STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	151567	A. BUILDING 00 B. WING	04/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FAMILY HOSPICE & PALLIATIVE CARE	108 SOUTH JEFFERSON STREET BERNE, IN 46711

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. 00	An Emergency Preparedness Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 418.113 [Hospice]. Survey Date: April 30, 2018 Facility Number: 010212 Provider Number: 151567 Census = 416 At this Emergency Preparedness survey, Family Hospice & Palliative Care was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 418.113.	E 0000		
L 0000 Bldg. 00	This was a federal hospice recertification, state relicensure, and complaint investigation survey. Complaint #: IN00219498; Unsubstantiated, lack of sufficient evidence. Unrelated finding was cited. Survey dates: April 18, 19, 20, 23, 24, 25, 26, and 30, 2018 Facility Number: 010212 Medicaid Number: not applicable Census: 416 active patients	L 0000		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	151567	A. BUILDING 00 B. WING	04/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FAMILY HOSPICE & PALLIATIVE CARE	108 SOUTH JEFFERSON STREET BERNE, IN 46711

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Sample: 13			
L 0539 Bldg. 00	418.56(a)(1) APPROACH TO SERVICE DELIVERY (1) The hospice must designate an interdisciplinary group or groups composed of individuals who work together to meet the physical, medical, psychosocial, emotional, and spiritual needs of the hospice patients and families facing terminal illness and bereavement. Interdisciplinary group members must provide the care and services offered by the hospice, and the group, in its entirety, must supervise the care and services. Based on record review and interview, the Interdisclipinary Group failed to ensure volunteer services was provided for 1 of 13 clinical records reviewed. (# 4) Findings include 1. Clinical record # 4 was reviewed on 4/26/18 and contained a plan of care for certification beginning 2/12/18, with orders for a volunteer to make 1 visit as of 2/15/18. The record evidenced a SN (skilled nursing) clinical note which indicated the patient's spouse requested a volunteer to help cover some hours in May and was told it may be difficult but the nurse would notify the volunteer coordinator. 2. The email from Registered Nurse (RN), employee W, to the volunteer coordinator was dated 3/29/18. The response back to the RN from the volunteer coordinator was at 2:39 PM and stated "Right now there is no one. VO [volunteer name] and [other volunteer name] patient loads are full. [Name of third volunteer] will not do	L 0539	L539 Upon notification during the survey on 4/30/18, the Volunteer Coordinator began to copy and paste her collaborative communication emails with the interdisciplinary team into the clinical records concerning arrangement of volunteer services. The President/CEO re-addressed on 5/23/18 with the interdisciplinary teams the regulatory requirement to review during IDT patient and/or family's request for volunteer services and to ensure that the plan of care reflects disciplines' ordered. RN Case Manager will continue to obtain a physician order for any changes in visit frequencies with patient/family involvement. Volunteer Coordinator will begin on 5/30/18 to complete a volunteer status note for IDT that will provide review of visit frequency, visit	07/30/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	151567	A. BUILDING 00 B. WING	04/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FAMILY HOSPICE & PALLIATIVE CARE	108 SOUTH JEFFERSON STREET BERNE, IN 46711

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	patient care needs. That is all that we have available." 3. During interview on 4/30/18 at 11:33 AM, employee C stated the volunteer coordinator indicated she had notified the nurse of her inability to find coverage for the request.		updates, upcoming visit status, and/or need for IDT assistance for volunteer coverage. 100% of the clinical records will be reviewed by 6/15/18 to ensure total compliance. If clinical records not in total compliance, re-education and clinical record review at 100% will continue to occur monthly until total compliance is achieved. If 100% compliant, 10% of the average daily census will be used to determine the number of clinical records that will be audited quarterly through the remainder of 2018 for evidence demonstrating collaborative documentation and volunteer visits per physician visit frequency orders. The QI Coordinator will be responsible for ensuring the completion of these quality reviews. The Hospice Director will be responsible for monitoring these corrective actions to ensure that this deficiency in corrected by 7/30/18 and will not recur.	
L 0550 Bldg. 00	418.56(c)(5) CONTENT OF PLAN OF CARE [The plan of care must include all services necessary for the palliation and management of the terminal illness and related conditions, including the following:] (5) Medical supplies and appliances necessary to meet the needs of the patient. Based on observation, record review, and	L 0550	L550 The patient's plan of care was modified by Hospice Care	07/30/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	151567	A. BUILDING 00 B. WING	04/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FAMILY HOSPICE & PALLIATIVE CARE	108 SOUTH JEFFERSON STREET BERNE, IN 46711

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	interview, the hospice failed to ensure all durable medical equipment (DME) needed by the patient was included on the plan of care for 1 of 3 home visit observations. (# 2) Findings include 1. The hospice's policy titled "Plan of care-Content," # FH-PCTS-46, revised 11/2017, stated "2. The plan of care includes, but is not limited to: ... E. Medical supplies and appliances necessary to meet the needs of the patient." 2. The clinical record for patient # 2 was reviewed on 4/24/18 and contained a plan of care dated 3/2/18 with the following DME listed: Trilogy machine, shower chair, electric wheelchair, and bedside commode. During a home visit with patient # 2 on 4/20/18 at 11:00 AM, the following DME were observed in the home: toilet riser and hoyer lift. The plan of care failed to evidence these DME. During this time, the patient stated they do not use the hoyer lift yet as there was not enough room in the house, but they did have the toilet riser for awhile. 3. During interview on 4/30/18 at 11:50 AM, the family care coordinator stated they needed to add the toilet riser and hoyer lift to the plan of care.		Director on 4/30/18 to include the missing durable medical equipment (toilet seat riser) onto the plan of care. The Hospice Care Director reviewed the requirement that all durable medical equipment needed by the patient will be included in the plan of care at the nurses' meeting on 5/9-10/18. 100% of the clinical records will be reviewed by 6/15/18 to ensure total compliance. If clinical records not in total compliance, re-education and clinical record review at 100% will continue to occur monthly until total compliance is achieved. If 100% compliant, 10% of the average daily census will be used to determine the number of clinical records that will be audited quarterly through the remainder of 2018 for evidence demonstrating that all durable medical equipment is included in the patient's plan of care. The QI Coordinator will be responsible for ensuring the completion of these quality reviews. The Hospice Director will be responsible for monitoring these corrective actions to ensure that this deficiency in corrected by 7/30/18 and will not recur.	
L 0555	418.56(e)(2) COORDINATION OF SERVICES			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	151567	A. BUILDING 00 B. WING	04/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FAMILY HOSPICE & PALLIATIVE CARE	108 SOUTH JEFFERSON STREET BERNE, IN 46711

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
Bldg. 00	[The hospice must develop and maintain a system of communication and integration, in accordance with the hospice's own policies and procedures, to-] (2) Ensure that the care and services are provided in accordance with the plan of care. Based on record review and interview, the hospice failed to ensure all visits were completed as ordered on the plan of care for 2 of 13 clinical records reviewed. (# 5 and 8) Findings include 1. The hospice's policy titled "Physician Orders," # FLC-PCTS-32, revised 11/2017, stated "3. Verbal orders are obtained from the physician or nurse practitioner in order to provide the following: ... B. Change in visit frequency if not within the range specified in the patient's plan of care; ... 4. documentation of receipt of the verbal order and of the written order sent to the physician for signature ate maintained in the patient's clinical record." 2. Clinical record # 5, start of care date 4/13/18, was reviewed on 4/26/18 and contained a plan of care with orders for Chaplain 1 time a month for 1 month on 4/14/18. The record failed to evidence the Chaplain completed the visit as evidenced by: During interview on 4/30/18 at 10:08 AM, employee C stated the chaplain missed the visit due to being off and when he came back, he only had 1 day to complete the visit so it was missed. 3. Clinical record # 8, start of care date 4/17/18, was reviewed on 4/26/18 and contained a plan of care with orders for Aide (HA) 2-3 times a week for 13 weeks on 4/17/18. The first HA visit was	L 0555	L555 Transitional Care Coordinator re-addressed on 4.30.18 with Chaplain the importance of maintaining compliance with physician-ordered visit frequencies. President/CEO informed Supportive Care Supervisor on 5/23/18 to immediately monitor compliance of Chaplain visits in relation to physician visit frequency order. President/CEO modified process as follows: aides will email (within our secured network) notification to RN Case Manager and to Aide Supervisor, RN of missed visit when there is no ability to make up visit during service week. After collaboration with patient/caregiver, RN Case Manager will initiate physician verbal order for visit frequency change. Notification of procedure change to nursing staff occurred on 5/25/18. 100% of the clinical records will be reviewed by 6/15/18 to ensure total compliance. If clinical records not in total compliance, re-education and clinical record review at 100% will continue to occur monthly until total compliance is achieved. If 100% compliant, 10% of the average	07/30/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	151567	A. BUILDING 00 B. WING	04/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FAMILY HOSPICE & PALLIATIVE CARE	108 SOUTH JEFFERSON STREET BERNE, IN 46711

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	not conducted until 4/23/18. The record failed to evidence HA services had been provided for the week of 4/17- 4/21/18. During interview on 4/26/18 at 1:55 PM, employee C stated it was a missed visit and the aide coordinator could not find a reason why the aide did not provided services the first week. 4. During interview on 4/30/18 at 1:55 PM, the administrator stated if a visit could not be made, they try to make it up during the same week and if it could not be done, they would need to notify the physician.		daily census will be used to determine the number of clinical records that will be audited quarterly through the remainder of 2018 for evidence demonstrating that the chaplain and aide visits are consistent with physician visit frequency orders. The QI Coordinator will be responsible for ensuring the completion of these quality reviews. The Hospice Director will be responsible for monitoring these corrective actions to ensure that this deficiency in corrected by 7/30/18 and will not recur.	
L 0579 Bldg. 00	418.60(a) PREVENTION The hospice must follow accepted standards of practice to prevent the transmission of infections and communicable diseases, including the use of standard precautions. Based on observation, record review and interview, the hospice failed to ensure all staff followed infection control policies and procedures for 1 of 3 home visit observations. (#2) Findings include 1. The hospice's policy titled "Hand Hygiene," # FLC-IPC-10, revised 11/08, stated "POLICY: ... To ensure the prevention and control of infections and communicable diseases, all employees will perform appropriate hand hygiene. ... Procedure: ... 7. Upon removal of gloves or other personal protective equipment, the employee will perform appropriate hand hygiene. 8. If re-gloving is	L 0579	L579 Aide Supervisor, RN re-instructed employee Y on hand hygiene upon re-gloving and prior to perineal area cleansing on 4/21/18. Employee Y is at 100% compliance. Aide Supervisor, RN will re-address with all aides the need to perform appropriate hand hygiene upon re-gloving and prior to perineal area cleansing to reduce the risk of infections by 5/25/18. Aide Supervisor, RN will make home visits two (2) per month beginning 5/10/18 for calendar	05/25/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	151567	A. BUILDING 00 B. WING	04/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FAMILY HOSPICE & PALLIATIVE CARE	108 SOUTH JEFFERSON STREET BERNE, IN 46711

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	necessary, perform appropriate hand hygiene before applying new gloves." 2. During home visit with patient # 2 on 4/20/18 at 11:00 AM, hospice aide (HA), employee Y, was observed providing a shower for the patient. Employee Y had donned clean gloves and washed the patient's upper torso, legs and feet. Employee Y obtained a clean wash cloth and proceeded to wash the patient's perineal area. Employee Y failed to change gloves after washing the patient's body and prior to proceeding to wash the patient's perineal area. 3. During interview on 4/30/18 at 11:30 AM, the family care coordinator stated the aid should have changed gloves prior to washing the perineal area.		year 2018 to ensure compliance with Hand Hygiene policy and re-train any aide who is not compliant. Hospice Director reviewed the hand hygiene policy and procedure at the nurses' meeting on 5/9-10/18. All staff were trained on 8/29-30/17 concerning hand hygiene at the annual Perk Day, which will continue annually. Will increase review of hand hygiene procedure with clinical staff from twice a year to quarterly. Hospice Director will be responsible for ensuring that these corrective actions are followed-through.	
L 0629 Bldg. 00	418.76(h)(1)(i) SUPERVISION OF HOSPICE AIDES (I) A registered nurse must make an on-site visit to the patient's home: (i) No less frequently than every 14 days to assess the quality of care and services provided by the hospice aide and to ensure that services ordered by the hospice interdisciplinary group meet the patient's needs. The hospice aide does not have to be present during this visit. Based on record review and interview, the hospice failed to ensure hospice aide (HA) supervisory visits were conducted every 14 days for 3 of 9 clinical records reviewed receiving HA services. (# 4, 7, and 9)	L 0629	L629 The Hospice Director re-instructed the RN Case Managers in the 5/9-10/18 nurse's meeting on the importance of being compliant with completing the aide supervisory visits no less than every 14 days per federal	07/30/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	151567	A. BUILDING 00 B. WING	04/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FAMILY HOSPICE & PALLIATIVE CARE	108 SOUTH JEFFERSON STREET BERNE, IN 46711

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Findings include 1. The hospice's policy titled "Aide Supervision," # FLC-HRM-04, dated 2/19/15 stated "2. A registered nurse will make an Aide Supervisory Visit ... A. If patient is on hospice ... the RN Case Manger or designee will conduct the Aide Supervisory Visit no greater than every 14 calendar days." 2. Clinical record # 4 was reviewed on 4/26/18 and contained a plan of care for certification beginning 2/12/18, with orders for skilled nurse (SN) 1-2 times a week for 13 weeks and HA 2-3 times a week for 13 weeks. The record failed to evidence HA supervisory visits were conducted every 14 days as evidened by: The HA services began on 2/14/18, but the spouse kept refusing visits until 2/26/18. The first HA supervisory visit was conducted on 3/5/18, and not again until 3/23/18; 18 days later. 3. Clinical record # 7 was reviewed on 4/26/18 and contained a plan of care for certification beginning 1/27/18, with orders for SN 1 time a week for 13 weeks and HA 1 time a week for 13 weeks. The record failed to evidence HA supervisory visits were conducted every 14 days as evidened by: A. The Routine SN visit dated 3/6/18 stated "(Supervisory Visit)" at the top of the form. The section titled "Supervision" failed to evidence the RN completed the supervisory visit and stated "Aide Supervision: No." B. The record evidenced a HA supervisory visit was conducted on 2/17/18 ad not again until 3/20/18; 21 days later.		regulations. 100% of the clinical records will be reviewed by 6/15/18 to ensure total compliance. If clinical records not in total compliance, re-education and clinical record review at 100% will continue to occur monthly until total compliance is achieved. If 100% compliant, 10% of the average daily census will be used to determine the number of clinical records that will be audited quarterly through the remainder of 2018 for evidence demonstrating that the aide supervisory visits were completed no less than every 14 days. The QI Coordinator will be responsible for ensuring the completion of these quality reviews. The Hospice Director will be responsible for monitoring these corrective actions to ensure that this deficiency in corrected by 7/30/18 and will not recur.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	151567	A. BUILDING 00 B. WING	04/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FAMILY HOSPICE & PALLIATIVE CARE	108 SOUTH JEFFERSON STREET BERNE, IN 46711

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	C. During interview on 4/26/18 at 11:35 AM, employee C stated the interdisciplinary note dated 3/21 said SN and social work visits only, and did not include the Aides. 4. Clinical record # 9 was reviewed on 4/26/18 and contained a plan of care for certification beginning 4/12/13, with orders for SN 1 time a week for 9 weeks and HA 2-3 times a week for 9 weeks. The record failed to evidence HA supervisory visits were conducted every 14 days as evidened by: A. The record evidenced a HA supervisory visit was conducted on 3/13/18 ad not again until 3/28/18; 15 days later. B. During interview on 4/26/18 at 1:10 PM, employee C stated he did not see any other supervision in the record. 5. During interview on 4/26/18 at 11:14 AM, employee C stated aide supervisory visits should be every 2 weeks.			
L 0672 Bldg. 00	418.104(a)(1) CONTENT Each patient's record must include the following: (1) The initial plan of care, updated plans of care, initial assessment, comprehensive assessment, updated comprehensive assessments, and clinical notes. Based on record review and interview the hospice failed to ensure documentation of collaboration of services was in the record for 1 of 13 clinical records reviewed. (# 4) Findings include	L 0672	L672 Upon notification during the survey on 4/30/18, the Volunteer Coordinator began to copy and paste her collaborative communication emails with the interdisciplinary team into the clinical record concerning	07/30/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	151567	A. BUILDING 00 B. WING	04/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FAMILY HOSPICE & PALLIATIVE CARE	108 SOUTH JEFFERSON STREET BERNE, IN 46711

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	1. Clinical record # 4 was reviewed on 4/26/18 and contained a plan of care for certification beginning 2/12/18, with orders for a volunteer to make 1 visit as of 2/15/18. The record evidenced a SN (skilled nursing) clinical note which indicated the patient's spouse requested a volunteer to help cover some hours in May and was told it may be difficult but the nurse would notify the volunteer coordinator. The response from the volunteer coordinator failed to be documented in the record as evidenced by: 2. The email from Registered Nurse (RN), employee W, to the volunteer coordinator was dated 3/29/18. The response back to the RN from the volunteer coordinator was at 2:39 PM and stated "Right now there is no one. VO [volunteer name] and [other volunteer name] patient loads are full. [Name of third volunteer] will not do patient care needs. That is all that we have available." 3. During interview on 4/30/18 at 11:33 AM, employee C stated the volunteer coordinator said she did notify the nurse that she was not able to find coverage for the request, but she did not document anything about it in the record.		arrangement of volunteer services. 100% of the clinical records will be reviewed by 6/15/18 to ensure total compliance. If clinical records not in total compliance, re-education and clinical record review at 100% will continue to occur monthly until total compliance is achieved. If 100% compliant, 10% of the average daily census will be used to determine the number of clinical records that will be audited quarterly through the remainder of 2018 for evidence demonstrating collaborative documentation per regulation. The QI Coordinator will be responsible for ensuring the completion of these quality reviews. The Quality Improvement Coordinator will be responsible for monitoring these corrective actions to ensure that this deficiency in corrected by 7/30/18 and will not recur.	
L 0677 Bldg. 00	418.104(a)(6) CONTENT [Each patient's record must include the following:] (6) Any advance directives as described in §418.52(a)(2). Based on record review and interview, the hospice failed to ensure documentation was placed in the correct record for 1 of 2 patients with similar names. (# 6 and 14)	L 0677	L677 As of mid-year 2017, the clinical records department was consolidated to one department at the main office to reduce errors and to enhance regulatory	06/05/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	151567	A. BUILDING 00 B. WING	04/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FAMILY HOSPICE & PALLIATIVE CARE	108 SOUTH JEFFERSON STREET BERNE, IN 46711

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Findings include 1. The hospice's policy titled "Clinical Records," # FLC-RCTS-01, revised 08/17, stated "Policy: ... 5. Each patient's clinical record includes, at a minimum, the following: ... F. Any wishes for advance directives and/or copies of advance directives (if applicable)." 2. The clinical record for patient # 6 was reviewed on 4/18/18. Start of care date was 5/26/15 with a diagnosis of congestive heart failure. Within the binder and paper portion of the record, was a copy of a Living Will dated 10/6/95 and a copy of an Appointment of Health Care Representative document dated 3/21/14. These two documents failed to evidence they belonged to patient # 6. 3. The Living Will and Appointment of Health Care Representative documents both evidenced the patient's first and last names were the same for patient # 6 and 14. The Living Will evidenced a middle initial, and the Appointment of Health Care Representative evidenced a middle name. 4. Clinical record # 6 failed to evidence the patient had a middle name. Clinical record # 6 evidenced the patient had 1 child. The record failed to evidence the patient had an adult child of the opposite gender as listed on the Appointment of Health Care Representative. 5. During interview on 4/26/18 at 10:04 AM, the adult child of patient # 14 called back and verified the birth date of their family member and stated the patient had lived in an assisted living facility in a separate town than patient # 6's address. 6. During interview on 4/30/18 at 10:15 AM, the		compliance. On 4/26/18, re-educated Medical Records staff of the importance of ensuring the proper placement of the correct patient's documentation in the correct patient's chart. A new process will be implemented on 5/29/18, for "Like Names." A colored sticker will be placed on the outside of the paper chart spine to alert people that this patient has a "like name" with another patient. Incoming documentation will be double-checked prior to filing the chart as follows: a stamp will be created to include two signatures and dates; one reviewer will place documentation in chart, sign, and date; and second reviewer will ensure proper placement is in correct patient chart, sign, date and file chart away. As of 6/5/18, 100% of the clinical records were reviewed to ensure that there were no misfiled advanced directives in patient's clinical records and there were no misfiled advanced directive. If clinical records not in total compliance, re-education and clinical record review at 100% will continue to occur monthly until total compliance is achieved. 100% of the clinical records of similar named patients were reviewed on 6/4/18 for all documentation placement and there were no misfiling of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	151567	A. BUILDING 00 B. WING	04/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FAMILY HOSPICE & PALLIATIVE CARE	108 SOUTH JEFFERSON STREET BERNE, IN 46711

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	administrator stated she found patient #14 in the system, patient #14 went by their middle name, so the paperwork was in the wrong record.		documentation in incorrect patient clinical charts. 100% of the clinical records for "Like Name" patients will be audited quarterly through 2018 for evidence that all forms are located in the correct patient's clinical record. The QI Coordinator will be responsible for ensuring the completion of these quality reviews. The Quality Improvement Coordinator will be responsible for monitoring these corrective actions to ensure that this deficiency in corrected and will not recur.	
L 0678 Bldg. 00	418.104(a)(7) CONTENT [Each patient's record must include the following:] (7) Physician orders. Based on record review and interview, the hospice failed to ensure orders for discontinuing Aide (HA) services were written and in the record for 1 of 9 records reviewed receiving HA services. (# 7) Findings include 1. The hospice's policy titled "Physician Orders," # FLC-PCTS-32, revised 11/2017, stated "3. Verbal orders are obtained from the physician or nurse practitioner in order to provide the following ... B. Change in visit frequency if not within the range specified in the patient's plan of care ... 4.	L 0678	L678 President/CEO modified process as follows: aides will email (within our secured network) notification to RN Case Manager and to Aide Supervisor, RN of missed visit when there is no ability to make up visit during service week. After collaboration with patient/caregiver, RN Case Manager will initiate physician verbal order for visit frequency change. Notification of procedure change to nursing staff occurred on 5/25/18. 100% of the clinical records will be	07/30/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	151567	A. BUILDING 00 B. WING	04/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FAMILY HOSPICE & PALLIATIVE CARE	108 SOUTH JEFFERSON STREET BERNE, IN 46711

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	documentation of receipt of the verbal order and of the written order sent to the physician for signature ate maintained in the patient's clinical record." 2. Clinical record # 7 was reviewed on 4/26/18 and contained a plan of care for certification beginning 1/27/18, with orders for skilled nurse (SN) 1 time a week for 13 weeks and HA 1 time a week for 13 weeks. The record failed to evidence an order was written to discontinue HA services. 3. The SN visit note dated 3/20/18, evidenced the patient's family requested to discontinue the aide services as of Sunday 3/18/18, and stated "Aide Supervision ... [family member] states that AID talks too much about how this visit is the only one they have and in imposition to their day ... [Family member] states that they want to discontinue AID services on Sunday." 4. During interview on 4/26/18 at 11:35 AM, employee C stated the nurse should have written an order in the system to identify an end date of aide services for patient # 7.		reviewed by 6/15/18 to ensure total compliance. If clinical records not in total compliance, re-education and clinical record review at 100% will continue to occur monthly until total compliance is achieved. If 100% compliant, 10% of the average daily census will be used to determine the number of clinical records that will be audited quarterly through the remainder of 2018 for evidence demonstrating that aide visits are consistent with physician visit frequency orders. The QI Coordinator will be responsible for ensuring the completion of these quality reviews. The Hospice Director will be responsible for monitoring these corrective actions to ensure that this deficiency in corrected by 7/30/18 and will not recur.	
L 0795 Bldg. 00	418.114(d)(1) CRIMINAL BACKGROUND CHECKS The hospice must obtain a criminal background check on all hospice employees who have direct patient contact or access to patient records. Hospice contracts must require that all contracted entities obtain criminal background checks on contracted employees who have direct patient contact or access to patient records. Based on record review and interview, the hospice failed to ensure it obtained criminal background check results on all staff prior to providing patient	L 0795	L795 The Employee E's Criminal Background Check was completed on 7/29/14 (uploaded for documentation evidence).	06/04/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	151567	A. BUILDING 00 B. WING	04/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FAMILY HOSPICE & PALLIATIVE CARE	108 SOUTH JEFFERSON STREET BERNE, IN 46711

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	care for 1 of 10 employee files reviewed. (E) Findings include 1. The hospice's policy titled "Criminal Background Checks," # FLC-HR-09, revised 9/17 stated "1. All employees who have access to patients and/ or access to patient records will have a criminal background check in accordance with state requirements." 2. Employee files were reviewed on 4/30/18. Employee file E, Licensed Practical Nurse (LPN) evidenced a hire date of 7/21/14 and first patient's contact date of 8/15/14. The Indiana State Police Criminal History Information form evidenced it was completed on 7/21/14. The file failed to evidence criminal background check results. 3. During interview on 4/30/18 at 12:05 PM, employee Z stated the hospice started getting results online and this employee has been here awhile.		Unfortunately, during the survey visit the criminal background check form was removed from Employee E's personnel file to be uploaded for a partnering hospital's security access login. After the survey on 5/4/18, the folder that held the personnel paperwork for the security access upload was filed in the employee's personnel files and HR Director rechecked files to ensure all documentation was complete. Implemented a process on 5/21/18, so when personnel documents are removed from the individual employee's file a place holder indicating what was removed will be placed in the personnel file until the document is returned. On 6/4/18, the HR Director reviewed all employee personnel files: 95 hospice employees and 18 home care employees. Each employee's personnel record had their criminal history check in their file.	