STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	151544	A. BUILDING 00 B. WING	06/29/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HARBOR LIGHT HOSPICE	1229 ARROWHEAD COURT CROWN POINT, IN 46307

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E 0000 Bldg. 00	A Federal Focused Infection Control and Complaint Survey was conducted from 6/23/20 - 6/29/20. Facility #: 009088 Active Patients: Crown Point - 60; Indianapolis - 14; Mishawaka - 65 At this Focused Infection Control Emergency Preparedness survey, in regards to staffing and implementation of staffing, Harbor Light Hospice was found to be in compliance with 42 CFR 418.113 Emergency Preparedness Requirements for Medicare Participating Providers and Suppliers for Hospice Agencies.	E 0000		
L 0000 Bldg. 00	A Federal Focused Infection Control and Complaint Survey was conducted from 6/23/20 - 6/29/20. Federal and State Deficiencies were cited with related and unrelated findings. Facility #: 009088 Active Patients: Crown Point - 60; Indianapolis - 14; Mishawaka - 65 Complaints: IN00322120 - substantiated with findings.	L 0000		

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

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	IN00302374 - unsubstantiated IN00296797 - substantiated with findings. IN00282662 - substantiated with findings. Quality Review completed on 8/17/2020 A4			
L 0512 Bldg. 00	418.52(c)(1) RIGHTS OF THE PATIENT The patient has a right to the following: (1) Receive effective pain management and symptom control from the hospice for conditions related to the terminal illness; Based on record review and interview, the hospice agency failed to ensure the registered nurse evaluated the patients pain level in 1 of 6 discharged clinical records reviewed, out of a total of 10 clinical records reviewed. (#1) The findings include: The agency policy dated April 1, 2014, policy number 09.09.01, titled "Pain Assessment and Reassessment" stated "... Policy Appropriate Hospice staff will assess and reassess patient's pain. Each patient will receive effective pain management and symptom control for conditions related to the terminal illness. ... Purpose To define processes for pain assessment and management. ... 2. Each patient will have pain reassessed on an ongoing basis using established criteria, including: Location Intensity (using pain rating scale). Duration. Frequency. Character, e.g., dull, throbbing, aching, sharp, etc. Current pain therapy or treatment. Effectiveness of current therapy or treatment...." Clinical record review on 6/26/20 for patient #1, start of care 5/9/19, evidenced an agency	L 0512	L512 **What is the deficiency? L512 418.52c(1) Rights of the Patient (1) Patient has the right to receive effective pain management and symptom control from the hospice conditions related to terminal illness.** 1. How are you going to correct the deficiency? Tag 512 L512 418.52c(1) Rights of the Patient- The Clinical Management staff have educated all nursing staff on patient rights and policy 9.09.01 Pain assessment and reassessment. 2. How are you going to prevent the deficiency from recurring in the future, even if already corrected? Monitoring and management for pain assessment will occur on 100% of admissions, recerts and during IDG meetings. This monitoring tool for tracking will be completed until the QAPI	09/18/2020

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	document titled "Routine visit - on 05-13-2019" electronically signed by employee L. This document had an area subtitled "Physical \ Pain Evaluation \ Pain Assessment" which stated "... Pain Assessment ... Pain Screening: Patient needs ongoing education and reinforcement of pain regimen, Family/PCG [patient caregiver] need ongoing education and reinforcement of pain regimen, Pain reported by PCG, Patient unable to provide details ... Pain Screening Tools. Numeric pain is also in Clinical Monitoring and within each location: 6. No standardized tool used...." There was no evidence of a patient centered pain evaluation, either using a pain assessment tool or through patient verbalization. During an interview on 6/29/20 at 10:41 a.m., employee A indicated the patient caregiver could not report a numeric pain for the patient and indicated that a FLACC scale [a tool used to assess pain for nonverbal patients] should have been used by the skilled nurse.		Committee determines deficiency is fully corrected. 3. Who is going to be responsible for numbers 1 and 2- The Executive Director, Patient care manager or designee is responsible for correcting the deficiency. 4. By what date are you going to have the deficiency corrected? September 18, 2020	
L 0513 Bldg. 00	418.52(c)(2) RIGHTS OF THE PATIENT [The patient has a right to the following:] (2) Be involved in developing his or her hospice plan of care; Based on record review and interview, the agency failed to ensure the patient/family had the right to be involved in developing the hospice plan of care in 1 of 10 clinical records reviewed. (#5) The findings include: Review of an agency policy dated 4/1/14 titled "Notice of Patient Rights and Responsibilities" stated, "... Hospice will provide each patient with a written notice of the patient's rights in advance of furnishing care to the patient or during the	L 0513	L513 **What is the deficiency? L512 418.52c(2) Rights of the Patient** 1. How are you going to correct the deficiency ? Tag L513 418.52c(2) Rights of the Patient- The Clinical Management staff have educated all staff on patient rights. This includes the right to be involved in developing his or her hospice plan of care. 2. How are you going to prevent	09/18/2020

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	initial assessment visit. ... Hospice protects and promotes the rights of each patient. ..." Review of an agency document on 6/23/2020 titled "Patient/Family Orientation for Hospice Care" stated, "... You have the right to: ... Be involved in developing your hospice plan of care; and to participate in changing the plan whenever possible and to the extent that you are competent to do so; and to be advised of any change in your plan of care before the change is made. ..." Clinical record review on 6/25/2020 for patient #5 evidenced an agency document titled "Disclosure Statement" dated and signed by the patient's Power of Attorney (POA) on 1/30/2020 which stated, "... Harbor Light Hospice recognizes that patients and their families have several rights. These rights include: participation in health care decisions ...." Record review evidenced an agency document titled "Team Care Plan" dated 6/24/2020 which indicated interventions the hospice aide was to provide to the patient including assist with transfers, assist with feeding, perineal care (cleaning of the patient's genitals, buttocks and surrounding area), assist with dressing, mouth care, shower, hair care and nail care. Record review of an agency document titled "Charts/Clinical Notes" dated 2/7/2020 and completed by the skilled nurse stated, "... POA was called and verified that pt [patient] is to get a shower from facility. Requested that pt receives nail and hair care from HLH [Harbor Light Hospice] and companionship if possible. Writer collaborated with PCM [patient care manager] [employee A] regarding aide care plan clarification. ..."		the deficiency from recurring in the future, even if already corrected? 100% of admissions contacts will be called within the first 15 days. Monitoring tools will be reviewed to ensure that the patient/POA have been educated on the right to help develop the hospice plan of care. This monitoring tool will be completed until the QAPI Committee determines deficiency is fully corrected. 3. Who is going to be responsible for numbers 1 and 2- The Executive Director , Patient care manager or designee is responsible for correcting the deficiency. 4. By what date are you going to have the deficiency corrected? September 18, 2020	

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	The clinical record failed to evidence hospice aide services were provided after 2/6/2020. During an interview on 6/25/2020 at 5:01 p.m., person I, patient's POA, indicated she was unaware that hospice aide visits had discontinued. During an interview on 6/29/2020 at 11:28 a.m., employee A indicated the last hospice aide visit was on 2/6/2020 and there was no clinical note documenting communication with the patient and family in regards to the discontinuation of hospice aide services.			
L 0516 Bldg. 00	418.52(c)(5) RIGHTS OF THE PATIENT [The patient has a right to the following:] (5) Have a confidential clinical record. Access to or release of patient information and clinical records is permitted in accordance with 45 CFR parts 160 and 164. Based on record review and interview, the hospice failed to ensure patient confidentiality in 1 of 10 clinical records reviewed. (Patient #7) The findings include: 1. An agency policy with a revised date of 12/1/2015, titled "Patient Confidentiality" stated "Policy ... All information related to provision of Hospice for specific patient is treated confidential, including patient records ... Procedure ... 9. Patient records will not be left in unattended areas in the office ... " 2. A review of facility documents on 6/29/2020, evidenced a document titled "HIPAA Breach	L 0516	L516 **What is the deficiency? L516 418.52c(5) Rights of the Patient The patient has a right to have a confidential clinical record. Access to or release of patient information and clinical records is permitted in accordance with 45 CFR parts 160 and 164.** 1. How are you going to correct the deficiency? Tag 516 418.52c (5) Rights of the Patient- The Clinical Management staff have educated all staff on patient rights. This includes the	09/18/2020

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	Incident Log." Line 2 of this document stated " 27 pages of medical records given to wrong patients family ... Family requested medical records. Rcvd [received] reco [record] and found 27 pages of reco for another patient ... " reported on 3/6/2020. During an interview on 6/29/2020, at 12:10 PM, Person E indicated they received 27 pages of person G's clinical record. During an interview on 6/29/2020, at 3:44 PM, Employee A, patient care manager, indicated the record of Person G became incorporated with patient #7's record and sent to patient #7's family by mistake, due to a possible mix up in the copy room.		right to have a confidential clinical record. 2. How are you going to prevent the deficiency from recurring in the future, even if already corrected? 100% of all records being sent outside Harbor Light Hospice will be monitored to ensure confidentiality. This monitoring will be completed until the QAPI Committee determines deficiency is fully corrected. 3. Who is going to be responsible for numbers 1 and 2- The Executive Director, Patient care manager or designee is responsible for correcting the deficiency. 4. By what date are you going to have the deficiency corrected? September 18, 2020	
L 0524 Bldg. 00	418.54(c) CONTENT OF COMPREHENSIVE ASSESSMENT The comprehensive assessment must identify the physical, psychosocial, emotional, and spiritual needs related to the terminal illness that must be addressed in order to promote the hospice patient's well-being, comfort, and dignity throughout the dying process. Based on record review and interview, the hospice agency failed to ensure the skilled nurse completed a complete comprehensive assessment in 1 of 6 discharged clinical records reviewed, out of a total of 10 clinical records reviewed. (#3) The findings include:	L 0524	L524 **What is the deficiency? L524 content of Comprehensive Assessment CFR(s):418.54(c) The comprehensive assessment must identify physical, psychosocial, emotional and spiritual needs**	09/18/2020

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	The agency policy with a revised date of December 30, 2015, policy number 09.06.01, titled "Initial Assessment/Comprehensive Assessment" stated "... Policy Each patient admitted by Hospice will have an appropriate initial assessment and comprehensive assessment performed and documented. ... Procedure ... 2. Each patient admitted will receive a comprehensive assessment. The comprehensive assessment will identify the patient's need for Hospice care and identify the patient's need for: Physical care ... All areas of Hospice care related to the palliation and management of the terminal illness and related conditions. 3. The comprehensive assessment will take into consideration the following factors: ... Complications and risk factors that affect care planning. ... 5. Each patient's comprehensive assessment includes a review of all medications the patient is currently taking (prescription, non-prescription, herbs, home remedies, other alternative treatments, etc.) to identify: ... Side effects ... Potential adverse effects...." Clinical record review on 6/26/20 for patient #3, start of care 12/18/18, evidenced an agency document titled "... Initial Visit - on 12-18-18" electronically signed and dated by employee R. This initial assessment had an area subtitled "Physical\Gastrointestinal" which stated "... Last Bowel Movement: Unknown...." Skilled nurse assessment documents dated 12/27/18, 12/31/18, and 1/3/19, failed to have the patient's last bowel movement and/or a gastrointestinal assessment. This patient was reported as incontinent of bowel and bladder, resided in a skilled nursing facility, however the skilled nurse was unable to assess the patient's last bowel movement during the initial/comprehensive assessment.		**related to the terminal illness that must be addressed in order to promote the hospice patients well-being, comfort and dignity.** 1. How are you going to correct the deficiency? Tag L524 content of Comprehensive Assessment CFR(s):418.54(c)- The Clinical Management staff will educate all Registered Nursing staff on L524 and 418.54(c). This will include education on policy 09.09.01 Initial Assessment/Comprehensive assessment. 2. How are you going to prevent the deficiency from recurring in the future, even if already corrected? 100% of all admission records will be monitored to ensure that the physical comprehensive requirements are being met. 10 percent of monthly average daily census will be monitored monthly. This monitoring will continue until the QAPI committee determines deficiency is corrected. 3. Who is going to be responsible for numbers 1 and 2- The Executive Director, Patient care manager or designee is responsible for correcting the deficiency. 4. By what date are you going to have the deficiency corrected? September 18, 2020	

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	During an interview on 6/26/20 at 3:12 p.m., employee G, patient care manager, indicated this was information the skilled nurse should have "got".			
L 0530 Bldg. 00	418.54(c)(6) CONTENT OF COMPREHENSIVE ASSESSMENT [The comprehensive assessment must take into consideration the following factors:] (6) Drug profile. A review of all of the patient's prescription and over-the-counter drugs, herbal remedies and other alternative treatments that could affect drug therapy. This includes, but is not limited to, identification of the following: (i) Effectiveness of drug therapy (ii) Drug side effects (iii) Actual or potential drug interactions (iv) Duplicate drug therapy (v) Drug therapy currently associated with laboratory monitoring. Based on observation, record review, and interview, the hospice agency failed to ensure that the skilled nurse ensured prn [as needed] medications had indications on use and medication dosages were properly calculated in 4 out of 4 active records, in a total sample of 10 patient records reviewed. (#2, #5, #8, #10) The findings include: 1. The agency policy with a revised date of 12/30/2015 titled "Medication Orders" stated "... Policy: Hospice will minimize errors and misinterpretation of written or verbal medication orders. Each patient's record will reflect a diagnosis, condition, or indication for use for each medication ...Procedure: ...8. Staff will verify with	L 0530	L530 **What is the deficiency? L530 content of Comprehensive Assessment CFR(s):418.54(c)6 The comprehensive assessment take into consideration the following factors (6) Drug profile. A review of all the patients prescription and over the counter drugs, herbal remedies and other alternative treatments could affect drug therapy. This includes but is not limited to identification of the following, -Effectiveness of drug therapy, ii-Drug side**	09/18/2020

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	the physician any incomplete, illegible or unclear medication orders prior to administering the medication and/or providing patient education about the medication." 2. Clinical record review on 6/25/2020 for patient #10, start of care 8/7/2019, evidenced an agency document titled "Medication Status" dated 4/3/2020. This document evidenced the order, "Ibuprofen By Mouth Suspension 100MG/5ML, 10 Milliliter every 6 hours as needed PO [by mouth], Special Instructions: Take 10ml to = 400 mg for pain. Start date 12-23-19, End date 01-04-2020." This document also evidenced order which stated, "Ensure By Mouth Liquid 8 Ounce Daily as needed PO. Special Instructions: 1 bottle as tolerated daily prn [as needed], Start date 08-07-2019". The order failed to list the prn indications. During an interview on 6/29/2020 at 2:05 p.m., employee A stated regarding Ibuprofen dosage, "That is an error". Employees A and B indicated that indication for use of Ensure PRN was not noted. 3. Clinical record review on 6/26/20 for patient #2, start of care 7/25/18, evidenced an agency document titled "Medication Status" dated as of 06/26/2020. This medication document stated "... Refresh Tears Ophthalmic Solution 0.5% 1 gtt [drop] ou [both eyes] drop twice a day as needed OP Special Instructions: 1 drop to each eye twice daily as needed...." There failed to be indications on when to give the eye drops as needed. This concern was reviewed with employee A and employee B, employee A and B remained silent.4. Clinical record review on 6/26/2020 for patient #5 evidenced a document titled "Clinical Physician Orders" from entity B with a last reviewed date of		**effects, iii-Actual or potential drug interactions, iv duplicate drug therapy, v-Drug therapy currently associated with laboratory monitoring.** 1. How are you going to correct the deficiency? Tag L530 content of Comprehensive Assessment CFR(s):418.54(c)6 The Clinical Management staff have educated all Nursing staff on L530 and 418.54(c)6. All nursing staff have also been educated on 08.02.01 Medication orders, 08.14.01 Medication Monitoring, 08.19.01 Medication reconciliation, and policy 09.09.01 Initial Assessment/Comprehensive assessment. 2. How are you going to prevent the deficiency from recurring in the future, even if already corrected? 100% of all active charts will be audited to ensure compliance and then 100% of all patients will be reviewed in IDG to ensure that all of the patients prn medications have an indication listed. This monitoring will continue until the QAPI committee determines deficiency is corrected. 3. Who is going to be responsible for numbers 1 and 2- The Executive Director, Patient care manager or designee is responsible for correcting the deficiency. 4. By what date are you going to have the deficiency corrected?	

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	6/10/2020 which indicated the patient's current medications included Morphine Sulfate (pain medication) liquid solution, calmoseptine ointment (medication for skin) and Ensure (oral supplement). Review of an agency document titled "Medication Status" dated 6/26/2020 failed to indicate the patient's current medications included Morphine Sulfate liquid solution, calmoseptine ointment and Ensure. The clinical record failed to evidence all of the patient's medications were reviewed. During an interview on 6/29/2020 at 11:40 a.m., employee A indicated the medication list should match between the hospice agency and entity B and the skilled nurse should have caught the omission of the liquid morphine. Employee A indicated the was no documentation the medications were reviewed if they were not listed on the agency's medication list. 5. During an observation on 6/25/2020, at 10:34 AM, Employee F applied Calmoseptine (moisture barrier cream) to patient #8's perineal area to prevent skin breakdown. The medication profile failed to evidence the Calmoseptine ointment listed with a description, dose, frequency, and route for medication. During an interview on 6/29/2020, at 2:37 PM, Employee A, patient care manager, indicated OTC medications should be included on the patient's medication profile. Clinical record review on 6/25/2020, for patient #8, start of care 12/16/2019, evidenced an agency document titled "Team Care Plan" as of 6/24/2020. This document had an area subtitled "Medications" which stated "Description/Dose/Frequency/Route ... Zofran		September 18, 2020	

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	[anti-nausea medication] By Mouth Tablet 4 MG 1 Tablet Three times a day as needed PO ... " This document failed to evidence indications in which Zofran should be administered. During an interview on 6/29/2020, at 2:35 PM, Employee A, patient care manager, indicated the care plan did not evidence PRN indications for the medication Zofran.			
L 0543 Bldg. 00	418.56(b) PLAN OF CARE All hospice care and services furnished to patients and their families must follow an individualized written plan of care established by the hospice interdisciplinary group in collaboration with the attending physician (if any), the patient or representative, and the primary caregiver in accordance with the patient's needs if any of them so desire. Based on record review and interview, the agency failed to ensure the care and services furnished to patients followed a written plan of care in 4 of 10 clinical records reviewed. (#3, #4, #5, #6) The findings include: 1. Review of an agency policy dated 4/1/14 titled "IDG [interdisciplinary group] Care Plan Process" stated, "... All care and services furnished to patients and their families follows an individualized written plan of care established by the IDG in collaboration with the attending physician (if any), the patient or representative and the primary caregiver in accordance with the patient's needs. ..." 2. Clinical record review on 6/25/2020 for patient #4 evidenced an agency document titled "Physician's Orders/Plan of Care" for period	L 0543	L543 **What is the deficiency? L543 content of Plan of Care CFR(s):418.56(b) All hospice care and services furnished to patients and their families must follow an individualized written plan of care established by the hospice interdisciplinary group in collaboration with the attending physician (if any), the patient or representative and the primary caregiver in accordance with the patients needs if any them so desire.** 1. How are you going to correct the deficiency? Tag L543 content of Plan of Care CFR(s):418.56(b)-The Clinical Management staff will educate all	09/18/2020

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	151544	A. BUILDING 00 B. WING	06/29/2020

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HARBOR LIGHT HOSPICE	1229 ARROWHEAD COURT CROWN POINT, IN 46307

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	11/13/18 - 2/10/19 which indicated the hospice aide was to provide 2 visits per week for 13 weeks for personal care and assistance with ADLs (activities of daily living). The document indicated the patient was a resident at entity D. Record review failed to evidence aide services were provided 2 times during the week of 11/25/18 and failed to evidence coordination of care with entity D. Record review of an agency document titled "Supplemental Orders from 12-29-18 to 2-9-19" and signed by the physician on 3/4/19 indicated the hospice aide visits were increased to 3 visits per week effective 12/30/18. Record review failed to evidence aide services were provided 3 times during the week of 12/30/18 and failed to evidence coordination of care with entity D. During an interview on 6/29/2020 at 11:11 a.m., employee A indicated the aide visit was refused on 11/28/18 and the aide visit on 1/4/19 was not provided since care was performed by entity D. Employee A indicated there was no clinical documentation of coordination of care with the physician and IDG regarding hospice aide visits were not completed per the plan of care. 3. Clinical record review on 6/25/2020 for patient #5 evidenced an agency document titled "Team Care Plan" dated 6/24/2020 which indicated interventions the hospice aide was to provide to the patient including assist with transfers, assist with feeding, perineal care (cleaning of the patient's genitals, buttocks and surrounding area), assist with dressing, mouth care, shower, hair care and nail care. Record review of an agency document titled "Charts/Clinical Notes" dated 2/7/2020 and		staff on L543 & 418.56(b) Plan of care, 09.12.01 IDG Care Plan Process. 2. How are you going to prevent the deficiency from recurring in the future, even if already corrected? 100% of all active charts will be audited to ensure compliance with aide frequency is being met. 100% of all patients that experience aide frequency changes will be monitored to ensure communication and care plan updates to family/patient/facility is happening. This monitoring will continue until the QAPI committee determines deficiency is corrected. 3. Who is going to be responsible for numbers 1 and 2- The Executive Director, Patient care manager or designee is responsible for correcting the deficiency. 4. By what date are you going to have the deficiency corrected? September 18, 2020	

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	151544	A. BUILDING 00 B. WING	06/29/2020

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	completed by the skilled nurse stated, "... POA [power of attorney] was called and verified that pt [patient] is to get a shower from facility. Requested that pt receives nail and hair care from HLH [Harbor Light Hospice] and companionship if possible. Writer collaborated with PCM [patient care manager] [employee A] regarding aide care plan clarification. ..." The clinical record failed to evidence hospice aide services were provided after 2/6/2020. During an interview on 6/29/2020 at 11:28 a.m., employee A indicated there were no hospice aide services after 2/6/2020. 4. Clinical record review on 6/25/2020 for patient #6 evidenced an agency document titled "Physician Orders/Plan of Care from 1-27-20 to 3-26-20" which indicated the hospice aide was to provide visits 3 times a week for 8 weeks beginning 1/2/20. Record review failed to evidence hospice aide services were provided 3 times a week during the week of 2/2/2020 and 2/16/2020. During an interview on 6/26/2020 at 11:35 a.m., employee B indicated the hospice aide visits were refused on 2/7/2020 and 2/20/2020. Employee B indicated there was no clinical documentation of coordination of care with the physician and IDG regarding hospice aide visits were not completed per plan of care.5. Clinical record review on 6/26/20, for patient #3, start of care 12/18/18, evidenced an agency document titled "Physician's Orders/Plan of Care from 12-18-18 to 03-17-19" dated and signed by the physician on 1/9/19. This plan of care had an area subtitled "Treatments" which stated "... AID [sic] 12-18-18 1 x week x 1 week 12-23-18 2 x week x 12 weeks Provide personal care and assistance with ADLs			

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	[activities of daily living]...." Clinical record review evidenced only 1 home health aide visit the week of 12/23/18 - 12/29/18. The agency failed to ensure the hospice aide reported as ordered on the plan of care 2 times weekly. During an interview on 6/26/20 at 3:38 p.m., employee B indicated the patient hospice aide services were discharged on 1/2/19.			
L 0545 Bldg. 00	418.56(c) CONTENT OF PLAN OF CARE The hospice must develop an individualized written plan of care for each patient. The plan of care must reflect patient and family goals and interventions based on the problems identified in the initial, comprehensive, and updated comprehensive assessments. The plan of care must include all services necessary for the palliation and management of the terminal illness and related conditions, including the following: Based on record review and interview, the hospice agency failed to ensure the content on the plan of care was complete in 4 of 10 clinical records reviewed. (#1, #4, #5, #6) The findings include: 1. The agency policy dated April 1, 2014, policy number 09.12.01, titled "IDG [interdisciplinary group] Care Plan Process" stated "... 8. An individualized written plan of care is developed for each patient. The plan of care reflects patient and family goals and interventions based on the problems identified in the initial, comprehensive and updated comprehensive assessments. The plan of care includes all services necessary for the	L 0545	L545 **What is the deficiency? L545 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 interventions based on the problems identified in the initial, comprehensive, and updated comprehensive assessments. The plan of care must include all services necessary for the palliation and management of the terminal**	09/18/2020

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	palliation and management of the terminal illness and related conditions, including: Interventions to manage pain and other symptoms. Effective pain and symptom management includes the ongoing assessment of the patient's physical, psychosocial, emotional and spiritual needs and reassessing the effectiveness of the current plan of care in order to address those needs. ... Drugs and treatments necessary to meet the needs of the patient...." 2. Clinical record review on 6/26/20, for patient #1, start of care 5/9/19, evidenced an agency document titled "Physician's Orders/Plan of Care from 05-09-19 to 08-05-19" This document had an area subtitled "Treatments" which stated "... Pulse Oximetry PRN [as needed]...." There failed to be any indications on this document as to when the patient would need their pulse oximetry assessed. During an interview on 6/26/20 at 10:22 a.m., employee G indicated she had seen that too. [no indications for prn usage of oximeter]3. Clinical record review on 6/25/2020 for patient #4 evidenced an agency document titled "Physician's Orders/Plan of Care" for certification period 11/13/2018 - 2/10/2019. This document stated, "... Acetaminophen [pain reliever medication] By Mouth Tablet 325 MG [milligrams] 325 Milligram as needed PO [by mouth] ...." but failed to evidence the indications for when the medication was to be administered. During an interview on 6/29/2020 at 10:55 a.m., employee A indicated the plan of care should include the indications for when the medication should be administered. 4. Clinical record review on 6/26/2020 for patient		**illness and related conditions.** 1. How are you going to correct the deficiency? Tag **L545 content of Plan of Care CFR(s):418.56(c)** The Clinical Management staff have educated all Nursing staff on L545 and 418.56(c). All nursing staff have also been educated on 09.12.01 IDG Care plan process. **NOTE- L530 was addressed prior in POC for prn medication indication** 2. How are you going to prevent the deficiency from recurring in the future, even if already corrected? 100% of all active charts will be audited to ensure compliance with indications being listed for prn treatments and then 100% of all patients will be reviewed in IDG to ensure that all of the patient with prn treatments have an indication listed. This monitoring will continue until the QAPI committee determines deficiency is corrected. 3. Who is going to be responsible for numbers 1 and 2- The Executive Director, Patient care manager or designee is responsible for correcting the deficiency. 4. By what date are you going to have the deficiency corrected? September 18, 2020	

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	#5 evidenced a document titled "Clinical Physician Orders" from entity B with a last reviewed date of 6/10/2020 which indicated the patient's current medications included Morphine Sulfate (pain medication) liquid solution, calmoseptine ointment (medication for skin) and Ensure (oral supplement). Review of an agency document titled "Team Care Plan" dated 6/24/2020 failed to indicate the patient's current medications included Morphine Sulfate liquid solution, calmoseptine ointment and Ensure. During an interview on 6/29/2020 at 11:40 a.m., employee A indicated the medication on the care plan should match between the hospice agency and entity B and the skilled nurse should have caught the omission of the liquid morphine. 5. Clinical record review on 6/25/2020 for patient #6 evidenced an agency document titled "Physician's Orders/Plan of Care" for certification period 1/27/2020 - 3/26/2020. This document stated, "... Pulse Oximetry [a test to determine the oxygen saturation in the blood] PRN [as needed] ...." but failed to evidence the PRN indications for when the pulse oximetry was to be performed. During an interview on 6/26/2020 at 11:30 a.m., employee B indicated the plan of care should include the PRN indications for the pulse oximetry.			
L 0554 Bldg. 00	418.56(e)(1) 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-			

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	(1) Ensure that the interdisciplinary group maintains responsibility for directing, coordinating, and supervising the care and services provided. Based on record review and interview, the hospice agency failed to ensure the interdisciplinary group (IDG) maintained responsibility for the coordination and supervision of the care and services provided to 2 of 6 discharged clinical records reviewed, out of a total of 10 clinical records reviewed. (#1, #3) The findings include: 1. The agency policy dated April 1, 2014, policy number 09.12.01, titled "IDG Care Plan Process" stated "Policy In order to assure that care provided is appropriately planned to meet each patient's specific needs and problems, Hospice will utilize data/information gathered during the comprehensive assessment, updates to the comprehensive assessment and reassessments, in the care planning process to provide care that is consistent with the patient and family needs, with patient's needs and goals as a priority. ... Procedure ... The IDG works together to meet the physical, medical, psychosocial, emotional and spiritual needs of Hospice patients and families facing terminal illness and bereavement. IDG members provide the care and services offered by Hospice. IDG supervises the care and services. ... Supervision of care by the IDG members is accomplished by face-to-face or telephone conferences, evaluations, discussions and general oversight, as well as by direct observations. 4. A registered nurse that is a member of the IDG is designated to provide coordination of care and to ensure continuous assessment of each patient's and family's needs and implementation of the IDG plan of care. ... 7. Each patient and primary	L 0554	L554 **What is the deficiency? L554 Coordination of Services 418.56e(1) The hospice must develop and maintain a system of communication and integration, in accordance with the hospices own policies and procedures to (1) Ensure that the interdisciplinary group maintains responsibility for directing, coordinating and supervising the care and services provided.** 1. How are you going to correct the deficiency? **What is the deficiency? L554 Coordination of Services 418.56e(1)** The Clinical Management staff will educate all staff on **L554 Coordination of Services 418.56e(1)**. All staff will also be educated on 9.12.01 IDG Care Plan Process, 9.15.01 Plan for Patient/Family Education. Education will also include Caregiver/Family member pharmacological education and safety of medication administration education from pharmacy staff. 2. How are you going to prevent the deficiency from recurring in the future, even if already corrected? 100% of all active charts will be	09/18/2020

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	caregiver(s) receives education and training appropriate to their responsibilities for the care and services identified in the plan of care. ... The plan of care includes all services necessary for the palliation and management of the terminal illness and related conditions, including: ... If the patient requires frequent use of PRN [as needed] visits the plan of care will be updated to include the need for additional visits. ... Drugs and treatments necessary to meet the needs of the patient. ... Documentation of the patient's or representative's level of understanding, involvement and agreement with the plan of care in the patient record...." 2. The agency policy with a revised date of December 30, 2015, policy number 9.15.01, titled "Plan for Patient/Family Education" stated "... Policy Hospice will educate and train patient/family according to the needs assessed by Hospice staff and as appropriate to the required services. Purpose To assess the patient/family's needs, to improve palliative care outcomes and to ensure competency in care provision. ... Procedure 1. Educational needs related to the patient's needs, disease process or Hospice services will be assessed as part of the referral and during the comprehensive assessment. The patient's record should reflect special consideration related to the education plan for the patient/family and include, but is not limited to: ... Emotional barriers or motivation to learn. Cognitive limitation. ... 2. Hospice staff understands that the assessment of patient/family's education needs are ongoing and will be regularly reassessed as needs change. 3. All patient/family education, the perceived comprehension, ability to demonstrate a taught skill and verbal recall will be documented in the patient's record...."		audited to ensure compliance with all care plan changes. 100% of all current/ active HOME patients will be audited to determine competency for administration of medications. 100% of all newly admitted HOME patients (OR if the person responsible for administering medications is identified through has changed) will be audited to determine competency for administration of medications. This monitoring will continue until the QAPI committee determines deficiency is corrected. 3. Who is going to be responsible for numbers 1 and 2- The Executive Director, Patient care manager or designee is responsible for correcting the deficiency. 4. By what date are you going to have the deficiency corrected? September 18, 2020	

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	3. Clinical record review for patient #1 on 6/26/20, start of care 5/9/19, evidenced an agency document titled "Medication Status" with a range in dates from 4/19/19 - 5/27/19. This medication status document listed the following narcotic/ benzodiazapine medications: Percocet [narcotic pain reliever] By Mouth 10-325 MG [milligram] 1 tablet every 4 hours as needed PO (by mouth), Comfort Kit placed in home in refrigerator. Not to be used until directed by nurse, Morphine Sulfate [narcotic pain medication] (Concentrate) By Mouth Solution 20 MG/ML 5 - 10 Milligram every 2 hours as needed by mouth or sublingual, Ativan [for anxiety, benzodiazipine] Injection solution 2MG/ML 0.5-1 Milligram every 2 hours as needed By mouth or sublingual, Xanax [for anxiety, benzodiazapine] by mouth 0.5 MG 1 tablet three times a day PO, Dilaudid [narcotic pain medication] By Mouth Tablet 2 MG 1-2 Tablet every 4 hours as needed PO. Clinical record review evidenced an agency document titled "... Initial Visit ..." dated 5/9/19 and electronically signed by employee K. This document indicated refills were needed for Xanax and Percocet and the refills were to be delivered. This document indicated there were no dosage errors and the patient caregiver manages the medication appropriately. Clinical record review evidenced an agency document titled "... Routine visit ..." dated 5/10/19 and electronically signed by employee L. This document indicated the patient was out of Dilaudid and Percocet, the refills were to be delivered, indicated no dosage errors and the patient caregiver manages the medications appropriately.			

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	Clinical record review evidenced an agency document titled "Charts / Clinical Notes" with an "Effective Date" of 5/10/19, and "Discipline" of Skilled Nurse. The document was electronically signed by employee L and timed 09:54:40 a.m. This document stated "... DIL [daughter in law] said pt [patient] is out of Percocet but has deluded [sic], call to admission nurse to check on status. ... Percocet was called to [name of pharmacy] along with Xanax, asked dr [doctor] staff to call in 3 days supply to local [name of pharmacy], I will p/u [pick up] and take for my visit." Clinical record review evidenced an agency document titled "Charts / Clinical Notes" with an "Effective Date" of 5/10/19, and the "Discipline" of Skilled Nurse. The document was electronically signed by employee L and timed 11:40:02 p.m. This document stated "... Note: 1) First worked on getting percocet today, then for Saturday delivery of a full count of percocet and dilaudid. Updated meds, clarified covered/non-covered meds. Person G (DIL) asking about ambien to help her sleep. ... Pt [patient] is alert, oriented to self, place, she is able to communicate and express her needs, mild confusion and forgetful (asked what day it was). ... During the last hospital stay she was receiving percocet alternating with dilaudid which was working well for the pain, 5 days ago she ran out of percocet and began giving dilaudid 2mg 14-16 x a day and was depleating [sic] the dilaudid. ... Delivered percocet, pt was given a dose." Clinical record review evidenced an agency document titled "... Routine visit ..." dated 5/13/19 and electronically signed by employee L. This document indicated the family/ patient caregiver needs ongoing education and			

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	reinforcement of pain regimen, the patient's pain was reported by the patient caregiver, and the patient was unable to provide details. This document also stated that patient caregiver manages medications appropriately, no refills are needed, needs reinforcement, and meds reconciled without any issue. Clinical record review evidenced an agency document titled "Charts / Clinical Notes" with an "Effective Date" of 5/13/19, and the "Discipline" of Skilled Nursing. This document was electronically signed by employee L and timed 10:16:16 p.m. This document stated "... Note: SW [social worker] gave me a message from person G, Dtr [daughter] in law about some confusion on the dosage of pain meds, and asked about the mattress. ... Person G, DIL had been giving percocet 2 tablets at a time when the order is 1 tab 10/325mg q [every] 4 hrs [hours], and is written on the med bottle is 1 tab. Noted that in her writing down the meds when she had a 8 hr lapse in pain medication, and another time lapse. She said that she was getting confused. I set up a form for her to give alternating pain meds of percocet and dilaudid 1 2 hrs until she is comfortable. We talked about seeing a increase in sedation, increased confusion, and unsteady gain. Narcotics were counted. ... She is alternating percocet with dilaudid, DIL says the pain seems to be increasing quickly. Pt lives with son and dtr in law, responsible for her care. ... Also asked [name of doctor] for ambien 5.0 mg that pt was taking before her hospitalization and has insomnia. While I was in the home pt was given dilaudid for pain." Clinical record review evidenced an agency document titled "... Oncall / Unscheduled visit" dated 5/14/19 and electronically signed by			

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	employee L. This document indicated daughter in law was given adjusted form for ability to understand medication administration, the patient caregiver manages meds appropriately, no refills were needed, patient caregiver understands / verbalized, needs reinforcement, and meds were reconciled without issue. Clinical record review evidenced an agency document titled "Charts / Clinical Notes" with an "Effective Date" of 5/14/19, and the "Discipline" of Skilled Nursing. This document was electronically signed by employee L and timed 08:33:04 p.m. This document stated "... Started Ambien 5 mg q hs [bedtime] insomnia, she had taken before she went to the hospital. Changed Xanax 0.5 mg from BID [twice daily] to TID [three times daily], increase in her anxiety, over use of pain medication for security. ... Prn visit due to pain control , educating main caregiver person G on how to give meds for good pain control, needed more direction due to giving wrong doses. We set up a schedule that she can understand. She has the sign out sheets but writes both meds on that sheet to know what she gave last and when she could give again, also educated on not waking her to give her medication. Pt has a long hx [history] or narcotic use for pain with several different ones, she has become accustomed to the medication. Pt has long hx of anxiety, attempting to manage it and I believe she will use less pain medication...." Clinical record review evidenced an agency document titled "Charts / Clinical Notes" with an "Effective Date" of 5/15/19, and the "Discipline" of Skilled Nursing. This document was electronically signed by employee M and timed 08:01:30 a.m. This document stated "... Triage received call from pt's daughter in law, person G,			

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	stating that the pt has been very lethargic today. Pt is now unresponsive with her head hanging back, mouth wide open. Pt will not open her eyes. Person G states that now that the pt's mouth is open, she noted that she did not swallow any of her PM medications, as they are still in her mouth. Person G states that she did clean the pt's mouth out, but the pt does not look well. Respirations are even and unlabored and pt does not seem to be in any pain or distress. Family requesting a nursing visit by hospice tonight. Triage contacted on-call nurse, [name], to make visit for assessment." Clinical record review evidenced an agency document titled "Charts/ Clinical Notes" with an "Effective Date" of 5/15/19, and the "Discipline" of Skilled Nursing. This note indicated it was an IDG summary. This document stated "... Pt is alert and oriented to self/place, mild dementia, forgetful, mild managed anxiety (hx anxiety ongoing). Able to express simple conversation, able to express some simple needs. Spends most of her time in bed, up to sit in living room, ... attempting to adjust pain meds for comfort, continuous teaching on pain meds with primary caregiver, person G. New medication ambien and increased Xanax from BID to TID. Pt seems to be using pain medicine for anxiety periods as comfort...." During the IDG meeting on 5/15/19 there was no indication of the patient's new condition change reported that morning of difficulty swallowing, there was no indication of discussion of the patient caregiver (person G) giving the patient 2mg of Dilaudid 14 - 16x a day or the patient caregiver giving double the dosage of Percocet ordered, and there failed to be mentioned that a special medication chart was developed for the			

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	151544	A. BUILDING 00 B. WING	06/29/2020

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patient caregiver due to her having difficulty managing certain patient medications. The IDG summary note did indicate the patient seemed to be using pain medicine for anxiety periods as comfort, however in the "Initial Visit" document dated 5/9/19, it indicated the patient caregiver managed the patient's medications.

During an interview on 6/26/20 at 3:51 p.m., employee G, patient care manager, indicated if the patient caregiver (person G) was found to be incompetent in properly administering medication they would notify the whole team, the social worker, and doctor.

During an interview on 6/26/20 at 4:06 p.m. employee A indicated the physician was notified by the nurse of concerns, but it was not clarified of what he was notified of.

4. Clinical record review on 6/26/20, for patient #3, start of care 12/18/18, evidenced an agency document titled "Physician's Orders/Plan of Care from 12-18-18 to 03-17-19" dated and signed by the physician on 1/9/19. This plan of care had an area subtitled "Treatments" which stated "... AID [sic] 12-18-18 1 x week x 1 week 12-23-18 2 x week x 12 weeks Provide personal care and assistance with ADLs [activities of daily living]...."

Clinical record review evidenced an agency document titled "Charts/Clinical Notes" with an entry dated 1/1/19. This entry failed to evidence the IDG team was informed of the patient's refusal of hospice aide visits.

During an interview on 6/26/20, employee B indicated she did not see anything about the hospice aide mentioned in the IDG notes.

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L 0556 Bldg. 00	418.56(e)(3) 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-] (3) Ensure that the care and services provided are based on all assessments of the patient and family needs. Based on record review and interview, the agency failed to ensure the care and services were provided based on all assessments of the patient and family needs in 1 of 4 active clinical records reviewed, out of a total of 10 clinical records reviewed. (#5) The findings include: Review of an agency policy dated 4/1/14 titled "Coordination of Patient Care" stated, "... Hospice has developed and maintains a system of communication and integration to: ... Ensure that care and services are provided in accordance with the plan of care and are based on all assessments of the patient and family needs. ..." Clinical record review on 6/25/2020 for patient #5 evidenced an agency document titled "Initial Visit" dated 1/31/2020 which indicated the patient needed assistance for grooming, bathing, transferring and feeding. Record review evidenced an agency document titled "Team Care Plan" dated 6/24/2020 which indicated interventions the hospice aide was to provide to the patient including assist with transfers, assist with feeding, perineal care (cleaning of the patient's genitals, buttocks and surrounding area), assist with dressing, mouth care, shower, hair care and nail care.	L 0556	L556 **What is the deficiency? L556 Coordination of Services 418.56e (3) The hospice must develop and maintain a system of communication and integration, in accordance with the hospices own policies and procedures to (3) Ensure that the care and services provided are based on all assessments of the patient and family needs.** 1. How are you going to correct the deficiency? **What is the deficiency? L556 Coordination of Services 418.56e (3)** The Clinical Management staff will educate all staff on **L556 Coordination of Services 418.56e (3)**. All Social Service, Nursing, Aides and Chaplain will be educated on policy 09.06.01 Initial Assessment/Comprehensive assessment, 11.03.01 Aide Documentation, 9.12.01 IDG Care planning process, 9.13.01 Coordination of patient care, 7.09.01 Care to residents in a SNF/NF.	09/18/2020

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HARBOR LIGHT HOSPICE	1229 ARROWHEAD COURT CROWN POINT, IN 46307

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	Record review of an agency document titled "Charts/Clinical Notes" dated 2/7/2020 and completed by the skilled nurse stated, "... POA [power of attorney] was called and verified that pt [patient] is to get a shower from facility. Requested that pt receives nail and hair care from HLH [Harbor Light Hospice] and companionship if possible. Writer collaborated with PCM [patient care manager] [employee A] regarding aide care plan clarification. ..." The clinical record failed to evidence hospice aide services were provided after 2/6/2020. During an interview on 6/25/2020 at 5:01 p.m., person I, patient's POA, indicated she was unaware the hospice aide visits had discontinued. Person I indicated the patient requires total care and needs companionship since family is unable to make visits to the facility in which the patient resides due to visitor restrictions. During an interview on 6/26/2020 at 1:45 p.m., person A, director of nursing at entity B where the patient resides, indicated hospice staff of all disciplines have not been restricted from entity B in over a month to allow patient care but family restrictions still in place. Person A also indicated the facility believed the hospice aide was providing care two times a week and was unaware hospice aide services were discontinued. During an interview on 6/29/2020 at 11:28 a.m., employee A indicated the last hospice aide visit was on 2/6/2020 and there was no clinical note documenting communication with the family, facility and physician in regards to the discontinuation of hospice aide services.		2. How are you going to prevent the deficiency from recurring in the future, even if already corrected? 100% of all current/ active patients receiving hospice aides will have visit frequency audits to ensure all visits are being met and to ensure the tasks being performed meet the needs of the patient. 100% of all current/ active patients that have changes in the aide visit frequency will be audited to ensure care plan is updated and communication has occurred. This monitoring will continue until the QAPI committee determines deficiency is corrected. 3. Who is going to be responsible for numbers 1 and 2- The Executive Director, Patient care manager or designee is responsible for correcting the deficiency. 4. By what date are you going to have the deficiency corrected? September 18, 2020	

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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 ongoing sharing of information with other non-hospice healthcare providers furnishing services in 3 of 10 clinical records reviewed. (#4, #5, #6) The findings include: 1. Review of an agency policy dated 4/1/14 titled "Coordination of Patient Care" stated "... Hospice has developed and maintains a system of communication and integration to: ... Provide for an ongoing sharing of information with other non-hospice healthcare providers furnishing services ...." 2. Review of an agency policy dated 4/1/14 titled "Care to Residents of a SNF/NF [Skilled Nursing Facility/Nursing Facility] or ICF/MR [Intermediate Care Facility for Mental Retardation]" stated, "... Hospice is responsible for providing all Hospice services including: Provision of Hospice Aide services ..." 3. Clinical record review on 6/25/2020 for patient #4 evidenced an agency document titled "Physician's Orders/Plan of Care" for period 11/13/18 - 2/10/19 which indicated the hospice aide was to provide 2 visits per week for 13 weeks for personal care and assistance with ADLs	L 0558	L558 **What is the deficiency?** **L558Coordination of Services 418.56e (5) The hospice must develop and maintain a system of communication and integration, in accordance with the hospices 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.** 1. How are you going to correct the deficiency? **What is the deficiency? L558 Coordination of Services 418.56e (5)** The Clinical Management staff will educate all staff on **L558 Coordination of Services 418.56e (5)**. All Social Service, Nursing, Aides and Chaplain will be educated on policy 09.06.01 Initial Assessment/Comprehensive assessment, 11.03.01 Aide Documentation, 9.12.01 IDG Care planning process, 9.13.01	09/18/2020

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	(activities of daily living). The document indicated the patient was a resident at entity D. Record review failed to evidence aide services were provided 2 times during the week of 11/25/18 and failed to evidence coordination of care with entity D. Record review of an agency document titled "Supplemental Orders from 12-29-18 to 2-9-19" and signed by the physician on 3/4/19 indicated the hospice aide visits were increased to 3 visits per week effective 12/30/18. Record review failed to evidence aide services were provided 3 times during the week of 12/30/18 and failed to evidence coordination of care with entity D. During an interview on 6/29/2020 at 11:11 a.m., employee A indicated the aide visit was refused on 11/28/18 and the aide visit on 1/4/19 was not provided since care was performed by entity D. Employee A indicated there was no clinical documentation of coordination of care with entity D to notify the hospice aide visit was not completed and to confirm patient care was provided. Employee A indicated the agency did not ensure all care on the aide care plan was provided since the agency did not request this information from entity D. 4. Clinical record review on 6/25/2020 for patient #5 evidenced an agency document titled "Team Care Plan" dated 6/24/2020 which indicated the patient was a resident at entity B. This document indicated interventions the hospice aide was to provide to the patient including assist with transfers, assist with feeding, perineal care (cleaning of the patient's genitals, buttocks and surrounding area), assist with dressing, mouth care, shower, hair care and nail care.		Coordination of patient care, 7.09.01 Care to residents in a SNF/NF. 2. How are you going to prevent the deficiency from recurring in the future, even if already corrected? 100% of all current/ active patients receiving hospice aides will have visit frequency audits to ensure all visits are being met and to ensure the tasks being performed meet the needs of the patient. 100% of all current/ active patients that have changes in the aide visit frequency will be audited to ensure care plan is updated and communication has occurred with facilities where patient resides. This monitoring will continue until the QAPI committee determines deficiency is corrected. 3. Who is going to be responsible for numbers 1 and 2- The Executive Director, Patient care manager or designee is responsible for correcting the deficiency. 4. By what date are you going to have the deficiency corrected? September 18, 2020	

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	Record review of an agency document titled "Charts/Clinical Notes" dated 2/7/2020 and completed by the skilled nurse stated, "... POA [power of attorney] was called and verified that pt [patient] is to get a shower from facility. Requested that pt receives nail and hair care from HLH [Harbor Light Hospice] and companionship if possible. Writer collaborated with PCM [patient care manager] [employee A] regarding aide care plan clarification. ..." The clinical record failed to evidence hospice aide services were provided after 2/6/2020. During an interview on 6/26/2020 at 1:45 p.m., person A, director of nursing at entity B, indicated she believed the hospice aide was providing care two times a week and was unaware hospice aide services were discontinued. During an interview on 6/29/2020 at 11:28 a.m., employee A indicated the last hospice aide visit was on 2/6/2020 and there was no clinical note documenting communication with entity B regarding the discontinuation of hospice aide services. 5. Clinical record review on 6/25/2020 for patient #6 evidenced an agency document titled "Physician Orders/Plan of Care from 1-27-20 to 3-26-20" which indicated the hospice aide was to provide visits 3 times a week for 8 weeks beginning 1/2/20. Record review failed to evidence hospice aide services were provided 3 times a week during the week of 2/2/2020 and 2/16/2020. During an interview on 6/26/2020 at 11:35 a.m., employee B indicated the hospice aide visits were refused on 2/7/2020 and 2/20/2020. Employee B indicated there was no documentation of			

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	coordination of care with entity J regarding hospice aide visits were not completed per plan of care.			
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 home health agency failed to maintain a program for identification, prevention, control and investigation of infectious and communicable diseases to include written standards, policies and procedures that are current and based on national standards for undiagnosed respiratory illness and COVID-19 including when to notify local and state public health officials if there are clusters of respiratory illness or cases of suspected or identified COVID-19. This deficient practice had the potential to affect all patients. The findings include: An agency policy dated 4/1/14 titled "Infections Control Surveillance System: Prioritized Risks Defined" stated, "... Hospice will perform targeted control surveillance as follows: Patient infections to be reported while patient is on service: ... Patient infections to be reported at time of admission: ... any reportable communicable disease (as defined by local health department) ... Written reporting of infections will occur through documentation on the applicable log (patient or employee). ..."	L 0580	L580 **What is the deficiency? L5580 Control CFR(s):418.60(b)(1) The hospice must maintain a coordinated agency-wide program for 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.** 1. How are you going to correct the deficiency? **What is the deficiency? L580 Control CFR(s):418.60(b)(1**) All nursing staff including Patient care managers will be educated on L580 and Control CFR(s):418.60(b)(1). Policy 05.11.01 Reporting of Epidemiological illnesses in patients, 5.02.01 Infection control plan, 10.01.01 Quality Performance and Quality	09/18/2020

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	An agency policy dated 4/1/14 titled "Reporting of Epidemiological Illnesses in Patients" stated, "... Records will be kept to identify any patterns or trends of communicable diseases. Data regarding communicable diseases will be reviewed an analyzed on an ongoing basis to identify any trends." Clinical record review for patient #5 on 6/29/2020 evidenced an untitled document dated 4/24/2020 which indicated the patient was tested for COVID-19 on 4/23/2020 and on 4/24/2020 the lab results detected COVID-19. Record review of an agency document dated 6/26/2020 titled "Medication Status" indicated the patient was taking Vitamin C and Zinc from 4/25/2020 to 6/24/2020 for COVID. Review of an undated agency document on 6/23/2020 titled "Infection Control Log Form" indicated the name of patient #5 with an infection site of the lungs. The document failed to evidence the location of the patient, date of infection, symptoms of infection, infectious organism and treatment of infection. During an interview on 6/29/2020 at 12:23 p.m., employee A indicated there was no documentation of an investigation related to the patient's infections. Employee A also indicated the infection log should have been completed for infection control surveillance with the patient's information related to the infection.		Improvement plan. 2. How are you going to prevent the deficiency from recurring in the future, even if already corrected? 100% of all current/ active patients will be audited for any active infections and infectious diseases, surveillance form completion, infection written on the infection control log, infection listed on care plan, was infection required to be reported / and reported to local and state public officials, and were logs turned into QAPI committee. 100% of all current/ active patients with NEWLY diagnosed infections – that occurred since last IDG will be audited for any active infections and infectious diseases, surveillance form completion, infection written on the infection control log, infection listed on care plan, was infection required to be reported / and reported to local and state public officials, and were logs turned into QAPI committee. Monitoring will continue until the QAPI committee determines deficiency is corrected. 3. Who is going to be responsible for numbers 1 and 2- The Executive Director, Patient care manager or designee is responsible for correcting the deficiency. 4. By what date are you going to have the deficiency corrected? September 18, 2020	

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L 0626 Bldg. 00	418.76(g)(2) HOSPICE AIDE ASSIGNMENTS AND DUTIES (2) A hospice aide provides services that are: (i) Ordered by the interdisciplinary group. (ii) Included in the plan of care. (iii) Permitted to be performed under State law by such hospice aide. (iv) Consistent with the hospice aide training. Based on record review and interview, the hospice aide failed to provide services included in the plan of care and ordered by the interdisciplinary group (IDG) in 1 of 10 clinical records reviewed. (#4) The findings include: Review of an agency policy dated 4/1/14 titled "Nursing Services" stated, "... Nursing care will be provided in accordance with the patient's IDG plan of care, under the supervision of a registered nurse. ..." Review of an agency policy dated 4/1/14 titled "Care to Residents of a SNF/NF [Skilled Nursing Facility/Nursing Facility] or ICF/MR [Intermediate Care Facility for Mental Retardation]" stated, "... Hospice is responsible for providing all Hospice services including: ... Provision of Hospice Aide services ..." Clinical record review on 6/25/2020 for patient #4 evidenced an agency document titled "Physician's Orders/Plan of Care" for period 11/13/18 - 2/10/19 which indicated the patient was a resident at entity D. This document indicated the hospice aide was to provide 2 visits per week for 13 weeks for personal care and assistance with ADLs (activities of daily living). Record review failed to evidence aide services were provided 2 times during the week of 11/25/18.	L 0626	L626 **What is the deficiency? L626 Hospice Aide Assignments and duties CFR(s):418.76(g)(2) Hospice aide provides services that are (i) Ordered by the interdisciplinary group(ii)Ordered by the interdisciplinary group(iii)Permitted to be performed under state law such hospice aide(iv)Consistent with the hospice aide training.** 1. How are you going to correct the deficiency? **What is the deficiency? L626 Hospice Aide Assignments and duties CFR(s):418.76(g)(2)** All nurses and Aides will be educated on 9.22.01 Nursing services, 9.12.01 IDG Care planning process, 9.13.01 Coordination of patient care, 7.09.01 Care to residents in a SNF/NF. 2. How are you going to prevent the deficiency from recurring in the future, even if already corrected? 100% of all current/ active newly admitted patients receiving hospice aides will have visit frequency audits to ensure all	09/18/2020

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	Record review of an agency document titled "Supplemental Orders from 12-29-18 to 2-9-19" and signed by the physician on 3/4/19 indicated the hospice aide visits were increased to 3 visits per week effective 12/30/18. Record review failed to evidence aide services were provided 3 times during the week of 12/30/18. During an interview on 6/29/2020 at 11:11 a.m., employee A indicated the aide visit was refused on 11/28/18 and there was no clinical documentation of who refused the visit and who entered on the schedule the visit was refused. Employee A indicated the aide visit on 1/4/19 was not provided since care was performed by entity D and there was no documentation of who entered on the schedule the care was performed by entity D. Employee A indicated the agency did not ensure all care on the aide care plan was provided since the agency did not request this information from entity D.		visits are being met, care plans are updated and the tasks being performed meet the needs of the patient. Monitoring will continue until the QAPI committee determines deficiency is corrected. 3. Who is going to be responsible for numbers 1 and 2- The Executive Director, Patient care manager or designee is responsible for correcting the deficiency. 4. By what date are you going to have the deficiency corrected? September 18, 2020	
L 0671 Bldg. 00	418.104 CLINICAL RECORDS A clinical record containing past and current findings is maintained for each hospice patient. The clinical record must contain correct clinical information that is available to the patient's attending physician and hospice staff. The clinical record may be maintained electronically. Based on record review and interview, the hospice failed to ensure correct clinical documentation, in relation to the comprehensive assessment in 1 of 1 patients who experienced pain and anxiety (#7), and 1 of 4 active clinical records requiring lab results, out of a total sample of 10 records reviewed. (#5,)	L 0671	L671 **What is the deficiency? L671 Clinical Records CFR(s): 418.104 – A clinical record containing past and current findings is maintained for each hospice patient. The clinical record must contain correct**	09/18/2020

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	The findings include: 1. Clinical record review for patient #7 on 6/25/2020, evidenced a document titled "Oncall/Unscheduled visit" electronically signed by Employee Q, on 1/28/2020. An area subtitled "Physical/ Clinical Monitoring" which had a subsection titled "Scales" which stated "Pain ... 03:14 am ... Actual 0 (0-10) ... Anxiety ... 03:14 am ... Actual 0 (0-10) ... " An area subtitled "Physical \ Neurological \ Emotion/ Behavior" stated " ... Mood: Anxious ... "Another area subtitled "Visit Type / Symptom Management" stated "Type of Visit: on Call/PRN [as needed] / Immediate Needs Visit ... Comprehensive: Emotion/ Behavior, Pain Evaluation, Care Management ... " Furthermore, an area subtitled "Physical \ Pain Evaluation \ Pain Assessment" stated, " ... Is pain an active problem for this patient?: 1. Yes ... " This document failed to evidence consistent documentation in regards to anxiety and pain comprehensive assessments. Clinical record review evidenced a document titled "Charts / Clinical Notes" which stated "... Facility nurse called triage and stated pt [patient] is in uncontrolled pain. Upon arrival patient was heard moaning before arriving into the room. Facility nurse [Person K] stated pt has currently been receiving 2 mg [milligrams] of Dilaudid [narcotic used to treat moderate to severe pain] every hour and 0.5 [sic] of Ativan [sedative used to relieve anxiety] every hour as ordered. Facility nurse noted medications are currently ineffective for pt ... " This note was electronically signed by Employee Q, on 1/28/2020, at 5:28 AM. During an interview on 6/29/2020, at 3:03 PM, Employee A acknowledged the inconsistencies		**clinical information that is available to the patients attending physician and hospice staff. The clinical record may be maintained electronically.** 1. How are you going to correct the deficiency? **What is the deficiency?** All clinical and clerical staff will be educated on L626 Hospice Aide Assignments and duties CFR(s):418.76(g)(2) policies 11.02.01 Patient record content and 11.13.1 Clinical Documentation. 2. How are you going to prevent the deficiency from recurring in the future, even if already corrected? 100% of all current patients and new admissions receiving lab work will be monitored to ensure consistent documentation is present for lab work. 25% of average daily census will be monitored on a monthly basis for consistent past and current clinical records findings for pain and anxiety concerns. Monitoring will continue until the QAPI committee determines deficiency is corrected. 3. Who is going to be responsible for numbers 1 and 2- The Executive Director, Patient care manager or designee is responsible for correcting the deficiency. 4. By what date are you going to have the deficiency corrected?	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	151544	A. BUILDING 00 B. WING	06/29/2020

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HARBOR LIGHT HOSPICE	1229 ARROWHEAD COURT CROWN POINT, IN 46307

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	within the clinical record and indicated the skilled nurse would be re-educated on comprehensive assessment documentation. During an interview on 6/29/2020, at 3:28 PM, Person E stated "Their [Harbor Light Hospice] night nurse wrote she could hear the patient screaming from down the hallway but documented on the pain/agitation chart a very low-end mark as to being comfortable and fine."2. Clinical record review on 6/25/2020 for patient #5 evidenced an agency document titled "Team Care Plan" dated 6/24/2020 which indicated the patient was to have monthly CBC (Complete Blood Count), CMP (Comprehensive Metabolic Panel) and Free Dilantin (test to monitor blood level of seizure medication) labs drawn. The clinical record failed to evidence lab results for March, April and May of 2020. During an interview on 6/29/2020 at 12:15 p.m., employee A indicated the patient was receiving monthly labs since admission to hospice on 1/31/2020 but there were not lab results in the clinical record. Employee A indicated she received copies of lab results from entity B after lab results were requested.		September 18, 2020	
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 hospice aide note failed to contain all the services provided in 1 of 6 discharged clinical records reviewed, out of a total of 10 clinical records reviewed. (#1)	L 0674	L674 **What is the deficiency? L674 Clinical Records CFR(s): 418.104(a)(3)– Each patient's record must include the following (3) Responses to**	09/18/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	The findings include: The agency policy dated April 1, 2014, policy number 11.02.01, titled "Patient Record Content" stated "... Policy Hospice will provide an accurate and current patient record for every patient seen by Hospice. The record, whether hard copy or in electronic form, will be made readily available on request by an appropriate authority. Purpose To ensure documentation of patient status, services and outcomes. ... Procedure 1. hospice will initiate and maintain an individual and accurate patient record containing past and current findings for each patient receiving care in compliance with all federal/state laws and regulations. The record must contain correct clinical information that is available to the patient's attending physician and Hospice staff. The record may be maintained electronically. Hospice will use a standardized format for records. The format will be periodically reviewed and updated, as necessary. 2. All entries must be legible, clear, complete and appropriately authenticated. 3. Each patient record will contain the following as applicable: ... Care/services provided by Hospice, including contracted staff (evaluations, treatments and progress notes). Date care/services provided and staff/title who provided care/services. ... Responses to medications, symptom management, treatments and services. ... Patient/family response to care/services...." The agency policy with a revised date of December 30, 2015, policy number 11.03.01, titled "Hospice Aide Documentation" stated "... Policy Hospice will ensure accurate documentation of Hospice Aide services. Purpose To provide documentation of the care performed by the Hospice Aide on each visit. ... Procedure 1. The		**medications, symptom management, treatments, and services.** 1. How are you going to correct the deficiency? **What is the deficiency? L674 Clinical Records CFR(s): 418.104(a)(3)–** All nurses and aides will be educated on L674 Clinical Records CFR(s): 418.104(a)(3) policy 11.02.01 patient record content, 11.03.01 hospice aide Documentation, 4.21.0 Hospice aide supervision. 2. How are you going to prevent the deficiency from recurring in the future, even if already corrected? 100% of all admissions will be audited to ensure authenticity and accuracy. This audit will include monitoring the care plan to ensure it reflects the individual needs of the patients identified in the initial assessment. Monitoring the care plan to ensure it reflects the individual needs of the patients identified in the admission clinical note? Monitoring to ensure the aide supervisory section properly completed? Monitoring will continue until the QAPI committee determines deficiency is corrected. 3. Who is going to be responsible for numbers 1 and 2- The Executive Director, Patient care manager or designee is responsible for correcting the deficiency.	

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	Hospice Aide will document services rendered to the patient on the appropriate Hospice Aide charting form. ... 3. The Patient Care Manager or designated RN [registered nurse] is responsible for reviewing the Hospice Aide's charting. ... This documentation must be completed upon completion of each patient visit." Clinical record review on 6/29/20, for patient #1, start of care 5/9/19, evidenced an agency document titled "Physician's Orders/Plan of Care from 05-09-19 to 08-06-19, dated and signed by the physician on 5/23/19. This document stated "... Aid 05-09-19 2 x week x 13 weeks Provide personal care and assistance with ADLs [activities of daily living]" Clinical record review evidenced an agency document titled "Visit History Information for [patient name] from 05-09-2019 to 05-27-2019" This document indicated it was for hospice aide visits. This document evidenced a visit on 5-13-19 and indicated assist with ambulation as "NA", perineal care as "NA", record bowel movement as "NA" assist to commode as "NA", assist with dressing/undressing as "NA", apply lotion of patient's choice as requested as "NA", apply deodorant as "NA", clean/file nails as "NA", brush/comb hair as "NA", shampoo as "NA", and shower as "NA" This document failed to evidence all responses to services were documented. During an interview on 6/29/20 at 10:43 a.m., employee G indicated NA means not applicable and indicated she would say that meant it didn't happen. Employee A indicated if the employee hit finish then documentation would come up as NA.		4. By what date are you going to have the deficiency corrected? September 18, 2020	

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	151544	A. BUILDING 00 B. WING	06/29/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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L 0679 Bldg. 00	418.104(b) AUTHENTICATION All entries must be legible, clear, complete, and appropriately authenticated and dated in accordance with hospice policy and currently accepted standards of practice. Based on record review and interview, the hospice agency failed to ensure the authenticity of all clinical records in 1 of 10 clinical records reviewed. (#1) The findings include: The agency policy dated April 1, 2014, policy number 11.02.01, titled "Patient Record Content" stated "... Policy Hospice will provide an accurate and current patient record for every patient seen by Hospice. ... Procedure 1. Hospice will initiate and maintain an individual and accurate patient record containing past and current findings for each patient receiving care in compliance with all federal/state laws and regulations...." Clinical record review of patient #1 on 6/29/20, start of care 5/9/19, evidenced an agency document titled "... Initial Visit ..." dated 5/10/19 and signed by employee K. This document had an area subtitled "Supervision \ Supervision" which stated "Aide Supervision Aide Supervision: Yes .. Is the Hospice Aide following the Care Plan?: Yes Are the patient/family satisfied with care?: Yes Has there been a change in service?: No ...." At the time of this visit the hospice aide had not yet been assigned to the patient. The clinical record lacked authenticity. During an interview on 6/29/20 at 10:32 a.m., employee A indicated of course there was no supervision and this was a tricky question.	L 0679	L679 **What is the deficiency? L679 Authentication CFR(s): 418.104(b)–All entries must be legible, clear, complete, and appropriately authenticated and dated in accordance with hospice policy and currently accepted standards of practice.** 1. How are you going to correct the deficiency? **What is the deficiency? L679 Authentication CFR(s): 418.104(b)–** All staff will be educated on L679 Authentication CFR(s): 418.104(b), policy 11.02.01 patient record content, and process for quality assurance review. 2. How are you going to prevent the deficiency from recurring in the future, even if already corrected? 100% of all admissions will be audited during the QA process to ensure authenticity and accuracy. This will include reviewing if the care plan reflects the individual needs of the patient identified in the initial assessment, does the pare plan reflect the individual needs of the patients identified in the admission clinical note? Reviewing if the aide supervisory section was properly completed	09/18/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	151544	A. BUILDING 00 B. WING	06/29/2020

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	Employee A indicated the employee could have reviewed the plan of care with the home health aide.		(on admission this should be answered no if the Aide is not present). Monitoring will continue until the QAPI committee determines deficiency is corrected. Who is going to be responsible for numbers 1 and 2- The Executive Director, Patient care manager or designee is responsible for correcting the deficiency. By what date are you going to have the deficiency corrected? September 18, 2020	
L 0680 Bldg. 00	418.104(c) PROTECTION OF INFORMATION The clinical record, its contents and the information contained therein must be safeguarded against loss or unauthorized use. The hospice must be in compliance with the Department's rules regarding personal health information as set out at 45 CFR parts 160 and 164. Based on observation, record review, and interview, the hospice agency failed to ensure all patient clinical records were safeguarded against unauthorized access and / or use. This deficient practice had the potential to affect all patients. The findings include: The agency policy with a revised date of December 1, 2015 titled "Policy Number: 06.02.01 Title: Patient Confidentiality...." stated "... 9. Patient records will not be left in unattended areas in the office, ... All patient records will be kept stored in metal file cabinets to minimize the possibility of damage from fire and water. Charts	L 0680	L680 **What is the deficiency? L680 Protection of information CFR(s) 418.104(C)The clinical record, its contents and the information contained therein must be safeguarded against loss or unauthorized use. The hospice must be in compliance with the Departments rules regarding personal health information as set out in 45CFR parts 160 and 164.** 1. How are you going to correct the deficiency?	09/18/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	151544	A. BUILDING 00 B. WING	06/29/2020

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	will be protected against unauthorized corruption, damage and/or intrusion...." On 6/25/2020 at 11:03 a.m., Harbor Light Hospice branch located in Mishawaka, IN was visited. Present at the time of visit was employee G, I, and J. Observation was made of the record room with the door unlocked, light off, and no one present in the room. This room was observed to be filled with metal file cabinets with multiple banker boxes of records stacked on top of the metal filing cabinets. The room failed to be locked to safeguard client records from unauthorized use. During an interview on 6/25/2020 at 11:05 a.m., employee G indicated they don't have many visitors other than the occasional delivery person.		**What is the deficiency? L680 Protection of information CFR(s) 418.104(C)** All staff have been educated on L680 Protection of information CFR(s) 418.104(C) and policy 06.02.01 Patient Confidentiality & 06.03.01 HIPAA Breach. 2. How are you going to prevent the deficiency from recurring in the future, even if already corrected? Daily, during office hours, the medical room and workstations will be audited to ensure patient records are safeguarded. Monitoring will include is the medical record room locked, are there records outside of the metal cabinets, is there any patient information left in an unsecured are or visible to those walking by the workstations? Monitoring will continue until the QAPI committee determines deficiency is corrected. 3. Who is going to be responsible for numbers 1 and 2- The Executive Director, Patient care manager or designee is responsible for correcting the deficiency. 4. By what date are you going to have the deficiency corrected? September 18, 2020	
L 0682 Bldg. 00	418.104(e)(1) DISCHARGE OR TRANSFER OF CARE (1) If the care of a patient is transferred to another Medicare/Medicaid-certified facility, the hospice must forward, to the receiving			

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	facility, a copy of- (i) The hospice discharge summary; and (ii) The patient's clinical record, if requested. Based on record review and interview, the agency failed to forward the receiving facility a copy of the hospice discharge summary after a patient's transfer to another facility in 1 of 6 closed records reviewed. (#4) The findings include: Review of an agency policy dated 4/1/14 titled "Discharge Summary" stated, "... If the care of a patient is transferred to another Medicare/Medicaid-certified facility, Hospice will forward, to the receiving facility; a copy of: The Hospice discharge summary...." Review of an agency document titled "Patient Distribution for the period 01-01-2018 through 06-23-2020" on 6/23/2020 evidenced patient #4 was discharged from the agency. Clinical record review on 6/25/2020 for patient #4 evidenced an agency document titled "Charts/Clinical Notes" dated 1/29/19 completed by employee A which indicated the patient was transferred to another hospice agency effective 1/29/19. Clinical record review failed to evidence a discharge summary. During an interview on 6/26/2020 at 11:05 a.m., employee B indicated the discharge summary was not completed and did not have a signature. During an interview on 6/29/2020 at 11:05 a.m., employee A indicated she did not believe the discharge summary was printed and there was not a signed copy. Employee A indicated she was unsure how the receiving agency could receive a	L 0682	L682 **What is the deficiency? L682 Discharge or transfer of care CFR(s): 418.104(e)(1) If the care of the patient is transferred to another Medicare/Medicaid-certified facility, the hospice must forward, to the receiving facility, a copy of (i) hospice discharge summary(ii) The patients clinical record if requested.** 1. How are you going to correct the deficiency? **What is the deficiency? L682 Discharge or transfer of care CFR(s): 418.104(e)(1)** All nursing staff and office staff will be educated on L682 Discharge or transfer of care CFR(s): 418.104(e)(1) and policies 9.27.1 Transfer referral criteria, 9.28.01 Discharge criteria, and 9.29.01 Discharge Summary. 2. How are you going to prevent the deficiency from recurring in the future, even if already corrected? 100% of patients that are transferred to another hospice will have monitoring for discharge summaries printed with verification that it was faxed to the receiving hospice. Monitoring will continue until the QAPI committee determines deficiency is corrected.	09/18/2020

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	151544	A. BUILDING 00 B. WING	06/29/2020

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	copy of the discharge summary since one was not printed.		3. Who is going to be responsible for numbers 1 and 2- The Executive Director, Patient care manager or designee is responsible for correcting the deficiency. 4. By what date are you going to have the deficiency corrected? September 18, 2020	
L 0692 Bldg. 00	418.106(d) ADMINISTRATION OF DRUGS AND BIOLOGICALS (1) The interdisciplinary group, as part of the review of the plan of care, must determine the ability of the patient and/or family to safely self-administer drugs and biologicals to the patient in his or her home. (2) Patients receiving care in a hospice that provides inpatient care directly in its own facility may only be administered medications by the following individuals: (i) A licensed nurse, physician, or other health care professional in accordance with their scope of practice and State law; (ii) An employee who has completed a State-approved training program in medication administration; and (iii) The patient, upon approval by the interdisciplinary group.			
	Based on record review and interview, the hospice agency failed to ensure the patient plan of care was updated to include the capability of the patient caregiver to safely administer patient medications, in 1 of 6 discharged clinical records reviewed, out of a total of 10 clinical records reviewed. (#1) The findings include:	L 0692	L692 **What is the deficiency? L692 Biologicals CFR(s): 418.106(d)(1) The interdisciplinary group, as part of the review of the plan of care, must determine the ability of the patient and/or family to safely self administer drugs and biologicals to the patient in his or her home.**	09/18/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	151544	A. BUILDING 00 B. WING	06/29/2020

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	The agency policy with a revised date of December 17, 2014, policy number 08.10.01, titled "Medication Disposal" stated "... Policy Hospice will educate patient/family/caregiver on policy and procedures for the management and disposal of controlled drugs in the patient's home. Purpose To define appropriate management and disposal of controlled substances. ... Procedure 1. At the time when controlled drugs are first ordered, Hospice will: Provide a copy of the Hospice written policies and procedures on the management and disposal of controlled drugs to the patient or patient representative and/or family. Discuss the Hospice policies and procedures for managing the safe use and disposal of controlled drugs with the patient or representative and the family in a language and manner that they understand to ensure that these parties are educated regarding the safe use and disposal of controlled drugs. Document in the patient's clinical record that the written policies and procedures for managing controlled drugs was provided and discussed. 2. Hospice's medication management and disposal policies include: Storage: ... Keep all medications out of reach of children and/or persons with altered mental status. ... Consider using a locked box to store controlled medications to prevent these medications from being stolen or taken by anyone other than the patient...." The agency policy dated April 1, 2014, policy number 08.19.01, titled "Medication Reconciliation" stated "... Policy Hospice will reconcile patient's medications at time of admission and on an ongoing basis. ... Procedure ... 3. The RN [registered nurse] or LPN [licensed practical nurse/ LVN [licensed vocational nurse] reviews the medications with the patient at each visit to ensure understanding of medication use.		**(2)Patients receiving care in a hospice that provides inpatient care directly in its own facility may only be administered medication by the following individuals(i) A licensed nurse, physician, or other health care professional in accordance with their scope of practice and state law(ii)An employee who has completed a State-approved training program in medication administration and (iii)The patient upon approval by the interdisciplinary team.** 1. How are you going to correct the deficiency? All nursing staff will be educated on L692 Biologicals CFR(s): 418.106(d)(1), policies 8.10.01 Medication Disposal, 8.19.01 Medication Reconciliation, 8.15.01 Response to Adverse Drug Reactions and Medication Errors, 8.12.01 Medication Administration, 9.15.01 Plan for patient and family education. 2. How are you going to prevent the deficiency from recurring in the future, even if already corrected? 100% of all current/ active HOME patients will be audited to determine competency for administration of medications and management of controlled substances. 100% of all newly admitted HOME patients (OR if the person responsible for administering medications is	

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	151544	A. BUILDING 00 B. WING	06/29/2020

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	The review includes; side effects, storage and administration of all medications. This review is documented on appropriate form or in Allscripts EMR [electronic medical record] system under the medication tab...." The agency policy dated April 1, 2014, policy number 08.15.01, titled "Response to Adverse Drug Reactions and Medication Errors" stated "... Policy Hospice will respond appropriately to actual or potential adverse drug reactions and medication errors. ... 1. Medication errors are to be reported immediately to the patient's physician and Director/Manager of Patient Services. All medication errors require the completion of a variance/incident report. 2. Adverse drug reaction and medication error reporting will be compiled and analyzed quarterly through QAPI [quality assessment performance improvement] program." The agency policy with a revised date of December 30, 2015, policy number 08.12.01, titled "Medication Administration" stated "... Purpose To ensure that physician's orders are followed and that medications are administered safely and accurately to the correct patient. ... 5. Staff will check all patient medicines to identify possible ineffective drug therapy or adverse reactions, significant side effects, drug allergies and contraindicated medication and report any problems to the physician. Patients will be assessed and reassessed on an ongoing basis for medication effectiveness and actual or potential drug related problems. Staff will use information from medication monitoring to assess the medication's continued administration and will communicate medication findings to patient's physician, IDG [interdisciplinary group] and other appropriate staff. ... 8. In the event of a		identified through has changed) will be audited to determine competency for administration of medications and controlled substances. This monitoring will continue until the QAPI committee determines deficiency is corrected. 3. Who is going to be responsible for numbers 1 and 2- The Executive Director, Patient care manager or designee is responsible for correcting the deficiency. 4. By what date are you going to have the deficiency corrected? September 18, 2020	

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	151544	A. BUILDING 00 B. WING	06/29/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HARBOR LIGHT HOSPICE	1229 ARROWHEAD COURT CROWN POINT, IN 46307

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	medication error or adverse drug reaction, the patient's physician is to be notified immediately. ... 11. The patient and family will be educated about potential adverse reactions and any other concerns. 12. Any unresolved, significant concerns about medications will be discussed by the nurse with the patient's physician and appropriate staff. ... 14. The IDG, as a part of the review of the plan of care, will determine initially and ongoing the ability of the patient/family/caregiver to safely self-administer drugs and biologicals to the patient in his/her home. The individualized IDG plan of care must identify if patient/family/caregiver and self administering drugs and biologicals. If the patient/family/caregiver is not capable of safely administering drugs and biologicals in the home, the issue will be addressed in the IDG care plan...." Clinical record review on 6/26/20 for patient #1, start of care 5/9/19, evidenced an agency document titled "Medication Status" which indicated the medication order for the patient. The patient medication list included (but was not limited to): Percocet [narcotic pain killer] By Mouth 10-325 mg [milligram] 1 tablet every 4 hours as needed, start date 4/19/19; Comfort Kit placed in home, started 5/16/19; Morphine Sulfate [narcotic pain reliever] By Mouth Solution 20mg / ml [milliliter] 5 - 10 milligram every 2 hours as needed by mouth or sublingual [under tongue], started 5/16/19; Ativan Injection Solution 2mg/ ml 0.5 - 1 milligram every 2 hours as needed by mouth or sublingual, started 5/16/19; Xanax [for anxiety] By Mouth tablet 0.5mg 1 tablet three times a day, start date 5/14/19; and Dilaudid [narcotic pain killer] By Mouth tablet 2mg 1-2 tablet every 4 hours as needed, started 5/10/19.			

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	151544	A. BUILDING 00 B. WING	06/29/2020

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	Clinical record review evidenced an agency document titled "... Initial Visit - on 05-09-2019" dated 5/10/19 and electronically signed by employee K. This document indicated the patient caregiver managed medications appropriately and refills were needed for Xanax [for anxiety] and Percocet [narcotic pain reliever]. This document also indicated that verbal medication instructions were given to the patient and patient caregiver and medications were reconciled without issue and there were no dosage errors. Clinical record review evidenced an agency document titled "Charts/Clinical Notes" dated 5/10/19 and electronically signed by employee L. This document stated "... During the last hospital stay she was receiving percocet alternating with dilaudid which was working well for the pain, 5 days ago she ran out of percocet and began giving dilaudid 2mg 14 - 16 x a day and was depleating [sic] the dilaudid...." The medication order indicated the medication of dilaudid should not have been given over 6 times daily. There was no evidence the skilled nurse educated the patient/patient caregiver on the medication error or evidence that the primary physician was notified of the excess administration of dilaudid. Clinical record review evidenced an agency document titled "... Routine Visit - on 05-10-2019" dated and electronically signed by employee L on 5/10/19. This document indicated the patient had pain and needed ongoing education and reinforcement of pain regimen. The document indicated the family/patient caregiver needed ongoing education and reinforcement of pain regimen. The document indicated the patient caregiver managed the medications appropriately, that refills were needed for percocet and dilaudid, the patient caregiver needed reinforcement for			

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	medication education, and the medications were reconciled without issue. Clinical record review evidenced an agency document titled "Charts/Clinical Notes" with one entry dated 5/10/19 and electronically signed by employee L. This entry stated "... She said pt [patient] is out of Percocet but has deluded, call to admission nurse to check on status. ... Percocet was called to Enclara along with Xanax, asked dr staff to call in 3 days supply to local [name of pharmacy], I will p/u [pick up] and take for my visit." Clinical record review evidenced an agency document titled "... Routine visit - on 05-13-2019" dated and electronically signed by employee L on 5/13/19. This document indicated the patient needed ongoing education and reinforcement of pain regimen, the family/pcg [patient/caregiver] needed ongoing education and reinforcement of pain regimen, pain reported by patient caregiver and patient was unable to provide details. This document indicated the patient caregiver managed the medications appropriately, education was provided on percocet, dilaudid dosages and a schedule was set up. This document indicated the medications were reconciled without issue and the patient caregiver demonstrated understanding by verbalization, and needed reinforcement. Clinical record review evidenced an agency document titled "Charts/Clinical Notes" with an entry dated 5/13/19 and electronically signed by employee L. This document stated "... [Person G] , DIL [daughter in law] had been giving percocet 2 tablets at a time when the order is 1 tab 10/325mg q [every] 4 hrs [hours], and is written on the med bottle is 1 tab. Noted that in her writing down the meds when she had a 8 hr lapse in pain			

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	medication, and another time lapse. She said that she was getting confused. I set up a form for her to give alternating pain meds of percocet and dilaudid q 2 hrs until she is comfortable. ... Narcotics were counted. ... Pt is having pain in her abdomen, lower left chest, lungs are clear but diminished in all lobes. She is alternating percocet with dilaudid, DIL says the pain seems to be increasing quickly...." Clinical record review evidenced an agency document titled "... Oncall/Unscheduled visit - on 05-14-2019" dated and electronically signed by employee L on 5/14/19. This document indicated the pain was well controlled with the current Plan of Care, patient needed ongoing education and reinforcement of pain regimen, family/pcg needed ongoing education and reinforcement of pain regimen, the DIL main caregiver was given a form adjusted for her abilities to understand, she needed reinforcement and additional teaching for better control of the patient's pain. The document indicated the physician was not contacted, the patient caregiver managed medications appropriately, they were reeducated on percocet and dilaudid administration schedule, the patient caregiver demonstrated understanding by verbalization and the patient and patient caregiver needed reinforcement, the medication was reconciled without issue and the skilled nurse reinforced giving pain medication. Clinical record review evidenced an agency document titled "Charts/Clinical Notes" with an entry dated and signed by employee L on 5/14/19. This entry stated "... Contacted [physician name] for Changes in meds: Started Ambien [sleep aid] 5 mg q hs [bedtime] insomnia, ... Changed Xanax 0.5 mg from BID [twice daily] to TID [three times daily], increase in her anxiety, over use of pain			

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	medication for security. ... Prn [as needed] visit due to pain control, educating main caregiver [person G] on how to give meds for good pain control, needed more direction due to giving wrong doses. We set up a schedule that she can understand. She has the sign out sheets but writes both meds on that sheet to know what she gave last and when she could give again, also educated on not waking her to give her medication...." Clinical record review evidenced an agency document titled "... Routine visit - on 05-15-2019" dated and electronically signed by employee J on 5/15/19. This document indicated the patient caregiver managed mediations appropriately, the patient was unable to manage medications, medications were reconciled without issue, and there were no dosage errors. Clinical record review evidenced an agency document titled "Charts/Clinical Notes" with an entry signed by employee M, timed 08:01:30a with an effective date of 5/15/19. This document stated "... Triage received call from pt's [patients] daughter in law, [person G], stating that the pt has been very lethargic today. Pt is now unresponsive with her head hanging back, mouth wide open. Pt will not open her eyes. [Person G] states that now that the pt's mouth is open, she noted that she did not swallow any of her PM medications, as they are still in her mouth...." Clinical record review evidenced an interdisciplinary group note titled "Charts/Clinical Notes" dated 5/15/19 and electronically signed by employee L. This document indicated she was attempting to adjust pain meds for comfort, that their was continuous teaching on pain meds with the primary caregiver, [person G], and that the			

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	patient seemed to be using pain medicine for anxiety periods as comfort. There was no evidence of any change to the patient's care plan. Clinical record review evidenced an agency document titled "... Oncall/Unscheduled visit - on 05-16-2019" dated and electronically signed by employee N on 5/16/19. This document indicated the patient was lethargic, the patient caregiver manages medications appropriately, the medications were reconciled without issue, and there were no dosage errors. Clinical record review evidenced an agency document titled "Charts/Clinical Notes" which had an entry dated 5/16/19 electronically signed by employee N. This entry stated "... [Person G] said her pills were still in her mouth due to she held them in mouth but she got them out. Left mouth swabs. ... Asked if there is a comfort kit in fridge and they said no but we have been told it will come by fed ex. Hospice nurse [employee N] looked in Enclara and no comfort kit has been shipped or profiled. Clinical record review evidenced an agency document titled "... Oncall/Unscheduled visit - on 05-16-2019" dated and electronically signed by employee O on 5/16/19. This document indicated patient caregiver manages medications appropriately, taught about comfort kit briefly, patient caregiver needs reinforcement, medications reconciled without issue, and no dosage errors. Clinical record review evidenced an agency document titled "Charts/Clinical Notes" with an entry dated 5/16/19 electronically signed by employee O. This document stated "... Family asking which meds can be crushed or to change			

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	delivery. Talked with Enclara pharmacist who states Ambien, Xanax, dilaudid, fleconide, remoron [sic], Percocet can be crushed, recommend dc [discontinue] iron, family in agreement, not recommended to crush ... In talking with [person G], she does not feel pt gets any of her meds on a reg [regular] basis at this time due to swallowing difficulty. She was unsure of what to do at this time and wants to talk over with other family and let [employee L] know tomorrow. Comfort kit was ordered ... might arrive by Saturday. Clinical record review evidenced an agency document titled "... Oncall/Unscheduled visit - on 05-17-2019" dated and electronically signed by employee L on 5/17/19. This document indicated pain was well controlled with current plan of care, patient needs ongoing education and reinforcement of pain regimen, family/pcg needed ongoing education and reinforcement of pain regimen, changes necessary, daughter in law was adjusting medications as they spoke about today and to see nurses notes. This document indicated the physician was not contacted that the patient caregiver managed medications appropriately, re-education was done on the use of percocet, dilaudid, xanax to reduce use of pain medication, verbal instructions were given to patient caregiver and patient caregiver demonstrated understanding by verbalization, patient caregiver needed reinforcement, and medications were reconciled without issue. Clinical record review evidenced an agency document titled "Charts/Clinical Notes" with an entry dated and electronically signed by employee L on 5/17/19. This document stated "... 2. All narcotics sheets have been filled out, counted, and education of use of narcotics and			

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	documenting them. [Person G] and I are working on reducing pain mediation and managing her anxiety better. ... 4. Supporting [person G] who is managing the medications and pt's care. Roxanol [morphine - narcotic pain killer] was ordered for local pharmacy so family would have it/they are aware. ... Spoke with [person G] about give [sic] a pain me every 4 hours, give 1 percocet or 1-2 dilaudid, and use 1/2 Xanax for anxiety ([person G] said that the Xanax makes her sleepy so we are trying to reduce with good effect) more scheduled during the day. ... Lock box was dropped off, RNCM [registered nurse case manager] has the second key. Comfort pak to come Saturday, family is aware to refrigerate when it come/under lock [sic]." Clinical record review evidenced an agency document titled "... Routine visit - on 05-20-2019" dated and electronically signed by employee L on 5/20/19. This document indicated the patient caregiver managed medications appropriately, refills were needed and will be delivered, no medications were taught this visit, and medications were reconciled without issue. Clinical record review evidenced an agency document titled "Charts/Clinical Notes" with an entry dated and electronically signed by employee L on 5/20/19. This entry stated "... 1. Several meds were ordered today. [Person G] continued to give pt the max of pain med that she could have, resulting in decreased amt [amount] of percocet and dilaudid. ... She continues to take percocet 10/325 and 2 hours later alternating meds, dilaudid 2mg 2 tabs, Xanax 0.5 bid, ambien at night to help sleep. ... Pt has some unusual behaviors, moves around room during the nights, mild confusion, hx [history] of strong drug use (addicted ?). Continue to teach about medication			

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	to [person G], timing, usage. Narcotic counts at each visit." Clinical record review evidenced an agency document titled "... Routine visit - on 05-23-2019" dated and electronically signed by employee J on 5/23/19. This document indicated no physician contact was required, person G stated things have been going well and pain regimen of alternating dilaudid and percocet had been effective using the maximum amount available, count of narcotics was attempted, 12 dilaudid tablets remained, an attempt was made to reorder from Enclara, script had been sent for 180 tablets and 90 were sent but no refills remained. The document indicated percocet counted tablets were of 2 different shapes and many of the tablets were soiled and imprints were unreadable, person G was unable to find the morphine concentrate bottle, person G was educated on utilizing the as needed medications only when asked for by the patient, all medications had been signed out at maximum dosages and minimum amount of time since being delivered. This document indicated that the patient caregiver managed medications appropriately, patient was unable to manage medications, refill needed for hydromorphone [narcotic pain medication], no medications were taught, medications were reconciled without issue, and there were no dosage errors. Clinical record review evidenced an agency document titled "... Oncall/Unscheduled visit - on 05-25-2019" dated and electronically signed by employee P on 5/26/19. This document indicated the patient caregiver managed medications appropriately, the use of haldol [for anxiety] was taught, the patient caregiver demonstrated understanding by verbalization, and medications were reconciled without an issue.			

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	Clinical record review evidenced an agency document titled "Charts/Clinical Notes" with an entry dated and electronically signed by employee P on 5/26/19. This document stated "... Family unable to located liquid Ativan during this writer's narcotic count; DIL [person G] stated other than the morphine, they only had one bottle of liquid, pointing to Haldol in comfort kit. Family maintains Ativan is not in the refrigerator. ... Pt is not in need of additional anxiolytics at this time, and 5 Ativan half-tabs remain in lock box from comfort kit. Family re-educated on safety/fall risk with end of life symptoms, medication use and narcotic logs, with understanding verbalized...." Clinical record review evidenced an agency document titled "... Oncall/Unscheduled visit - on 05-26-2019" dated and electronically signed by employee Q on 5/26/19. This document indicated no physician contact was required, the patient caregiver managed the medications appropriately, there is a history of substance abuse in the home, verbal and written instructions were given to the patient caregiver and the caregiver needed reinforcement, medications were reconciled and problems were identified, and there was no dosage errors. Clinical record review evidenced an agency document titled "Charts/Clinical Notes" with an entry dated and electronically signed by employee Q on 5/26/19. This document stated "... Numerous family members present and each arguing over the other. Med count was done and numerous doses were not recorded. Per daughter-in-law patient rec'd [received] Percocet, 2 Tabs q3*. Last dose recorded was Saturday @ 5:00 p.m. until Sunday afternoon at 3:00. Pt's. Youngest son was present and unbeknownst to			

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	daughter-in-law and this writer was eavesdropping on most of the conversation. He followed this writer outside and began asking numerous questions and sharing his anger regarding the rest of the family. This writer encouraged him to discuss situation with his family as this writer could offer him no more information, He became angrier and stated "everyone in the house needs to be drug tested and arrested for stealing meds from my dying mother".Again he was encouraged to talk to his family as this writer was unable to help him...." Clinical record review evidenced the patient expired on 5/27/19. Clinical record review failed to evidence the plan of care was ever updated to include the patient's difficulty swallowing, the medication education and administration concerns, and the numerous prn visits made due to pain and neurological concerns. During an interview on 6/26/20 at 3:51 p.m., employee G indicated if the daughter in law was found to be incompetent with administering medications they would notify the whole team, social worker and doctor. Employee G also indicated that she did not see anything in the clinical notes the agency administrator was notified of medication concerns. During an interview on 6/26/20 at 4:06 p.m., employee G indicated that the physician was notified, but it was not clarified if the physician was notified of the patient's medication issues or difficulty swallowing. During an interview on 6/26/20 at 4:09 p.m., employee G indicated when bottles of patient's			

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	morphine and ativan come up missing this should be reported to the physician and a care plan meeting should be set up.			