STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	151586	A. BUILDING 00 B. WING	01/10/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
KINDRED HOSPICE	5550 S EAST STREET, SUITE A INDIANAPOLIS, IN 46227

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E 0000 Bldg. 00		E 0000		
	An Emergency Preparedness survey was conducted by the Indiana State Department of Health in accordance with the requirements at 42 CFR 418.113. Survey Dates: 12-31-19, 1-2-20, 1-3, 1-6, 1-7, 1-8, 1-9, 1-10-20 Facility Number: 003901 Provider Number: 151586 Medicaid Number: 200471710 Current Active Census: 82 Unduplicated Census Last 12 Months: 337 At this Emergency Preparedness survey, VistaCare USA, LLC, d.b.a. Kindred Hospice (Indianapolis South) was found to have been in compliance with Emergency Preparedness Requirements for Medicare Participating Providers and Suppliers, 42 CFR 418.113.			
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	This visit was for a Federal Recertification and State Licensure survey of a Medicare hospice agency. Survey Dates: 12-31-19, 1-2-20, 1-3, 1-6, 1-7, 1-8, 1-9, 1-10-20			

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

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	Facility Number: 003901 Provider Number: 151586 Medicaid Number: 200471710 Current Active Census: 82 Unduplicated Census Last 12 Months: 337 Clinical Record Review: 14 Home visits: 3 Quality Review Completed: 2/5/2020 by Area 3			
L 0533 Bldg. 00	418.54(d) UPDATE OF COMPREHENSIVE ASSESSMENT The update of the comprehensive assessment must be accomplished by the hospice interdisciplinary group (in collaboration with the individual's attending physician, if any) and must consider changes that have taken place since the initial assessment. It must include information on the patient's progress toward desired outcomes, as well as a reassessment of the patient's response to care. The assessment update must be accomplished as frequently as the condition of the patient requires, but no less frequently than every 15 days. Based on record review and interview, the skilled nurse failed to ensure visit notes included patient's progress toward desired outcomes and goals in 4 (Patients #5, 6, 7, and 8) of 4 records reviewed of patients with skin impairments/	L 0533	L533: Administrator/ designee will educate all nursing staff on ensuring visit notes include evidence of the patient's progress towards desired outcome and goals, specifically the requirement	02/08/2020

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	wounds. The findings included: 1. Review of a policy, with "Kindred at Home & Hospice Affiliates" in the upper left hand corner, dated April 2019, titled "Provision of Care and Record Management- Hospice Nursing Care: Policy No. 4-002" on 1/8/20 at 11:45 A.M., evidenced, " ... The hospice nurse will 3(G). Prepare clinical and progress notes that demonstrate progress toward established goals ... 9(a) ...Providing services in accordance with organizational policies and procedures ... " 2. Review of a document, titled "January Monthly Nursing Meeting-2019" on 1/8/20 at 11:50 A.M., evidenced, "Wound documentation- We are required to assess our patient's wounds at minimum weekly, we may NOT accept/use the measurements or assessment of the ECF (extended care facility) nurse, their assessment is supplemental to ours. Wound assessment is to be documented weekly on a Skin Tool, regardless of the number of wounds, to allow tracking for compliance with wound policy. Documentation must include education provided to FSN (facility skilled nurse) or CG (caregiver), who is providing wound care in our absence, and we must document that we have visualized their competence to perform wound care as ordered." 3. On 1/8/20 at 4:40 P.M., the administrator stated the January Monthly Meeting 2019 process for wound care documentation still applied and should be implemented by the hospice agency as of January 8 2020. The administrator stated, "Nursing staff are required to get weekly wound measurements and visualize wounds at least weekly."		to measure wounds no less than weekly and documentation of wound healing. Education will include policies 4-027 The Plan of Care, Policy 4-002 Hospice Nursing Care, and Lippincott Procedure “Wound Palliative Care, Home Care”. Administrator/Designee will audit 100% of active patient records with wounds weekly to ensure documentation of patient’s progress towards goals, specifically wound measurements no less than weekly and documentation of wound healing. Once a 100% threshold is maintained for 6 consecutive weeks, audits will be reduced to 10 records or 10% of average daily census (whichever is greater) quarterly. Findings will be incorporated into QAPI and reported to the governing body, as evidence by completion of the quarterly QAPI Meeting Minutes. The Administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	

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	4. Review of clinical records for patient #5, evidenced patient #5 elected hospice benefits on 6/5/19. The patient was admitted with a hospice diagnosis of chronic obstructive pulmonary disease. Review of a "Wound Record Report" on 1/7/20 at 2:00 P.M., evidenced Wound #1 had a documented onset date of 7/3/19. Review of skilled nursing visit notes evidenced care visits were made on 7-17 and 7-19-19. These visit notes failed to evidence wound measurements for the week of 7-14 to 7-20-10. After request, the hospice agency was unable to provide additional documentation of wound care measurements for patient #5. Wound #2 had a documented onset date of 7/3/19. The Wound record report failed to evidence wound measurements on 7/17/19 and 7/19/19. Upon request, the hospice agency was unable to provide additional wound care measurements. The above failure to document wound care measurements evidenced that the agency failed to follow operational policies and procedures required to demonstrate progress toward established outcomes and goals for patient #5. 5. Review of clinical records for patient #6, evidenced that patient #6 elected hospice benefits on 9/16/19. The patient was admitted with a hospice diagnosis of Atherosclerotic disease. Review of a "Wound Record Report" on 1/3/20 at 12:07 PM, where Wound #1 had an onset date of 10/23/19 and was inactivated on 12/29/19. The "Wound Record Report" failed to evidence wound measurements on each nursing care visit of 10/30/19; 11/7/19; 11/13/19; 11/23/19 or 11/25/19 for patient #6. The above failure to document wound care measurements evidenced that the			

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	agency failed to follow operational policies and procedures required to demonstrate progress toward established outcomes and goals for patient #6. 6. Review of clinical records for patient #7 evidenced that patient #7 elected hospice benefits on 11/7/2018. The patient was admitted to hospice with a diagnosis of Hypertensive heart and chronic kidney disease with heart failure. Review of a "Wound Record Report" on 1/10/20 at 2:10 P.M., where Wound #1 had an onset date of 7/25/19. and inactivated on 12/26/19. The "Wound Record Report" evidenced wound measurements on 7/29/19. The "Wound Record Report" failed to evidence wound measurements, or documentation of wound healing, after 7/29/19 for patient #7, up to date of review on 1/10/10. Upon request, the hospice agency was unable to provide additional documentation of wound care measurements. Patient #7's wound #2 had an onset date of 9/3/19, and inactivated (no longer part of the plan of care) on 12/17/19. The "Wound Record Report" evidenced wound measurements on 9/6/19; the "Wound Record Report" failed to evidence wound measurements, or documentation of wound healing, after 7/29/19 for patient #7, up to the date of review on 1/10/10. After request, the hospice agency was unable to provide additional wound care measurements. Patient #7's wound #3 had an onset date of 12/13/19, and inactivated on 12/20/19. The "Wound Record Report" failed to evidence wound measurements, or documentation of wound healing, after 7/29/19 for patient #7, up to the date of review on 1/10/10. Upon request, the			

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	hospice agency was unable to provide documentation of additional wound care measurements. Patient #7's wound #4 had an onset date of 12/13/19, and inactivated on 12/20/19. The "Wound Record Report" failed to evidence wound measurements, or documentation of wound healing, after 7/29/19 for patient #7, up to the date of review on 1/10/10. Upon request, the hospice agency was unable to provide documentation of additional wound care measurements. The above failure to document wound care measurements evidenced that the agency failed to follow operational policies and procedures required to demonstrate progress toward established outcomes and goals for patient #7. 7. Review of clinical records for patient #8, evidenced that patient #8 elected hospice benefits on 10/14/19. Patient #8 was admitted with a hospice diagnosis of Senile Degeneration of the Brain. Review of a "Wound Record Report" on 1/7/20 at 2:35 PM, evidenced wound #2 had an onset date of 10/14/19, and inactivated on 11/6/2019. Review of the "Wound Record Report" failed to evidence any wound measurements for patient #8. Wound #3 had an onset date of 10/18/19, and inactivated on 11/6/19. The "Wound Record Report" failed to evidence any wound measurements for patient #8. The above failure to document wound care measurements evidenced that the agency failed to follow operational policies and procedures required to demonstrate progress toward established outcomes and goals for patient #8.			

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	8. On 1-10-20 at 2:30 P.M., the administrator reviewed and verified the above findings. The administrator acknowledged the above clinical record documentation was not in accordance with agency policy. When queried for further pertinent information or documentation, the administrator stated having nothing further to present to be reviewed.			
L 0548 Bldg. 00	418.56(c)(3) CONTENT OF PLAN OF CARE [The plan of care must include all services necessary for the palliation and management of the terminal illness and related conditions, including the following:] (3) Measurable outcomes anticipated from implementing and coordinating the plan of care. Based on record review and interview, the agency failed to identify measurable outcomes in the implementation and coordination of care for 5 (Patients #3, 4, 5, 6, 7) of 14 clinical records reviewed. The findings included: 1. Review of a policy, with "Kindred at Home & Hospice Affiliates," in the left upper corner, dated October 2019, titled "Provision of Care and Record Management", Subtitled "THE PLAN OF CARE Policy No. 4-027" on 1/2/2020 at 11:03 A. M, evidenced the policy stated, "The written plan of care will contain, but will not be limited to, the following: Q. Statement of treatment goals; W. Measurable outcomes anticipated from implementing and coordinating the plan of care." 2. Review of clinical record for patient #3, evidenced patient #3 elected hospice benefits on	L 0548	L548: Administrator/designee will educate all staff on development of specific, objective, measurable goals and documentation towards identified goals. Education will include policies 4-027 The Plan of Care, 4-032 Interdisciplinary Group Meeting, 4-031 Interdisciplinary Group Plan of Care, 5-002 Patient Focused Performance Improvement. Administrator /Designee will audit 10 records or 10% of average daily census (whichever is greater) of active patient records monthly to ensure the content of the IDG note contains specific, objective, measurable goals by all members of the IDG. Once a 100% threshold is	02/08/2020

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	11/12/2019. Patient #3 was admitted to hospice with a primary diagnosis of Vascular Dementia. Review of the interdisciplinary plan of care, dated 11/14/19, evidenced plan and goals for the next 2 weeks, Skilled Nursing Services, "Monitor pain levels and evaluate effectiveness of current pain regimen. Monitor pts. (patient's) ability to transfer safely and evaluate need for more assistance or change in care setting. Monitor pts. (patient's) loc (level of consciousness) and decline in condition or strength. Monitor lower right left for increased edema worsening skin color and blood flow, and s/s (signs and symptoms) of blood clot." The plan of care failed to evidence measurable goals in relation to pain relief regimen, and failed to evidence specific, measurable goals for edema management. 3. Review of clinical record for patient #4, evidenced patient #4 elected hospice benefits on 12/30/2019. Patient #4 was admitted to hospice with a primary diagnosis of Malignant Neoplasm of the Bronchus and Lungs. Review of the interdisciplinary plan of care, dated 1/2/20, evidenced plan and goals for the next 2 weeks for Skilled Nursing Services, "Monitor pain levels and evaluate effectiveness of current pain regimen. Monitor respiratory status and evaluate effectiveness of current respiratory treatments to ensure patient is breathing comfortably and adequately supported. Monitor blood sugar levels sand provide continuing education to wife in patient on diabetes, nutrition, and how to monitor and manage blood sugar levels. Monitor patient's ambulation and evaluate whether appropriate assistive devices are in place and whether changes are required to ensure patient safety. Monitor welling of lower bilateral ankles and feet, and evaluate effectiveness of recent edition of diuretic. " These goals failed to be		maintained for 3 consecutive months, audits will be reduced to 10 records or 10% of average daily census (whichever is greater) quarterly. Findings will be incorporated into QAPI and reported to the governing body, as evidence by completion of the quarterly QAPI Meeting Minutes. The Administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	

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	measurable in relation to an established goal for patient #4's pain regimen. 4. Review of clinical record for patient #5, evidenced patient #5 elected hospice benefits on 6/5/2019. Patient #5 was admitted to hospice with a primary diagnosis of Chronic Obstructive Pulmonary Disease. Review of the interdisciplinary plan of care, dated 12/5/19, evidenced plan and goals for the next 2 weeks for Skilled Nursing Services, "Monitor pain level and evaluate effectiveness of current pain regimen. Monitor patient's level of consciousness for any changes and alert health care providers as soon as possible. Monitor patients breathing pattern for worsening condition of dyspnea or respiratory distress. Evaluate effectiveness of current respiratory treatments and need for possible change to plan of care. Monitor signs and symptom of UTI (urinary tract infection) and evaluate effectiveness of additional antibiotic added." The plan of care failed to evidence specific, objective, and measurable goals in relation to an established goal for patient #5's pain level. 5. Review of clinical record for patient #6, evidenced patient #6 elected hospice benefits on 9/16/19. Patient #6 was admitted to hospice with a primary diagnosis of Atherosclerotic heart disease. Review of patient #6's Interdisciplinary plan of care, dated 11/14/19, evidenced plan and goals for the next 2 weeks, for Skilled Nursing services, " ... Maintain pt. (patient) comfort, assess for change, advocate for pt. (patient), wound care, discuss code status with pt/family, provide education and support as needed. Monitor medications." The plan of care failed to evidence specific, objective, and measurable goals in relation to wound care.			

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	Review of patient #6's Interdisciplinary plan of care, dated 12/4/19, evidenced Skilled Nursing services plan and goals for the next 2 weeks, 1 X per week, to "Assess for changes in condition/decline, manage symptoms, monitor medications and effectiveness and refill needs, provide wound care and supplies, provide pt. (patient) support with other disciplines and family support. Provide education to family on hospice philosophy, scope of practice, and what full code status entails." The plan of care failed to evidence specific, objective, and measurable goals for skilled nurse visits in relation to wound care and education. Chaplain Services, evidenced plan and goals for the next 2 weeks, "2 X 2/Month visit frequency." The plan of care failed to evidence goals for the care period. 6. Review of clinical record for patient #7, evidenced patient #7 elected hospice benefits on 11/7/2018. Patient #7 was admitted to hospice with a primary diagnosis of malignant hypertension, heart/kidney stage 5 with heart failure. Skilled Nursing Services, 1 time per week, evidenced plan and goals for the next 2 weeks, "Monitor patient's skin integrity daily as patient with increased immobility. Patient will attend each meal and eat as able for nutritional comfort. Patient will ambulate safely with use of wheelchair to prevent risk of falls." The plan of care failed to evidence specific, objective, and measurable goals in relation to skin integrity, mobility, and falls. Review of the Interdisciplinary plan of care, dated 7/3/19, evidenced plan and goals for the next 2			

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	weeks, Chaplain Services, " 1 X / 2 Weeks." The plan of care failed to evidence goals for chaplain care visits. Social Work (SW) Services, evidenced plan and goals for the next 2 weeks, "SW will see pt 1 X / Month" The plan of care failed to evidence goals for social worker care visits. Review of the Interdisciplinary plan of care for patient #7, dated 8/15/19, evidenced a blank amount of visits ordered and plan and goals for the next 2 weeks, Chaplain services, "SCC (Spiritual Care Chaplain) will remain available for additional spiritual support, if requested. IDG to monitor spiritual needs." The plan of care failed to evidence goals for chaplain care visits. Skilled nursing services, evidenced 1 X / week visitsordered and plan and goals for the next 2 weeks, "Monitor LOC (level of consciousness) for any changes and evaluate potential reasons Monitor Pt's. (patient's) Input for adequate intake for nutritional comfort. Monitor patient's toe for worsening condition and change POC and wound care to reflect new needs." The plan of care failed to evidence specific, objective, and measurable goals in relation to nutritional comfort, and failed to evidence specific, objective, and measurable goals in relation how worsening condition would be measured. 7. On 1/6/20 at 3:37 P.M., the administrator and a corporate employee, Employee LL, were queried whether it was Kindred's expectation for all core members of the interdisciplinary team to identify and document measurable goals, which were patient specific, in the Hospice IDG Comprehensive Assessment and Plan of care (or Updated) Report, the corporate employee replied,			

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	"Yes, it is the expectation for them [clinicians] to include that information." 8. On 1-10-20, at 2:30 P.M., the administrator reviewed the above plans of care for patients #3, 4, 5, 6, 7, and verified the above findings. When queried for further pertinent information or documentation, the administrator stated having nothing further to present to be reviewed.			
L 0549 Bldg. 00	418.56(c)(4) CONTENT OF PLAN OF CARE [The plan of care must include all services necessary for the palliation and management of the terminal illness and related conditions, including the following:] (4) Drugs and treatment necessary to meet the needs of the patient. Based on record review, the agency failed to implement drugs and treatment necessary to meet the needs of the patient in 1 (Patient #2) of 14 clinical records reviewed. The findings included: Review of a policy, with "Kindred at Home & Hospice Affiliates," in the left upper hand corner, dated October 2019, titled "Provision of care and Record Management-The plan of care: Policy No. 4-027" on 1/7/20 at 3:15 P.M., evidenced the policy stated, " ... 14. The plan of care will include all services necessary for the palliation and management of the terminal illness and related conditions, including drugs and treatments necessary to meet the needs of the patient." Review of the clinical record for patient #2, evidenced patient #2 elected hospice benefits on 3/12/19. Patient #2 was admitted with a hospice	L 0549	L549: Administrator/ designee will educate all nursing staff on the requirement that drugs and treatments necessary to meet the needs of the patient must be implemented as problems are identified. Education will include policies 4-027 The Plan of Care, 4-050 Medication Profile, 4-002 Hospice Nursing Care. Administrator /Designee will audit 10 records or 10% of average daily census (whichever is greater) of active patient records monthly to ensure drugs and treatments are implemented to meet the needs of the patient.	02/08/2020

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	diagnosis of Alzheimer's disease. Review of a Hospice IDG Comprehensive Assessment and Plan of Care Update Report", dated 12/18/19, evidenced an entry by the registered nurse, "Pt. (patient) has had multiple issues with constipation ... Pt. [patient] will be free from constipation with use of softeners and laxatives." Review of document titled, "Client Medication Report" for patient #2, failed to evidence an order had been obtained for stool softeners or laxatives, for symptom management. Review of a Hospice IDG Comprehensive Assessment and Plan of Care Update Report", dated 12/26/19, failed to evidence stool softeners and laxatives on patient #2's medication list. The clinical record for patient #2 failed to evidence the hospice had provided drugs and treatment necessary to meet patient #2's assessed needs. On 1-10-20, at 2:30 PM, the administrator reviewed the clinical records and verified the above findings. When queried for further pertinent information or documentation, the administrator stated having nothing further to offer to be reviewed.		Once a 100% threshold is maintained for 3 consecutive months, audits will be reduced to 10 records or 10% of average daily census (whichever is greater) quarterly. Findings will be incorporated into QAPI and reported to the governing body, as evidenced by completion of the quarterly QAPI Meeting Minutes. The Administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	
L 0557 Bldg. 00	418.56(e)(4) COORDINATION OF SERVICES [The hospice must develop and maintain a system of communication and integration, in accordance with the hospice's own policies and procedures, to-] (4) Provide for and ensure the ongoing sharing of information between all disciplines providing care and services in all settings, whether the care and services are provided directly or under arrangement.	L 0557	L557: Administrator/designee will	02/08/2020

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	Based on record review, the agency failed to ensure the ongoing sharing of information between all disciplines providing care and services in 3 (Patients #2, 5, and 6) of 14 clinical records reviewed. The findings included: 1. Review of a policy, with "Kindred at Home & Hospice Affiliates," in the left upper hand corner, dated April 2019 titled "Provision of Care and Record Management-Hospice Nursing Care, Policy No. 4-002" stated "The hospice nurse will participate in developing and implementing the plan of care and will report the condition of patient and family/ caregiver to the attending physician, medical director and interdisciplinary group on a regular basis, as well as changes in the plan of care." 2. Review of a document titled, "December Monthly HHA Meeting 2019," evidenced the document stated, "Aide Care Plans- Remember to notify the nurse regarding each aide task that is not completed. Ideally to notify via phone call." 3. Review of patient #2's clinical record, evidenced patient #2 elected hospice benefits on 3/12/19. Patient #2 was admitted with a hospice diagnosis of Alzheimer's disease. Review of a skilled nurse visit note, dated 8/28/19, failed to evidence notification from the skilled nurse to the physician of a new integumentary impairment of "Pt [patient] is pale with a reported rash under her (patient #2's) breast in which HHA (home hospice aide) applied protective skin care." The above clinical record failed to evidence notification of a change in patient #2's integumentary status from the skilled nurse to the physician.		educate all staff on policies 4-027 The Plan of Care, 4-031 Interdisciplinary Group Plan of Care, 4-099 Care/Service Coordination and all nurses on policy 4-002 Hospice Nursing Care to ensure ongoing of sharing of information between all disciplines providing care and services, with emphasis placed upon sharing of information between the skilled nurse and physician and the hospice aide and skilled nurse. Education with the hospice aides will focus on notifying the Registered Nurse Case Manager of any services refused or change in patient status. Administrator /Designee will audit 10 records or 10% of average daily census (whichever is greater) of active patient records monthly to ensure sharing of information between all disciplines providing care and services, particularly sharing of information between the skilled nurse and physician and the hospice aide and skilled nurse. Once a 100% threshold is maintained for 3 consecutive months, audits will be reduced to 10 records or 10% of average daily census (whichever is greater) quarterly. Findings will be incorporated into QAPI and reported to the governing body, as evidence by completion of the	

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	4. Review of clinical record for patient #5, evidenced patient #5 elected hospice benefits on 6/5/19. Patient #5 was admitted with a hospice diagnosis of Chronic Obstructive Pulmonary disease. Review of a hospice aide visit note, dated 6/27/19, failed to evidence notification from the hospice aide to the skilled nurse that patient #5 refused all hospice aide services. 5. Review of clinical record for patient #6, evidenced patient #6 elected hospice benefits on 9/16/19. Patient #6 was admitted with a hospice diagnosis of Atherosclerotic disease. Review of a hospice aide visit note, dated 10/14/19, failed to evidence the hospice aide had notified the skilled nurse of a new wound. The above clinical record failed to evidence notification from the hospice aide to the registered nurse of a change in patient #6's integumentary status. 6. On 1-10-20 at 2:30 P.M., the above findings were reviewed with the administrator, who verified the findings. When queried for additional pertinent information or documentation, the administrator stated having nothing further to offer to be reviewed.		quarterly QAPI Meeting Minutes. The Administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	
L 0558 Bldg. 00	418.56(e)(5) COORDINATION OF SERVICES [The hospice must develop and maintain a system of communication and integration, in accordance with the hospice's own policies and procedures, to-] (5) Provide for an ongoing sharing of information with other non-hospice healthcare providers furnishing services unrelated to the terminal illness and related conditions. Based on record review and interview, the agency failed to provide for an ongoing sharing of	L 0558	L558: Administrator / Designee will educate all staff on policies 4-039 Provision of Care to	02/08/2020

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	information with outside non-hospice healthcare providers in 1 (Patient # 2) of 2 clinical records reviewed with outside care providers, of a total sample of 14. The findings included: 1. Review of a policy, with "Kindred at Home & Hospice Affiliates," in the left upper hand corner, dated April 2019, titled "Provision of Care and Record Management- Hospice Nursing Care, Policy no. 4-002, stated "The hospice nurse will " ... 3.(O) Assure communication and integration between the hospice and other non-hospice health care providers involved in the patient's care documenting such in the medical record." 2. Review of a document, titled, "April Monthly Nursing Meeting-2019", on 1/3/20 at 11:00 A. M., evidenced a document which stated "Hospice/ Facility Coordination Task Plan of Care, to be completed and left in the facility chart and updated as changes occur to the POC (plan of care.) ... Physician orders-Facility Requirements; review the facility chart/ EMR (electronic medical record) for new orders every visit, Get a copy of their new orders to upload in to our chart, if not signed you will need to replace this once it is." 3. Review of a document titled, "June Monthly Nursing Meeting-2019, on 1/3/20 at 11:00 A. M, evidenced the document stated, "Facility Plan of Cares, Required as a condition of participation to show cohesion of the facility and hospice POC. We are at risk for a conditional and this is an ongoing compliance issue!! ... Friendly reminders, filing in facility charts is to be done weekly." 4. Review of the clinical record for patient #2,		Residents of SNF/NF or ICF/IID and 4-037 Coordination of Care with Contracts/Agreements to ensure provision of on-going sharing of information with outside non-hospice healthcare providers Education will include the requirement that the record evidence clear communication between hospice and facility staff, evidence of an integrated plan of care and a current medication profile. Administrator /Designee will audit 10 records or 10% of average daily census (whichever is greater) of active SNF/NF patient records monthly to ensure evidence of clear communication between hospice and facility staff, evidence of an integrated plan of care and a current medication profile . Once a 100% threshold is maintained for 3 consecutive months, audits will be reduced to 10 records or 10% of average daily census (whichever is greater) quarterly. Findings will be incorporated into QAPI and reported to the governing body, as evidence by completion of the quarterly QAPI Meeting Minutes. The Administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	

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	evidenced patient #2 elected hospice benefits on 3/12/19. The patient was admitted with a hospice diagnosis of Alzheimer's disease. During a home visit observation of a hospice aide for patient #2, who resided in an assisted living facility, on 1-10-20, at 9:00 A.M., a review of the hospice binder revealed a medication profile dated 5/30/19, a recertification order dated 3/12/19, an IDG meeting and plan of care update report, dated 6/13/19, and an IDG meeting and plan of care update report, dated 1/8/19. Review of the medication administration record on 1/10/20 at 9:35 A.M., with the name of an outside assisted living facility name on the document, reviewed by a facility LPN (licensed practical nurse) dated 12/25/19, evidenced the following medication orders: -9/5/19- Offer nutritional supplements as desired -10/31/19- Tramadol HCL 50 mg tablet; give 2 tablets by mouth every 6 hours, as needed for mod/severe pain -10/31/19- Phenazopyridine 100 mg tablet; give 1 tablet by mouth 3 times a day as needed, for UTI (urinary tract symptoms -10/31/19- Proctosol-HC 2.5% cream; Apply topically 3 times a day as needed, for hemorrhoid pain -12/11/19- Senna 8.6 mg tablet; give 1 tablet by mouth once a day; DX (diagnosis): Constipation A comparative review of the hospice client medication report provided by corporate employee MM, a resource nurse, on 1/2/20, failed to evidence an order for the use of Phenazopyridine, Proctosol, Senna, or nutritional			

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	supplements. The hospice client medication report evidenced an order for: -3/12/19-Tramadol Oral 50 mg; 1 tablet 4 times daily as needed for breakthrough pain -3/12/19- Tramadol Oral 50 mg; 1 tablet 4 times daily for pain The above clinical record failed to evidence care had been coordinated as required by hospice policy, to include cohesion, coordination, and integration of services between the hospice and outside non-hospice care provider facility in relation to patient #2's care. On 1/2/20, at 10:30 A. M., corporate employee MM, a resource nurse, stated "all patients in facilities should have the most recent and updated copy of the plan of care, orders, and medications in the hospice binders."			
L 0561 Bldg. 00	418.58(a)(1) PROGRAM SCOPE (1) The program must at least be capable of showing measurable improvement in indicators related to improved palliative outcomes and hospice services. Based on record review and interview, the hospice failed to demonstrate capability of showing improvement, including failure to timely complete and prepare reports for root cause analysis, toward QAPI (quality assessment and performance improvement) goal of 18% for live discharges for 1 (3rd) of 3 quarter reviewed. The findings included: Review of a policy, "Patient Focused Performance Improvement," with "Kindred at Home & Hospice	L 0561	L561: The Regional Director of Clinical Operations, Area Director of Education, or designee will educate the Administrator on policy 5-001 Improving Organizational Performance and the organization QAPI Plan with emphasis on timely completion and preparation of reports for root cause analysis specific to live discharge analysis.	02/08/2020

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	Affiliates," in the left upper hand corner, last reviewed/revised December 2018, evidenced the policy stated, " ... As part of the hospice-wide QAPI (quality assessment and performance improvement) process, opportunities for improvement related to patient outcomes will be identified through continuous measurement of patient satisfaction survey results, clinical/service record review, monitoring of incidents and infection control reports and adverse event reports ... When an opportunity to improve performance is identified, a focused study (indicator) will be developed to measure and improve associated processes ... " Review of a policy, "Improving Organizational Performance," with "Kindred at Home & Hospice Affiliates," in the left upper hand corner, last reviewed/revised March 2019, evidenced the policy stated, " ... Performance improvement results will be utilized to address problem issues, improve the quality of care and patient safety, and will be incorporated into program planning and process design and modifications ... Identify and participate in benchmarking activities that utilize: 1. Internal standards: a. Measuring current performance against past performance ... " Review of QAPI binder with meeting minutes from 2019 quarters 1, 2, and 3 evidenced the quality indicator of Live discharges with a QAPI established goal of 18%. Quarter 1 (Meeting held 5-15-19) Revocation 11 Transfer 2 For Cause 3 Extended Diagnosis 7 Late attending certificate of terminal illness (CTI)		Area Director of Education or designee will audit 100% of live discharge reports weekly for evidence of root cause analysis completion and reporting to the Administrator and Area Vice President of Operations.. Once a 100% threshold is maintained for 6 consecutive weeks, audits will be reduced to 50% of live discharge reports quarterly. Findings will be incorporated into QAPI and reported to the governing body, as evidence by completion of the quarterly QAPI Meeting Minutes. The Administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	

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	0 Payor change 2 TOTAL 25 = 23.8% A performance improvement plan was established. Quarter 2 (Meeting held 8-15-19) Revocation 10 Transfer 3 For Cause 10 Extended Diagnosis 6 Late attending certificate of terminal illness (CTI) 1 Payor change 2 TOTAL 32 = 29.4% The performance improvement plan was updated. Quarter 3 (Meeting held 11-6-19) Revocation 13 Transfer 3 For Cause 2 Extended Diagnosis 3 Late attending certificate of terminal illness (CTI) 1 Payor change 0 TOTAL 22 = 27.5% Review of the 11-6-19, QAPI meeting minutes evidenced the performance improvement project (PIP) for the 3rd quarter of 2019 was updated for live discharges; to add the additional requirement of Root Cause Analysis report on each live discharge within 48 hours of the patient's discharge.			

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	On 1-3-20 at 3:54 PM, the administrator presented 1 Root Cause Analysis report, dated 12-12-19, date of patient's last visit 11-21-19, more than 48 hours after the live discharge. The administrator stated the remaining Root Cause Analysis reports for the 3rd Quarter live discharges had not yet been located. Review of the above 3 quarters of QAPI data, failed to evidence measurable improvement to the defined goal of 18% for 3 of 3 quarters reviewed. Review of agency live discharge performance improvement project (PIP), evidenced an updated PIP from the 3rd quarter meeting on 11-6-19, which added the requirement of Root Cause Analysis on each live discharge to be completed within 48 hours of the discharge, reviewed, and forwarded to the Area Vice President of Operations (AVPO.) The hospice failed to demonstrate Root Cause Analysis (RCA) reports from 11-7-19, were completed as required by the PIP, within 48 hours of discharge. Failure to complete the RCA reports within 48 hours, and failure to complete and review the RCA reports for correctable cause(s) of live discharge, represented failures to obtain progress/demonstrate measurable improvement in live discharges. On 1-6-20 at 9:45 AM, the employee I, the current administrator since 12-8-19, stated during the year of 2019, the average census was approximately 80 patients. At this time, the administrator presented 15 Root Cause Analysis reports, all dated 1-5-20, for live discharges which occurred in the 3rd quarter, after the 11-6-19, amended PIP which required a RCA for each live discharge. The administrator verified all 15 RCA reports were completed more than 48 hours after discharge. When asked for further pertinent information or documentation, the administrator stated having			

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	nothing further to present to be reviewed.			
L 0562 Bldg. 00	418.58(a)(2) PROGRAM SCOPE (2) The hospice must measure, analyze, and track quality indicators, including adverse patient events, and other aspects of performance that enable the hospice to assess processes of care, hospice services, and operations. Based on record review and interview, the hospice quality assessment and performance improvement program failed to analyze adverse events in relation to falls, to enable the hospice to assess their care planning, patient/caregiver education, and coordination of care, for 3 (1st, 2nd, and 3rd quarter) of 3 quarters of adverse event reports reviewed. The findings included: Review of a policy, with "Kindred at Home & Hospice Affiliates," in the left upper hand corner, titled, "Incident Reporting," last reviewed/ revised May 2019, evidenced the policy stated, "Purpose: To define the reporting, follow-up, and feedback process for incidents involving patients ... Kindred at Home & Hospice Affiliates (the hospice) will maintain a process for generating incident reports and follow-up corrective action, if applicable. The five (5) purposes of the incident report are: 1. To facilitate the early detection of problems or compensable events ... 2. To establish a foundation for early investigation of all potentially serious events ... All events or occurrences listed within this policy must be reported, as well as any other occurrences presenting risks to patients ... The incident reporting system will be part of the hospice's	L 0562	L562 The Regional Director of Clinical Operations, Area Director of Education, or designee will educate the Administrator on policy 5-001 Improving Organizational Performance and the organization QAPI Plan with emphasis on analyzing adverse events, specifically patient falls. Additionally, the Administrator / designee will educate all staff on company policy 5-005 Incident Reporting and 5-003 Measuring Performance of the Environmental Safety Program to ensure staff are knowledgeable of fall reporting expectations and process. The Administrator, Area Director of Education or designee will review falls weekly for 3 months to measure and analyze trends. All falls will be addressed and reviewed by the IDG. Falls will then be monitored quarterly for trending, tracking and to measure ongoing patient quality outcomes. Findings will be incorporated into QAPI and reported to the governing body, as evidenced by	02/08/2020

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	overall performance improvement [QAPI] and risk management plan ... The incident report will be utilized for analysis tracking and trending ... Corrective actions will be implemented and evaluated for effectiveness as indicated ... " Review of a policy, with "Kindred at Home & Hospice Affiliates," in the left upper hand corner, titled, "Measuring Performance of the Environmental Safety Program," last reviewed/ revised December 2018, evidenced the policy stated, "As part of the the QAPI program, the hospice will assess, through defined measures, the effectiveness of the environmental safety program ... Maintaining safe environments for patients ... Any areas demonstrating a pattern or trend will be analyzed by the QAPI Committee for development of recommendations and actions ... " Review of the Incident Report Log and incident reports on 1-9-20, evidenced 33 patient incident reports (28 were patient falls) for the 1st quarter of 2019; 23 patient incidents for the 2nd quarter (23 were falls); 39 patient incidents for the 3rd quarter (35 were patient falls.) Review of the incident reports from the 3rd quarter of 2019 (July, August, and September) evidenced in July there were 17 incidents- 15 were patient falls; "falls happening in ALFs" was documented. For August there were 9 incident reports, 7 of which were patient falls. In September there were 13 incident reports, 12 of which were patient falls, a trend was noted of "ALF falls." Review of the 5-15-19, 1st quarter meeting minutes evidenced 28 patient falls of 33 total incident reports. The meeting minute notes failed to evidence analysis of the patient falls for actions within the power of the hospice to implement		completion of the quarterly QAPI Meeting Minutes The Administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	

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	measures to reduce the risk of falls for patients. On 1-6-20 at 11:54 AM, the above findings were reviewed with employee I, the administrator since 12-8-19, who verified the findings. When queried for further pertinent information or documentation, the administrator stated having nothing further to present to be reviewed.			
L 0570 Bldg. 00	418.58(c)(3) PROGRAM ACTIVITIES (3) The hospice must take actions aimed at performance improvement and, after implementing those actions, the hospice must measure its success and track performance to ensure that improvements are sustained. Based on record review and interview, the hospice agency failed to collect all the data needed to identify possible trends in infection control/prevention for 2 of 3 quarters reviewed in 2019, and failed to evaluate the 1st quarter performance improvement plan related to staff education in relation to an identified trend in infections at the 1st quarter quality assessment and performance improvement meeting. The findings included: Review of a document, with "Kindred at Home & Hospice Affiliates" in the upper left hand corner, titled "Infection Control Policy," last reviewed/ revised May 2019, was provided on 1-6-20 at 10:39 A.M., and evidenced the policy stated " ... the hospice will utilize its safety and performance improvement process to identify risks for the acquisition and transmission of infectious agents on an ongoing basis ... "	L 0570	L570 The Regional Director of Clinical Operations, Area Director of Education, or designee will educate the Administrator on policy 5-001 Improving Organizational Performance and the organization QAPI Plan with emphasis on evaluation of patient infections. Additionally, the Administrator / designee will educate all staff on policies 6-027 Infection Control, 6-015 Evaluating and Maintaining Records of Infection Among Personnel, 6-014 Evaluating and Maintaining Records of Infection Among Patients to ensure staff are knowledgeable of infection reporting expectations and process. The Administrator, Area Director of Education or designee will review	02/08/2020

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	Review of an identified performance indicator in the list of "Selected Performance Indicators," stored in the front of the QAPI binder, evidenced patient infections must be tracked/ trended if the symptoms resulted in testing and/or treatment being ordered. The QAPI binder evidenced, "Infections should be documented on the Infection Report ... Administrator/ Branch director or designee completes a report. The information will be tracked, trended, reported in quarterly QAPI Committee meeting. The document evidenced the data was required to be collected monthly/ quarterly/ annually. Review of the QAPI binder evidenced the hospice agency failed to document in the "Infection Control Monthly Tracking Log (a report which identified the patient's name, place of residence, and type of infection only)" for 3 of 12 months (June, August and October, 2019) reviewed. The agency failure to maintain Infection Control Monthly Tracking Log data for 3 of 12 months, represented a gap in data for use in infection control and prevention activities, to include trends in the missing months. Review of the agency "Infection Control Monthly Report (a report which contained follow up information regarding type of infection, treatment, and resolution)" failed to evidence data for 4 of 12 months (January, February, March, and April, 2019) reviewed. The agency failure to maintain Infection Control Monthly Reports for 4 of 12 months, represented a gap in data for use in infection control and prevention activities, to include trends by type of infection, residence of patients, or a pattern in staff who had provided care.		infections weekly for 3 months to measure and analyze trends. All infections will be addressed and reviewed by the IDG. Infections will then be monitored quarterly for trending, tracking and to measure ongoing patient quality outcomes. Findings will be incorporated into QAPI and reported to the governing body, as evidenced by completion of the quarterly QAPI Meeting Minutes The Administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	

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	151586	A. BUILDING 00 B. WING	01/10/2020

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	Review of quarter 2 of the QAPI meeting minutes located in the 2019 QAPI binder, titled, "2019 Hospice Quality Assessment Performance Improvement Plan," failed to evidence the agency had implemented and evaluated the 1st quarter performance improvement plan (PIP) as written, which required staff education reinforcing the agency's Infection Control Policy, and implementation of prophylactic (preventative) antibiotics for Urinary Tract Infections. The target date of completion documented was 6-30-19. Upon request, the administrator was unable to provide documentation the identified 1st quarter performance improvement plan education had been provided by 6-30-19. Review of the 3rd quarter QAPI meeting minutes, located in the 2019 QAPI binder, titled, "2019 Hospice Quality Assessment Performance Improvement Plan," evidenced identification of a negative trends of "increased wound/skin infections from 0 in the 2nd quarter, to 3 in the 3rd quarter; increased URI (upper respiratory infections) from 4 in the 2nd quarter, to 5 in the 3rd quarter. Review of the QAPI 2019 plan documentation failed to evidence the agency had developed and implemented a PIP for the identified increase and identified trends of wound/skin infections and upper respiratory infections. On 1-8-20 at 9:50 A.M., the above findings of the review of the Infection Control findings, with the administrator, the administrator, and, corporate employee LL (Regional Director of Clinical Operations), and corporate employee MM, a branch administrator who had resource duties, all verified the Infection Control documentation had not been completed in accordance with hospice			

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	policy; the failure to collect document, and analyze data for several months of 2019, did not provide complete data upon which the hospice could implement measures to prevent/ reduce the risks of acquisition and transmission of infections. The administrator verified staff education provided in 2019 did not meet the education required by the performance improvement project from the 1st quarter related to The administrator verified the Infection Control findings were not trackable, and there were many gaps in the Infection Control data for 2019.			
L 0572 Bldg. 00	418.58(d)(1) PERFORMANCE IMPROVEMENT PROJECTS (1) The number and scope of distinct performance improvement projects conducted annually, based on the needs of the hospice's population and internal organizational needs, must reflect the scope, complexity, and past performance of the hospice's services and operations. Based on record review and interview, the hospice failed to maintain data for required indicators of quality care in relation to complaints for the 2019 hospice quality assessment performance improvement program. The findings included: Review of a policy, with "Kindred at Home & Hospice Affiliates," in the left upper hand corner, last reviewed/ revised September 2019, titled "Complaint/ Grievance Process" on 1-3-20 at 11:05 A.M., evidenced the policy stated " ... The QAPI Committee will review patient grievance trends on a quarterly basis. Identified trends will be followed through the established performance	L 0572	L572 The Regional Director of Clinical Operations, Area Director of Education, or designee will educate the Administrator on policy 5-001 Improving Organizational Performance and the organization QAPI Plan with emphasis on evaluation of complaints Additionally, the Administrator / designee will educate all staff on policies 2-006 Complaints/Grievances Process and 5-002 Patient Focused Performance Improvement to ensure staff are knowledgeable of complaint reporting expectations and process.	02/08/2020

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	improvement process ... " Review of a policy, "Patient Focused Performance Improvement," with "Kindred at Home & Hospice Affiliates," in the left upper hand corner, last reviewed/ revised December 2018, evidenced the policy stated, " ... As part of the hospice-wide QAPI (quality assessment and performance improvement) process, opportunities for improvement related to patient outcomes will be identified through continuous measurement of patient satisfaction survey results, clinical/ service record review, monitoring of incidents and infection control reports and adverse event reports ... When an opportunity to improve performance is identified, a focused study (indicator) will be developed to measure and improve associated processes .... " Review of a policy, "Improving Organizational Performance," with "Kindred at Home & Hospice Affiliates," in the left upper hand corner, last reviewed/ revised March 2019, evidenced the policy stated, " ... Performance improvement results will be utilized to address problem issues, improve the quality of care and patient safety, and will be incorporated into program planning and process design and modifications ... Identify and participate in benchmarking activities that utilize .... " Review of the 1st quarter QAPI meeting minutes on 1-3-20 at 11:31 A. M, which included February and March 2019, complaints, evidenced the committee met on 5-15-19,. The meeting minutes evidenced "Negative trends: Communication less than what is desired by family. A performance improvement plan (PIP) was documented to address negative trends: "Re-educate staff to determine communication expectations and		The Administrator, Area Director of Education or designee will review complaints weekly for 3 months to measure and analyze trends. All complaints will be addressed and reviewed by the IDG. Complaints will then be monitored quarterly for trending, tracking and to measure ongoing patient quality outcomes. Findings will be incorporated into QAPI and reported to the governing body, as evidenced by completion of the quarterly QAPI Meeting Minutes The Administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	

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	preferences at admission and ongoing with changes in patient condition and needs with a target date of 6-30-19." Upon request the documentation of staff education was presented, offered to staff on 12-11-19, 12-12-19, 12-13-19, titled "Education Spotlight," and listed Complaints/Grievances and Communication Barriers, as the subject matter of the education. The education provided was not completed by the QAPI PIP target date of 6-30-19. The failure to timely implement the educational components identified in the 5-15-19, QAPI meeting minutes represented a missed opportunity for improvement. On 1-3-20 at 2:19 PM, Employee I, the administrator, verified the findings.			
L 0580 Bldg. 00	418.60(b)(1) CONTROL The hospice must maintain a coordinated agency-wide program for the surveillance, identification, prevention, control, and investigation of infectious and communicable diseases that- (1) Is an integral part of the hospice's quality assessment and performance improvement program; and Based on record review and interview, the agency failed to maintain a coordinated agency-wide program for the surveillance, identification, prevention, control, and investigation of infections. The findings included: Review of a procedure with "Kindred at Home & Hospice Affiliates" in the upper left hand corner reviewed/ revised May 2019 titled, "Infection	L 0580	L580 The Regional Director of Clinical Operations, Area Director of Education, or designee will educate the Administrator on the requirement that the hospice maintains a coordinated agency-wide program for the surveillance, identification, prevention, control, and investigation of infections. This will include, but not be limited to, measuring, analyzing and tracking	02/08/2020

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	Control Policy" was provided on 1-6-20 at 10:39 A.M. The policy evidenced, " ... the Administrator/ Branch Director or designee will be responsible for managing and coordinating infection control activities and reporting of infection control activities to the QAPI (Quality Assessment and Performance Improvement) committee ... " The infection control log located in the QAPI binder was reviewed on 1-8-20 at 10:38 A.M. Review of the agency's QAPI binder failed to evidence infection control logs (a list of patients with infection, type, and place of residence) for 3 (June, August, and September) of 9 months reviewed, and failed to evidence Infection Control reports (follow up reports of laboratory testing, treatment, and resolution of infections) for 9 (January, February, March, April, May, June, July, August, September) of 9 months reviewed. This failure represented a missed opportunity to make the Infection Control program an integral part of the hospice's quality assessment and performance improvement program, and to identify measures within the hospice's ability to control to reduce the risk of infection and infection transmission to its patients. On 1-8-20, at 10:38 A.M., the current administrator, since 12-8-2019, employee I, verified the QAPI program was not complete and agency wide, or implemented as required by policy. When queried for further pertinent information or documentation, the administrator stated having nothing further to present to be reviewed.		all infections through completion of infection control reports and infection control logs. The Administrator / designee will educate all staff on company policy 6-027 Infection Control, 6-015 Evaluating and Maintaining Records of Infection Among Personnel, 6-014 Evaluating and Maintaining Records of Infection Among Patients. The Administrator, Area Director of Education or designee will review infections weekly for 3 months to measure and analyzed trends. This will include obtaining a prescribed antibiotic report Monthly from Optum Pharmacy reports, in order to compare prescribed antibiotics to completed infection control logs. All infections will be addressed and reviewed by IDG. Infections will then be monitored quarterly for trending, tracking and to measure ongoing patient quality outcomes. Findings will be incorporated into QAPI and reported to the governing body, as evidenced by completion of the quarterly QAPI Meeting Minutes The Administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	

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L 0581 Bldg. 00	418.60(b)(2) CONTROL [The hospice must maintain a coordinated agency-wide program for the surveillance, identification, prevention, control, and investigation of infectious and communicable diseases that-] (2) Includes the following: (i) A method of identifying infectious and communicable disease problems; and (ii) A plan for implementing the appropriate actions that are expected to result in improvement and disease prevention. Based on record review and interview, the hospice failed to document infection reports (follow up reports which included laboratory testing, treatment, and resolution of reported infections) for 4 (January, February, March, and April 2019) of 12 months reviewed; failed to document in the infection logs (a report of name of patient, type of infection, and place of residence) for 3 (June, August and October) of 12 months reviewed; and failed to maintain an effective infection control program which documented sufficient data upon which to identify trends, for 12 of 12 months of infection reports reviewed. The findings included: 1. Review of a policy, with "Kindred at Home & Hospice Affiliates," in the left upper hand corner,	L 0581	L581 The Regional Director of Clinical Operations, Area Director of Education, or designee will educate the Administrator on Policy 5-008 Aggregation of Data/Information to ensure the QAPI program has been developed, implemented and maintains an effective, ongoing, hospice-wide data driven quality assessment and performance improvement plan. This will include, but not be limited to, measuring, analyzing and tracking all infections. The Administrator / designee will educate all staff on company policy 6-027 Infection Control, 6-015 Evaluating and Maintaining Records of Infection	02/08/2020

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	last reviewed /revised December 2018, titled "Aggregation of Data/Information," evidenced the policy stated " ... The hospice will maintain data/information that will support its leadership and management decisions ... Senior management will identify and define the types of information to be collected and aggregated ... Data and records will be maintained in such a manner as to make uniform a system of periodic reporting ... " 2. Review of a policy with "Kindred at Home & Hospice Affiliates" in the upper left hand corner, last reviewed/revised May 2019 titled, "Infection Control Policy" was provided on 1-6-20, at 10:39 A.M. The policy evidenced " ... provide for surveillance systems to track the occurrence and transmission of infections ... " 3. Review of a policy with "Kindred at Home & Hospice Affiliates" in the upper left hand corner, last reviewed/revised May 2019 titled, "Infection Control Policy" was provided on 1-6-20, at 10:39 A.M. The policy evidenced " ... to determine the effectiveness of the infection control plan, the hospice will measure, assess, improve, and redesign (as appropriate) the surveillance, identification, prevention, and control function annually through its performance improvement program ... " 4. Review of the infection control logs located in a binder titled "Infection Control Monthly Tracking Log" evidenced the following infections: January, there were thirty (30) infections documented February, there were twenty five (25) infections documented		Among Personnel, 6-014 Evaluating and Maintaining Records of Infection Among Patients, ensuring staff know when and how to identify infection and complete infection control reports. The Administrator, Area Director of Education or designee will review infections weekly for 3 months to measure and analyzed trends. This will include obtaining a prescribed antibiotic report monthly from Optum Pharmacy reports, in order to compare prescribed antibiotics to completed infection control Logs All infections will be addressed and reviewed by IDG. Infections will then be monitored quarterly for trending, tracking and to measure ongoing patient quality outcomes. Findings will be incorporated into QAPI and reported to the governing body, as evidenced by completion of the quarterly QAPI Meeting Minutes The Administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	

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	March, there were forty one (41) infections documented April, there were seven (7) infections documented May, there were ten (10) infections documented June, failed to evidence documentation of reported infections July, there were five (5) infections documented August, failed to evidence documentation of reported infections September, there were two (2) infections documented October, failed to evidence documentation of any reported infections November, there were eight (8) infections documented December, there were seven (7) infections were documented 5. Review of the infection control reports located in a binder titled "Infection Control Monthly Report" failed to evidence the following: January failed to evidence if any lab testing was ordered for any of the 30 infections, or resolution of any of the 30 infections. February failed to evidence if any lab testing was ordered for any of the of the 25 infections, or resolution of any of the 25 infections.			

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	March failed to evidence if any lab testing was ordered for any of the 41 infections, or resolution of any of the 41 infections. April failed to evidence if any lab testing was ordered for any of the 7 infections, or resolution of any of the 7 infections. May failed to evidence if any lab testing was ordered for any of the 9 of the 10 infections, or resolution for 9 of the 10 infections. June evidenced that there was one (1) treatment and resolution documented July evidenced 2 of 5 treatments and resolutions were documented August evidenced nine (9) treatments and resolutions documented September failed to document if any lab testing was ordered for any of the 2 infections, or resolution of any of the 2 infections. October evidenced seven (7) treatments and resolutions documented November evidenced the treatment and resolution for 2 of the 8 infections documented December failed to evidence documentation of the treatment or resolution of infection for 2 of the 7 infections documented 6. Review of the 2019 Infection Control logs and reports failed to evidence the hospice agency had maintained data/ information sufficient to support decisions to be made by leadership and management, and failed to evidence the hospice			

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	agency maintained a uniform system of reporting of complete data and records. The hospice failed to determine the effectiveness of the infection control plan, and failed to measure, assess, improve, and design the surveillance, identification, prevention, and control function for 12 of 12 months reviewed (152 patient infections) and failed to provide for surveillance systems to document the tracking of the occurrence and transmission of patient infections for 12 of 12 months reviewed. 7. On 1-8-20 at 9:50 A.M. during the Infection Control review of findings, the administrator, and corporate employee LL, Regional Director of Clinical Operations, and corporate employee MM a branch administrator who had resource duties, verified the Infection Control findings above for 2019; and verified the Infection Control documentation had not been completed in accordance with hospice policy; data was not sufficient and complete to provide tracking, trending, analysis, and decision making; verified the Infection Control findings were not trackable because there were numerous gaps in the Infection Control data reported.			
L 0629 Bldg. 00	418.76(h)(1)(i) SUPERVISION OF HOSPICE AIDES (I) A registered nurse must make an on-site visit to the patient's home: (i) No less frequently than every 14 days to assess the quality of care and services provided by the hospice aide and to ensure that services ordered by the hospice interdisciplinary group meet the patient's needs. The hospice aide does not have to be present during this visit. Based on record review and interview, the agency	L 0629	L629: The Administrator/designee will educate all nursing staff on	02/08/2020

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	failed to perform on-site supervisory visits of the hospice aide by the registered nurse, no less frequently than every 14 days, to assess the quality of care and services provided by the Hospice Aide for 1 (Patient #5) of 14 clinical records reviewed. The findings included: Review of a policy with "Kindred at Home & Hospice Affiliates" in the left upper corner, dated April 2019, titled "Provision of Care and Record Management, Hospice Nursing Care-Policy No. 4-002, #4 evidenced, " ... The hospice registered nurse will supervise licensed practical/vocational nurses, hospice aides, homemakers and volunteers in the home, and may follow the family/caregiver into the bereavement period, per organizational policy. Supervision will be conducted according to state/federal/accreditation bodes regulations." Review of clinical record #5 evidenced patient #5 elected hospice benefits on 6/5/19. Patient #5 was admitted to hospice with a primary diagnosis of Chronic Obstructive Pulmonary Disease. Hospice Aide visits were ordered ..... Review of Visit Notes, completed by a registered nurse, dated 7/23/19, 7/25/19, 7/30/19, 8/1/19, 8/6/19, 8/8/19, 8/13/19, 8/15/19, 8/20/19, 8/22/19, 8/27/19, and 8/29/19, failed to evidence documentation of a supervisory visits for the hospice aide at least every 14 days. During an interview on 1/7/20 at 4:45 P.M., the administrator stated, "The expectation is for the registered nurse (RN) to perform supervisory visits for hospice aides and licensed practical		policies 4-002 Hospice Nursing Care and 8-027 Responsibilities/Supervision of Clinical Services to include the requirements of aide supervision occurring no less frequently than every 14 days. Administrator /designee will audit 10 records or 10% of average daily census (whichever is greater) of active patient records with a hospice aide assignment monthly, to ensure completion of a supervisory visit by an RN no less frequently than every 14 days. Once a 100% threshold is maintained for 3 consecutive months, audits will be reduced to 10 records or 10% of average daily census (whichever is greater) quarterly. Findings will be incorporated into QAPI and reported to the governing body, as evidence by completion of the quarterly QAPI Meeting Minutes. The Administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	

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	nurse (LPN) a minimum of every 14 days." On 1-10-20, at 2:30 P.M., the administrator verified supervisory visits of the patient #5's hospice aide had not been conducted at least each 14 days.			
L 0674 Bldg. 00	418.104(a)(3) CONTENT [Each patient's record must include the following:] (3) Responses to medications, symptom management, treatments, and services. Based on record review and interview, the agency failed to ensure the hospice registered nurses documented patients' response to medications, symptom management, treatments, and services, for 2 (Patients #2 and 5) of 14 clinical records reviewed. The findings included: 1. Review of a policy, with "Kindred at Home & Hospice Affiliates," in the left upper hand corner, dated April 2019, titled "Provision of Care and Record Management- Hospice Nursing Care: Policy 4-002" on 1-7-20 at 3:02 P.M., evidenced the policy stated " ... 3.(k) The hospice nurse will Provide an ongoing evaluation of the patient and family/caregiver response to care ... " 2. Review of a policy, with "Kindred at Home & Hospice Affiliates," in the left upper hand corner, dated October 2019, titled "Provision of Care and Record Management-The plan of care: Policy No. 4-027" on 1/7/20 at 3:05 P.M., evidenced the policy stated " ... 7. Each patient will be monitored for his/her response to care or services provided against established patient goals and patient outcomes to evaluate progress toward goals ... "	L 0674	L674: The Administrator/designee will educate nursing staff on policies 4-002 Hospice Nursing Care, 4-027 The Plan of Care, and 4-050 Medication Profile with a focus on identification and documentation of patient response to medications, symptom management, treatments and services. Administrator /designee will audit 10 records or 10% of average daily census (whichever is greater) of active patient records monthly, to ensure the hospice registered nurse documents the patient's response to medications, symptom management, treatments and services Once a 100% threshold is maintained for 3 consecutive months, audits will be reduced to 10 records or 10% of average daily census (whichever is greater) quarterly. Findings will be incorporated into QAPI and	02/08/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	151586	A. BUILDING 00 B. WING	01/10/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
KINDRED HOSPICE	5550 S EAST STREET, SUITE A INDIANAPOLIS, IN 46227

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	3. Review of clinical records for patient #2, evidenced patient #2 elected hospice benefits 3/12/19. The patient was admitted with a hospice diagnosis of Alzheimer's disease. Review of a physician's order, number 3995087, for patient #5 on 1/7/20, dated 12/10/19, evidenced the order stated, "begin Ciprofloxacin 500 mg twice a day for 7 days for a Urinary Tract Infection." Review of a physician's order, number 4059370, for patient #5 on 1/7/20, dated 12/27/19, evidenced an order to "begin Bactrim DS 160/80 mg 1 tablet by mouth daily for 7 days." After requested on 1/7/20 at 3:47 P.M., the administrator, and a corporate employee MM, a resource registered nurse, were unable to provide evidence of assessment and documentation of responses to medications, symptom management, and treatment for patient #2, and verified the clinical record failed to evidence a goal or progress toward goals in relation to patient #2's urinary symptoms/ infection. 4. Review of the clinical record for patient #5 evidenced patient #5 elected hospice benefits on 6/5/19. Patient #5 was admitted with a diagnosis of Chronic Obstructive Pulmonary disease. Review of a Visit note report for patient #5 dated 1/3/20, evidenced "no genitourinary deficits identified urine clear, without odor and quantity sufficient ... Patient denies any signs or symptoms of a urinary tract infection." Review of a Visit Note report for patient #5 dated 1/6/20, evidenced an entry by a registered nurse		reported to the governing body, as evidence by completion of the quarterly QAPI Meeting Minutes. The Administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	151586	A. BUILDING 00 B. WING	01/10/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
KINDRED HOSPICE	5550 S EAST STREET, SUITE A INDIANAPOLIS, IN 46227

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	which evidenced genitourinary assessment of "urgency/ frequency, burning ... Patient states that her signs and symptoms of a urinary tract infection are continuing such as burning with urination and urgency. Patient is requesting a different antibiotic to see if it will be helpful." After requested on 1/7/20 at 3:47 PM, the administrator and corporate employee MM, a resource registered nurse, were unable to provide evidence of the initial onset and treatment of the patient's urinary tract infections.			