiver will acknowledge support and understanding of plan ... Progress: 30% ... Goal: Establish/maintain normal bowel habits ... Progress: 30% ... Goal: Patient/caregiver will demonstrate understanding of measures to prevent/alleviate constipation ... Progress: 30% ... Goal: Patient/caregiver will demonstrate ways to achieve/maintain adequate nutrition and fluid intake ... Progress: 30% ...." The record failed to evidence objective measurement of patient-specific goals.

7. The clinical record of patient #13 was reviewed on 5/4/2021 at 2:00 PM and indicated a hospice election date of 11/22/2019 with a primary diagnosis of Alzheimer's Disease (brain disorder that causes problems with memory, thinking and behavior). The record contained a document dated 1/23/2019, completed by LPN D, titled "Skilled Nursing Visit Note," stated " ...Description ... LPN Routine Visit ... Care Plan Documentation ... Goal: Patient/caregiver will acknowledge support and understanding of communication needs ... Progress: 10% ... Goal: Patient/caregiver will acknowledge support and understanding of plan ... Progress: 10% ... Goal: Patient/caregiver will be able to verbalize/demonstrate appropriate level of assistance and cueing when the patient is using assistive device: alternating pressure mattress,

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L 533	Continued From page 19 broda chair ... Progress: 10% ... Goal: Family/caregiver will verbalize how to minimize risks of altered mobility ... Progress: 10% ... Goal: Family/caregiver verbalize/demonstrate measure to achieve optimum comfort level ... Progress: 10% ... Goal: Family/caregiver will verbalize understanding of disease process, including prognosis, symptoms, treatment, and complications ... Progress: 10%...." The record failed to evidence objective measurement of patient-specific goals. 8. The clinical record of patient #14 was reviewed on 5/5/2021 at 9:48 AM and indicated a hospice election date of 12/9/2020 with a primary diagnosis of cauda equina syndrome (nerve roots are compressed and disrupt motor and sensory function to the lower extremities and bladder). The record contained a document dated 4/27/2021, completed by RN L, titled "Skilled Nursing Visit Note," stated " ...Description ... RN Aide Supervision with RN Visit ... Care Plan Documentation ... Goal: Patient will be maintained in safe environment and oriented as appropriate for stage of disease process ... Progress: 90% ... Goal: Patient will remain free of preventable complications ... Progress: 90% ... Goal: Patient's symptoms will be consistent with stage of disease process and problems managed as well as disease process will allow ... Progress: 90% ... Patient/caregiver will acknowledge support and understanding of plan ... Progress: 100% ... Patient/caregiver can identify ways to deal with feelings ... Progress: 90%...." The record failed to evidence objective measurement of patient-specific goals. 9. The clinical record of patient #15 was reviewed on 5/5/2021 at 12:41 PM and indicated a hospice	L 533		

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election date of 9/25/2020 with a primary diagnosis of chronic ischemic heart disease (narrowed heart arteries that cause less blood and oxygen to reach the heart muscle). The record contained a document dated 1/15/2021, completed by RN E, titled "Skilled Nursing Visit Note," stated " ...Description ... RN Aide Supervision with RN Visit ... Care Plan Documentation ... Goal: Knowledgeable of signs/symptoms to report to registered nurse/medical doctor ... Progress: 70% ... Goal: Knowledgeable of use, side effects of medications ... Progress: 70% ... Goal: Patient/caregiver demonstrate proper administration of oxygen ... Progress: 70% ... Goal: Patient/caregiver understand all aspects of therapy and treatments ... Progress: 70% ... Goal: Patient/caregiver will acknowledge support and understanding of plan ... Progress: 80% ... Goal: Establish/maintain normal bowel habits ... Progress: 70% ... Goal: Patient/caregiver will verbalize decreased signs/symptoms of constipation ... Goal: Patient will be able to verbalizes/demonstrate appropriate level of assistance and cueing when using assistive device: Electric hospital bed, reactive air mattress with pump, rollator, wheelchair, gel cushion, oxygen concentrator with nasal cannula ... Progress: 80%...." The record failed to evidence objective measurement of patient-specific goals.

10. The clinical record of patient #17 was reviewed on 5/5/2021 at 12:07 PM and indicated a hospice election date of 4/23/2021 with a primary diagnosis of heart disease unspecified (heart conditions that include diseased vessels, structural problems, and blood clots). The record contained a document dated 4/29/2021, completed by LPN D, titled "Skilled Nursing Visit

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Note," stated " ...Description ... LPN Routine Visit ... Care Plan Documentation ... Goal: Patient/caregiver verbalize understanding/demonstrate adequate fluid intake ... Progress: 10% ... Goal: Patient's skin integrity will be maintained with proper skin care and use of adult incontinence supplies ... Progress: 10% ... Goal: Patient's skin remains free of breakdown ... Progress: 10% ... Goal: Patient/caregiver can describe measures-maintain [sic] adequate nutrition/hydration ... Progress: 10% ... Goal: Patient's nutritional needs will be met as patient's condition/comfort allows ... Progress: 10%...." The record failed to evidence objective measurement of patient-specific goals.

11. The clinical record of patient #22 was reviewed on 5/7/2021 at 1:30 PM and indicated a hospice election date of 3/15/2021 with a primary diagnosis of malignant neoplasm of the prostate (abnormal cells divide uncontrollably and destroy body tissue in the man's gland that produces the seminal fluid that nourishes and transports sperm). The record contained a document dated 1/15/2021, completed by RN E, titled "Skilled Nursing Visit Note," stated " ...Description ... RN Aide Supervision with RN Visit ... Care Plan Documentation ... Goal: Patient/caregiver will verbalize feelings, emotions and stressor [sic] ... Progress: 80% ... Goal: Patient/caregiver will verbalize appropriate interventions for stress/anxiety management ... Progress: 80% ... Goal: Patient/caregiver will acknowledge support and understanding of communication needs ... Progress: 80% ... Goal: Patient/caregiver will be able to verbalize/demonstrate appropriate level of assistance and cueing when the patient is using assistive device ... Progress: 80% ... Goal: Patient/caregiver maintain necessary measures

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to reduce risk and avoid wound infection ... Progress: 80%...." The record failed to evidence objective measurement of patient-specific goals.

12. The clinical record of patient #23 was reviewed on 5/7/2021 at 2:00 PM and indicated a hospice election date of 2/9/2021 with a primary diagnosis of senile degeneration of brain (changes in mental health, such as a decline in judgment or memory loss). The record contained a document dated 4/29/2021, completed by RN M, titled "Skilled Nursing Visit Note," stated " ...Description ... RN Aide Supervision with RN Visit ... Care Plan Documentation ... Goal: Anxiety/agitation controlled through course of care ... Progress: 50% ... Goal: Family/caregiver will demonstrate measures to decrease patient's agitation/anxiety ... Progress: 50% ... Goal: Family/caregiver maintain and modify environment according to patient's cognitive and comfort status ... Progress: 50% ... Goal: Family/caregiver will demonstrate measures to decrease patient's agitation/anxiety ... Progress: 50% ... Goal: Family will have needed support at time of death ... Progress: 30% ... Goal: Survivor will be knowledgeable of bereavement services and, when needed, will use available support to achieve a more positive grief outcome ...." The record failed to evidence objective measurement of patient-specific goals.

13. The clinical record of patient #24 was reviewed on 5/6/2021 at 1:50 PM and indicated a hospice election date of 1/2/2021 with a primary diagnosis of atherosclerosis native arteries of extremities (narrowing and hardening of the arteries that supply the legs and feet). The record contained a document dated 3/22/2021, completed by RN N, titled "Skilled Nursing Visit

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L 533	Continued From page 23 Note," stated " ...Description ... RN Aide Supervision with RN Visit ... Care Plan Documentation ... Goal: Patient/caregiver will verbalize understanding of disease process, treatments, s/s [signs/symptoms] exacerbations to report ... Progress: 30% ... Goal: Patient/caregiver can describe/demonstrate measures to improve/maintain skin integrity ... Progress: 30% ... Goal: Patient/caregiver can describe interventions to prevent skin breakdown ... Progress: 30% ... Goal: Patient/caregiver to avoid personal contact ... Progress: 100% ... Goal: Patient/caregiver verbalize understanding/demonstrate necessary measures to reduce risk and avoid infection ... Progress: 100% ... Goal: Patient/caregiver verbalize understanding/demonstration proper handwashing ... Progress: 100%...." The record failed to evidence objective measurement of patient-specific goals. 14. During an interview on 5/10/2021 at 2:25 PM, when asked if all goals should be patient-specific and measurable, the Family Patient Care Coordinator, indicated "yes." When asked how the agency evaluated the patient's progress towards goals, she indicated, "There's a percentage they have to meet, but there's no outline of the percentage requirements."	L 533		
L 545	CONTENT OF PLAN OF CARE CFR(s): 418.56(c) The hospice must develop an individualized written plan of care for each patient. The plan of care must reflect patient and family goals and interventions based on the problems identified in the initial, comprehensive, and updated comprehensive assessments. The plan of care	L 545		

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must include all services necessary for the palliation and management of the terminal illness and related conditions, including the following:

This STANDARD is not met as evidenced by:
Based on record review and interview, the hospice failed to develop an individualized plan of care for all needs identified in the comprehensive assessment for 3 of 25 clinical records reviewed (#1, 4, 6).

Findings include:

1. An undated policy titled, "Plan of Care - Content," stated, " ...The plan of care includes, but is not limited to ... treatments necessary to meet the needs of the patient ...."

2. The clinical record of patient #1 was reviewed on 4/27/21 at 5:30 PM and indicated a hospice election date of 3/11/2021 with a primary diagnosis of cerebrovascular disease unspecified (group of conditions, diseases, and disorders that affect the blood vessels and blood supply to the brain). The record contained a plan of care with the benefit period dates 3/11/2021 to 5/9/2021, which stated " ...Other Pertinent Diagnosis ... Other seizures ..." The plan of care failed to evidence seizure precautions being listed.

3. The clinical record of patient #4 was reviewed on 4/28/2021 at 3:41 PM and indicated a hospice election date of 10/13/2017 with a primary diagnosis of congestive heart failure (chronic condition in which the heart doesn't pump blood as well as it should). The record contained a plan of care with the benefit period dates 3/26/2021 to

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L 545	Continued From page 25 5/24/2021, which stated " ...Medication ... Xarelto [treats and prevents blood clots] oxygen [supplement] ...." The plan of care failed to evidence bleeding and oxygen precautions being listed. 4. The clinical record of patient #6 was reviewed on 5/3/2021 at 2:30 PM and indicated a hospice election date of 3/10/2021 with a primary diagnosis of congestive heart failure (chronic condition in which the heart doesn't pump blood as well as it should). The record contained a plan of care with the benefit period dates 3/10/2021 to 6/7/2021 which failed to evidence any skilled nursing interventions. 5. During an interview on 5/10/2021 at 2:25 PM, when asked if a patient with a history of seizures should have seizure precautions listed on their plan of care, the Family Patient Care Coordinator stated, "yes."	L 545		
L 553	REVIEW OF THE PLAN OF CARE CFR(s): 418.56(d) A revised plan of care must include information from the patient's updated comprehensive assessment and must note the patient's progress toward outcomes and goals specified in the plan of care. This STANDARD is not met as evidenced by: Based on observation, record review, and interview, the hospice failed to ensure that the IDG (Interdisciplinary Group) discussed all problems identified on the problem list and its progress toward for 2 of 2 observations of a patient review during IDG (Interdisciplinary	L 553		

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Group) meeting (#4, 12).

Findings include:

1. An undated policy, titled "Coordination of Services," stated "...The IDT [interdisciplinary team] meets every two weeks to provide care planning for the hospice's patients/caregivers ... Each patient/caregiver is discussed, at a minimum, every 15 days ...."

2. The clinical record of patient #4 was reviewed on 4/28/2021 at 3:41 PM and indicated a hospice election date of 10/13/2017 with a primary diagnosis of congestive heart failure (chronic condition in which the heart doesn't pump blood as well as it should). The record contained a plan of care, with a benefit period of 1/25/21 to 3/25/21, that indicated orders for, but are not limited to, "Albuterol ... Aldactone ... Carvedilol ... Lantus ... Lasix ... MiraLAX ... Oxygen 2-6 liters per minute via nasal cannula; continuous as needed; For SOB may titration [sic] ... Pepcid ... Potassium chloride ... Reglan ... Spiriva ... Symbicort ... Tamsulosin ... Trazodone ... Xarelto ...."

On 4/29/2021, during a home visit with patient #4, the medications that were reported to be taken by the patient were observed. The medications included Aldactone, Reglan, Spiriva, Symbicort, Xarelto, Aspirin, and Loratadine. Aspirin and Loratadine were not included on the list of medications on the plan of care.

During observation of the Interdisciplinary Group's meeting on 5/6/2021 at 9:00 AM, the patient's recertification was discussed, but failed to discuss medications to ensure they had been

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L 553	Continued From page 27 updated to reflect what the patient was taking. 3. The clinical record of patient #12 was reviewed on 5/4/2021 at 1:15 PM and indicated a hospice election date of 10/30/2020 with a primary diagnosis of dementia (group of thinking and social symptoms that interferes with daily functioning). During observation of the Interdisciplinary Group's meeting on 5/6/2021 at 9:00 AM, the patient's recertification was discussed, but failed to evidence a discussion of the patient's total plan of care and review of all active problems. 4. During an interview on 5/11/2021 at 4:45 PM, when asked if the Interdisciplinary Group Meetings should go over the comprehensive picture of each patient, even if there are no changes, the administrator stated, "Per our policy, it says we are going to update as needed."	L 553		
L 555	COORDINATION OF SERVICES CFR(s): 418.56(e)(2) [The hospice must develop and maintain a system of communication and integration, in accordance with the hospice's own policies and procedures, to-] (2) Ensure that the care and services are provided in accordance with the plan of care. This STANDARD is not met as evidenced by: Based on record review and interview, the hospice failed to evidence that all services were provided in accordance with the plan of care for 1 of 17 active records reviewed (#14).	L 555		

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Findings include:

An undated document titled "Registered Nurse - Case Manager," dated 6/6/2017, stated, " ...submits accurate documentation within 24 hours of visit ... responsible for following all policies and procedures of the agency regarding service delivery, documentation, and care coordination ...."

An undated policy titled, "Physician Orders," stated, " ...Verbal orders are obtained from the physician in order to provide the following ... services ... to meet the needs of the patient ... Documentation of the receipt of the verbal order and of the written order sent to the physician are maintained in the patient's clinical record ...."

An undated policy titled, "Plan of Care - Content," stated, " ...The plan of care includes, but is not limited to ... treatments necessary to meet the needs of the patient ...."

The clinical record of patient #14 was reviewed on 5/5/2021 at 9:48 AM and indicated a hospice election date of 12/9/2020 with a primary diagnosis of cauda equina syndrome (nerve roots are compressed and disrupt motor and sensory function to the lower extremities and bladder). The record contained a document dated 1/14/2021, completed by Registered Nurse (RN) O, titled "Skilled Nursing Visit Note," stated, " ...Description ... RN PRN [as needed] Visit ... Narrative Notes ... Writer placed a 16 fr [French] 10 cc [cubic centimeter] balloon Foley catheter using sterile technique ...." The record failed to evidence an order was obtained for the catheter.

During an interview on 5/10/2021 at 2:25 PM,

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L 555	Continued From page 29 when asked if a nurse anchored a catheter on a patient, should there be an order for a catheter in their chart, the Family Patient Care Coordinator stated, "yes."	L 555		
L 625	HOSPICE AIDE ASSIGNMENTS AND DUTIES CFR(s): 418.76(g)(1) (1) Hospice aides are assigned to a specific patient by a registered nurse that is a member of the interdisciplinary group. Written patient care instructions for a hospice aide must be prepared by a registered nurse who is responsible for the supervision of a hospice aide as specified under paragraph (h) of this section. This STANDARD is not met as evidenced by: Based on record review and interview, the hospice failed to provide patient-specific written instructions for the aide for patient care in 21 of 25 records reviewed that have home health aide services (#1, 2, 3, 4, 6, 8, 9, 10, 12, 13, 14, 15, 16, 17, 20, 21, 22, 23, 24). Findings include: 1. An undated job description titled "Hospice Aide," stated " ...Job Duties ... Renders services in strict accordance with the written plan of care ...." 2. An undated policy titled "Hospice Aide Assignments and Duties," stated " ...The hospice RN [Registered Nurse] responsible for supervising the hospice aide prepares written patient care instructions that are patient-specific and not generic ...." 3. The clinical record of patient #1 was reviewed	L 625		

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on 4/27/21 at 5:30 PM and indicated a hospice election date of 3/11/2021. The record contained a document titled "Aide Care Plan," and stated, " ...Interventions ... oxygen precautions ... standard precautions ... bath bed .... Sponge bath ... straighten room ....", but failed to document skills, equipment needed, when or how often to complete interventions.

4. The clinical record of patient #2 was reviewed on 4/29/2021 at 9:00 AM and indicated a hospice election date of 4/1/2021. The record contained a document titled "Aide Care Plan," and stated, " ...Interventions ... assist with positioning, repositioning, alignment ... assist with transfers, ambulation, exercise program ... transfer to bed/chair with assistance ... bath partial ... bath shower ....", but failed to document skills, equipment needed, when or how often to complete interventions.

5. The clinical record of patient #3 was reviewed on 5/3/2021 at 11:47 AM and indicated a hospice election date of 12/17/2018. The record contained a document titled "Aide Care Plan," and stated, " ...Interventions ... companionship/emotional support ... recognize and report any changes in the patient's skin condition ... report to RN [Registered Nurse] if no BM [bowel movement] ... change patient linen ... light housekeeping ... standard precautions ... universal precautions ....", but failed to document skills, equipment needed, when or how often to complete interventions.

6. The clinical record of patient #4 was reviewed on 4/28/2021 at 3:41 PM and indicated a hospice election date of 10/13/2017. The record contained a document titled "Aide Care Plan," and stated, "

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L 625	Continued From page 31 ...Interventions ... Assist with transfers, ambulation, exercise program ... companionship ... fall precautions ... oxygen precautions ... standard precautions ....", but failed to document skills, equipment needed, when or how often to complete interventions. 7. The clinical record of patient #6 was reviewed on 5/3/2021 at 2:30 PM and indicated a hospice election date of 3/10/2021. The record contained a document titled "Aide Care Plan," and stated, " ...Interventions ... assist with positioning, repositioning, alignment ... assist with transfers ... incontinent [sic] care ... change patient linen ... light housekeeping ... may provide companionship and emotional support ... fall precautions ... oxygen precautions ....", but failed to document skills, equipment needed, when or how often to complete interventions. 8. The clinical record of patient #8 was reviewed on 5/3/2021 at 2:45 PM and indicated a hospice election date of 3/6/2021. The record contained a document titled "Aide Care Plan," and stated, " ...Interventions ... assist with positioning, repositioning, alignment ... assist with transfers ... Total hip precautions ... incontinent [sic] care ... report to RN [Registered Nurse] if no BM [bowel movement] ... shampoo ... companionship and emotional support ....", but failed to document skills, equipment needed, when or how often to complete interventions. 9. The clinical record of patient #9 was reviewed on 5/4/2021 at 9:30 AM and indicated a hospice election date of 5/9/2019. The record contained a document titled "Aide Care Plan," and stated, " ...Interventions ... assist with transfers ... incontinent [sic] care ... fall precautions ... safety	L 625		

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precautions ....", but failed to document skills, equipment needed, when or how often to complete interventions.

10. The clinical record of patient #10 was reviewed on 5/4/2021 at 10:00 AM and indicated a hospice election date of 11/23/2019. The record contained a document titled "Aide Care Plan," and stated, " ...Interventions ... recognize and report any changes in patient's skin condition ... ROM [range of motion] exercises ... assist with transfers ... report to RN [Registered Nurse] if no BM [bowel movement] ... may provide companionship ... may provide emotional support ....", but failed to document skills, equipment needed, when or how often to complete interventions.

11. The clinical record of patient #12 was reviewed on 5/4/2021 at 1:15 PM and indicated a hospice election date of 10/30/2020. The record contained a document titled "Aide Care Plan," and stated, " ...Interventions ... transfer to bed/chair with assistance ... up in chair/wheelchair ... report to RN [Registered Nurse] if no BM [bowel movement] ... incontinent [sic] care ... catheter care ... companionship ... aromatherapy ... Angel Touch ... do patient laundry ....", but failed to document skills, equipment needed, when or how often to complete interventions.

12. The clinical record of patient #13 was reviewed on 5/4/2021 at 2:00 PM and indicated a hospice election date of 11/22/2019. The record contained a document titled "Aide Care Plan," and stated, " ...Interventions ... incontinent [sic] care ... universal precautions ... standard precautions ... oxygen precautions ... provide

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companionship and emotional support ... shave ... shampoo ....", but failed to document skills, equipment needed, when or how often to complete interventions.

13. The clinical record of patient #14 was reviewed on 5/5/2021 at 9:48 AM and indicated a hospice election date of 12/9/2020. The record contained a document titled "Aide Care Plan," and stated, " ...Interventions ... assist with positioning, repositioning, alignment ... assist with transfers ... incontinent [sic] care ... report to RN [Registered Nurse] if no BM [bowel movement] ... change patient linen ... companionship and emotional support ... fall precautions ... standard precautions ... universal precautions ....", but failed to document skills, equipment needed, when or how often to complete interventions.

14. The clinical record of patient #15 was reviewed on 5/5/2021 at 12:41 PM and indicated a hospice election date of 9/25/2020. The record contained a document titled "Aide Care Plan," and stated, " ...Interventions ... up in chair/wheelchair ... fluid intake - encourage fluids ... report to RN [Registered Nurse] if no BM [bowel movement] ... incontinent [sic] care ... change patient linens ... companionship and emotional support ... universal precautions ... standard precautions ... oxygen precautions ... shave ....", but failed to document skills, equipment needed, when or how often to complete interventions.

15. The clinical record of patient #16 was reviewed on 5/5/2021 at 4:40 PM and indicated a hospice election date of 4/23/2021. The record contained a document titled "Aide Care Plan,"

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and stated, " ...Interventions ... give SSE [sic] as directed by RN [Registered Nurse] ... incontinent [sic] care ... make patient bed ... shave ... fall precautions ... standard precautions ....", but failed to document skills, equipment needed, when or how often to complete interventions.

16. The clinical record of patient #17 was reviewed on 5/5/2021 at 12:07 PM and indicated a hospice election date of 4/23/2021. The record contained a document titled "Aide Care Plan," and stated, " ...Interventions ... recognize and report any changes in the patient's skin condition ... companionship ... bath - partial ... bath - bed ... bath - shower ... bath ... change patient linen ... report to RN [Registered Nurse] if no BM [bowel movement] ... incontinent [sic] care ... companionship and emotional support ... fall precautions ... standard precautions ... universal precautions ... shampoo ... shave ... denture care ....", but failed to document skills, equipment needed, when or how often to complete interventions.

17. The clinical record of patient #20 was reviewed on 5/5/21 at 3:35 PM and indicated a hospice election date of 1/20/2021. The record contained a document titled "Aide Care Plan," and stated, " ...Interventions ... recognize and report any changes in the patient's skin condition ... give SSE [sic] as directed by RN [Registered Nurse] ... incontinent [sic] care ... report to RN [Registered Nurse] if no BM [bowel movement] ... change patient linen ... bath - partial ... bath - bed ... bath - shower ... bath ... shampoo ... water temperature check ... assess pain ... report pain to nurse ... companionship and emotional support ... fall precautions ... oxygen precautions ... standard precautions ... universal

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precautions ....", but failed to document skills, equipment needed, when or how often to complete interventions.

18. The clinical record of patient #21 was reviewed on 5/5/21 at 3:35 PM and indicated a hospice election date of 8/11/2020. The record contained a document titled "Aide Care Plan," and stated, " ...Interventions ... assist with transfers ... recognize and report any changes in the patient's skin condition ... bath - shower chair ... bath - tub ... bath - partial ... bath - complete ... bath - bed ... change patient linen ... report to RN [Registered Nurse] if no BM [bowel movement] ... incontinent [sic] care ... give SSE [sic] as directed by RN [Registered Nurse] ... shampoo ... water temperature check ... assess pain ... report pain to nurse ... fall precautions ... oxygen precautions ... standard precautions ... universal precautions ....", but failed to document skills, equipment needed, when or how often to complete interventions.

19. The clinical record of patient #22 was reviewed on 5/7/2021 at 1:30 PM and indicated a hospice election date of 3/15/2021. The record contained a document titled "Aide Care Plan," and stated, " ...Interventions ... provide companionship and emotional support ... incontinent [sic] care ... report to RN [Registered Nurse] if no BM [bowel movement] ... change patient linen ... do patient laundry ... shampoo ... shave ... fall precautions ... standard precautions ... universal precautions ...", but failed to document skills, equipment needed, when or how often to complete interventions.

20. The clinical record of patient #23 was reviewed on 5/7/2021 at 2:00 PM and indicated a

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hospice election date of 2/9/2021. The record contained a document titled "Aide Care Plan," and stated, " ...Interventions ... assist with positioning, repositioning, alignment ... assist with transfers ... incontinent [sic] care ... report to RN [Registered Nurse] if no BM [bowel movement] ... bath - partial ... bath - complete ... fall precautions ... standard precautions ... universal precautions ....", but failed to document skills, equipment needed, when or how often to complete interventions.

21. The clinical record of patient #24 was reviewed on 5/6/2021 at 1:50 PM and indicated a hospice election date of 1/2/2021. The record contained a document titled "Aide Care Plan," and stated, " ...Interventions ... assist with positioning, repositioning, alignment ... ROM [range of motion] exercises ... companionship ... incontinent [sic] care ... give SSE [sic] as directed by RN [Registered Nurse] ... change patient linen ... bath - bed ... bath - shower ... fall precautions ... standard precautions ....", but failed to document skills, equipment needed, when or how often to complete interventions.

22. During an interview on 5/10/2021 at 2:25 PM, when asked if all aide care plans be patient-specific, the family patient care coordinator stated, "yes."