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	151569	A. BUILDING _____ B. WING _____	04/22/2019

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E 000	Initial Comments An Emergency Preparedness Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 418.113. Survey Dates: April 15, 16, 17, 18, and 22, 2019 Facility #: 010652 Provider #: 151569 Census: 0 Unduplicated admissions: 23 At this Emergency Preparedness survey, Spencer County Hospice was found not in compliance with Emergency Preparedness Requirements for Medicare Participating Providers and Suppliers, 42 CFR 418.18 for Hospices.	E 000		
E 001	Establishment of the Emergency Program (EP) CFR(s): 418.113 The [facility, except for Transplant Center] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section.* The emergency preparedness program must include, but not be limited to, the following elements: *[For hospitals at §482.15:] The hospital must comply with all applicable Federal, State, and local emergency preparedness requirements. The hospital must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this	E 001		

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

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E 001	Continued From page 1 section, utilizing an all-hazards approach. *[For CAHs at §485.625:] The CAH must comply with all applicable Federal, State, and local emergency preparedness requirements. The CAH must develop and maintain a comprehensive emergency preparedness program, utilizing an all-hazards approach. This CONDITION is not met as evidenced by: Based on record review and interview, the agency failed to ensure the comprehensive emergency preparedness program met all requirements to meet the health, safety, and security needs of their staff and patient population for 1 of 1 agency (E0001); the agency failed to develop and implement emergency preparedness policies and procedures for 1 of 1 agency (E0013); the agency failed to ensure the Emergency Preparedness communication plan was reviewed and updated at least annually for 1 of 1 agency (E0029). The cumulative effect of these systemic problems resulted in the hospice's inability to be in compliance the Condition of Participation 418.113 Establishment of the Emergency Program for Hospices.	E 001		
E 013	Development of EP Policies and Procedures CFR(s): 418.113(b) (b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.	E 013		

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E 013	Continued From page 2 *Additional Requirements for PACE and ESRD Facilities: *[For PACE at §460.84(b):] Policies and procedures. The PACE organization must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must address management of medical and nonmedical emergencies, including, but not limited to: Fire; equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. The policies and procedures must be reviewed and updated at least annually. *[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area. This STANDARD is not met as evidenced by: Based on record review and interview, the agency failed to develop and implement emergency preparedness policies and	E 013		

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E 013	Continued From page 3 procedures for 1 of 1 agency. Findings include: During a review on 4/18/19 at 11:24, the emergency preparedness binder was reviewed and lacked policies and procedures related to emergency preparedness. During an interview on 4/18/19 at 2:00 p.m., the Administrator indicated they felt the binder itself was a policy and no separate policies and procedures were developed.	E 013		
E 029	Development of Communication Plan CFR(s): 418.113(c) (c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually. This STANDARD is not met as evidenced by: Based on record review and interview, the agency failed to ensure the Emergency Preparedness communication plan was reviewed and updated at least annually for 1 of 1 agency. Findings include: During a review on 4/18/19 at 11:24 a.m., the Emergency Preparedness Binder was reviewed and lacked evidence of it being reviewed and updated at least annually. During a review on 4/22/19 at 11:30 a.m., the Emergency Preparedness Binder was reviewed for any updates and indicated the following:	E 029		

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E 029	Continued From page 4 The Spencer County Hospice Staff Phone List indicated Former Employee V as the social worker. The current Social Worker, Employee A, start date was 11/19/18, was not included in the phone list. The Phone List indicated Former Employee W as the Volunteer Coordinator. The current Volunteer Coordinator, Employee H, start date was 3/12/18, was not included in the phone list. The EMA Director in Warrick County was listed as Non-Employee X. Non-employee Y is currently the Warrick County EMA Director and took the position in July 2017. A review of the Emergency Preparedness Binder, the tabletop exercise had a document on the front, dated 11/28/18, which indicated, "Interdisciplinary Team Meeting Roster for Update to Comprehensive Assessment and Plan of Care For the Following Patients:" with the following written on the copy in blue ink, "Emergency Prep Table Top & Policy Review." During an interview on 4/22/19 at 10:15 a.m., the Administrator indicated they would review the Emergency Preparedness program when they would conduct their yearly tabletop exercises.	E 029		
L 000	INITIAL COMMENTS This survey was for a Federal recertification and State relicensure survey for hospice. Survey Dates: April 15, 16, 17, 18, and 22 of 2019 Facility Number: 010652	L 000		

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L 000	Continued From page 5 Provider Number: 151569 Census = 0 active patients / 23 unduplicated admissions Home visits 0/ Record reviews 8 Spencer County Hospice was found out of compliance with Conditions of Participation 42 CFR 418.54 Initial and Comprehensive Assessment and 42 CFR 418.56 Interdisicplinary Group, Care Planning and Coordination of Services. Revised 06/06/2019.	L 000		
L 509	EXERCISE OF RIGHTS/RESPECT FOR PROPRTY/PERSON CFR(s): 418.52(b)(4)(ii) [The hospice must:] (ii) Immediately investigate all alleged violations involving anyone furnishing services on behalf of the hospice and immediately take action to prevent further potential violations while the alleged violation is being verified. Investigations and/or documentation of all alleged violations must be conducted in accordance with established procedures; This STANDARD is not met as evidenced by: Based on record review and interview, the agency failed to ensure an investigation was completed for a patient who had missing narcotics for 1 of 1 patient reviewed who had missing medication. (Patient 3)	L 509		

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L 509	Continued From page 6 Findings include: An undated policy, titled, "Abuse, Neglect, Mistreatment and Exploitation," was provided by the Administrator on 4/18/19 at 1:47 p.m. The policy indicated, but was not limited to, "Spencer County Hospice follows all Federal and State requirements regarding alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source and misappropriation of patient property by anyone providing services on behalf of the hospice." An undated policy, titled, "Adverse Events," was provided by the Administrator on 4/18/19 at 1:47 p.m. The policy indicated, but was not limited to, "Any event that deviates from accepted practice ... 2. Examples of reportable incidents include, but are not limited to: ... g. problems related to the safe use and handling of narcotics. The incident report must be accurately completed on the standardized incident reporting form as soon as feasible and submitted to the employee's immediate supervisor. The reporting employee's supervisor or designee is responsible for immediate follow-up and corrective action as appropriate to the adverse event. Documentation of all follow-up and corrective action is completed with the original incident report and submitted to and maintained by the Clinical Director." During a record review on 4/6/19 at 11:00 a.m., Patient 3's clinical record included a handwritten letter written by the Administrator which indicated it was given to the Rockport City Police. The letter indicated Patient 3 had a sealed 30 ml (milliliter) bottle of Roxanol (a narcotic) 20 mg (milligram)/ml which could not be located in the	L 509		

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L 509	Continued From page 7 home. During a review, the Incident Log/ Binder lacked an incident report or investigation of Patient 3's missing narcotic. During an interview on 4/16/19 at 2:25 p.m., the Administrator indicated he/she noticed the missing Roxanol and had it replaced in the home. The Administrator indicated there had been a lot of private caregivers in and out of the home during that time. The Administrator notified the local police department, but did not complete an incident report or further investigation.	L 509		
L 520	INITIAL & COMPREHENSIVE ASSESSMENT OF PATIENT CFR(s): 418.54 This CONDITION is not met as evidenced by: Based on record review and interview, the hospice agency failed to ensure skilled nursing completed a comprehensive review of all the patient's medications for identification of effectiveness of drug therapy, drug side effects, actual or potential drug interactions, duplicate drug therapy or drugs currently associated with laboratory monitoring (see L530); failed to take a failed to assess the patient's termperature, failed to ensure skilled nursing appropriately assessed a patient when there were changes in condition, failed to take a temperature during assessments, failed to appropriately identifed wounds, and failed to ensure the updated comprehensive assessment included specific measurements of wounds, the specifics on how wound care was being provided, and the patient's tolerance to wound care. (See L533)	L 520		

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L 520	Continued From page 8 The cumulative effect of these systemic problems resulted in the hospice's inability to be in compliance the Condition of Participation 418.54: Initial and Comprehensive Assessment of Patient.	L 520		
L 530	CONTENT OF COMPREHENSIVE ASSESSMENT CFR(s): 418.54(c)(6) [The comprehensive assessment must take into consideration the following factors:] (6) Drug profile. A review of all of the patient's prescription and over-the-counter drugs, herbal remedies and other alternative treatments that could affect drug therapy. This includes, but is not limited to, identification of the following: (i) Effectiveness of drug therapy (ii) Drug side effects (iii) Actual or potential drug interactions (iv) Duplicate drug therapy (v) Drug therapy currently associated with laboratory monitoring. This STANDARD is not met as evidenced by: Based on record review, the hospice failed to provide documentation that they completed a comprehensive review of all the patient's medications for identification of effectiveness of drug therapy, drug side effects, actual or potential drug interactions, duplicate drug therapy, or drugs currently associated with laboratory monitoring for 8 of 8 records reviewed. (Patients 1, 2, 3, 4, 5, 6, 7, 8) Findings Include:	L 530		

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L 530	Continued From page 9	L 530		

1. An undated policy titled, "Medication Profile" was provided by the Administrator on 4/18/19 at 2 p.m. The policy indicated, but was not limited to, "A patient-specific medication profile is maintained for each patient and reviewed, at a minimum every fifteen days. 1. When a patient is admitted to hospice, a medication profile is initiated to document all of the patient's prescription and over-the-counter drugs, herbal remedies and other alternate treatments that could affect drug therapy. 2. The patient's medication profile is reviewed by the IDG whenever there is a significant change and at a minimum every fifteen days."

1. Clinical record #1 was reviewed on 4/15/19 at 11:08 a.m., and failed to evidence documentation that the agency conducted a comprehensive drug review.

2. Clinical record #2 was reviewed on 4/15/19 at 2:14 p.m., and failed to evidence documentation that the agency conducted a comprehensive drug review.

3. Clinical record #3 was reviewed on 4/16/19 at 11:00 a.m., and failed to evidence documentation that the agency conducted a comprehensive drug review.

4. Clinical record #4 was reviewed on 4/17/19 at 9:34 a.m., and failed to evidence documentation that the agency conducted a comprehensive drug review.

5. Clinical record #5 was reviewed 4/15/19 at 11:00 a.m., and failed to evidence documentation that the agency conducted a comprehensive drug review.

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L 530	Continued From page 10 6. Clinical record #6 was reviewed 4/17/19 at 10:00 a.m., and failed to evidence documentation that the agency conducted a comprehensive drug review. 7. Clinical record #7 was reviewed 4/18/19 at 1 p.m.,and failed to evidence documentation that the agency conducted a comprehensive drug review. 8. Clinical record #8 was reviewed 4/18/19 at 2:03 p.m., and failed to evidence documentation that the agency conducted a comprehensive drug review. 9. During an interview on 4/17/19 at 11:30 a.m., the Administrator was unable to provide evidence that the hospice completed a medication review as part of the comprehensive assessment for patients 1-8, except a letter dated 4/17/19 from a pharmacy indicated they (pharmacy) conducted a comprehensive drug review and their system fenerated ptential medication side effects along with patient education information, that would be printed on a receipt.	L 530		
L 533	UPDATE OF COMPREHENSIVE ASSESSMENT CFR(s): 418.54(d) The update of the comprehensive assessment must be accomplished by the hospice interdisciplinary group (in collaboration with the individual's attending physician, if any) and must consider changes that have taken place since the initial assessment. It must include information on the patient's progress toward desired outcomes, as well as a reassessment of the patient's response to care. The assessment update must	L 533		

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be accomplished as frequently as the condition of the patient requires, but no less frequently than every 15 days.

This STANDARD is not met as evidenced by:
Based on record review and interview, the agency failed to take a failed to assess the patient's termperature, for 4 of 8 records reviewed (Patient 1, 4, 5, 6), failed to ensure skilled nursing appropriately assessed a patient when there were changes in condition, failed to appropriately identifed wounds and failed to ensure the updated comprehensive assessment included specific measurements of wounds, the specifics on how wound care was being provided, and the patient's tolerance to wound care for 1 of 3 patient with skin integumentary issues. (Patient 5)

Findings include:

1. An undated policy titled, "Comprehensive Assessment of the Patient", was provided by the Administrator on 4/18/19 at 2 p.m The policy indicated, but was not limited to "The hospice IDG conducts and documents a patient-specific comprehensive assessment that identifies the patient's need for hospice care, including medical, nursing ..."

2. An undated policy titled, "Standards of Practice", was provided by the Administrator on 4/18/19 at 2 p.m. The policy indicated, but was not limited to "... provides care and services according to accepted standards of practice and State and Federal laws and regulations ... 2. All care is provided according to the patient's plan of care established by the hospice IDG ..."

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3. An article dated, January 2019, by the CDC, titled, "Urinary Tract Infection (Catheter-Associated Urinary Tract Infection [CAUTI] and Non-Catheter-Associated Urinary Tract Infection [UTI]) and Other Urinary System Infection [USI]) Events" states, "Fever is a non-specific symptom of infection and cannot be excluded from UTI determination because it is clinically deemed due to another recognized cause."
https://www.cdc.gov/nhsn/pdfs/pscmanual/7psccauticurrent.pdf

4. The clinical record of patient #5, election date 12/11/17, benefit period of 12/11/17 to 3/10/18, was reviewed on 4/16/19. The patient's diagnosis was Alzheimer's. The skilled nurse failed to evidence clear wound measurements and accurate identification of wounds as indicated by the following:

The Hospice Nursing Visit/ Assessment Update Note for 12/15/17 indicated a 3 cm Stage 1 pressure area to the patient's right buttock that was red and non-blanchable. This note failed to indicate if the measurement was 3 cm in diagmeter, 3 cm in height or 3 cm in width.

The Hospice Nursing Visit/ Assessment Update Note for 1/3/18 indicated a 2 x 2 cm Stage 2 pressure area to the patient's right buttock with a black wound bed. This not assessment was not accurate as black wound beds are considered unstageable.

The Hospice Nursing Visit/ Assessment Update Note for 1/14/18 indicated a 2 cm x 2.5 cm unstageable pressure ulcer to the patient's

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sacrum with a black wound bed and red surrounding skin. This failed to indicate if the 2.5 cm was heighth or width.

The record included documentation on 1/29/18 that a low air bed/mattress was on order and initiated on 1/31/18, 47 days after a Stage 1 pressure ulcer was identified. The skilled nurse failed to put measures in place on 12/15/17 to prevent further deterioration of the patient's right buttock wound.

Review of the clinical record for the benefit period of 12/6/18 to 2/3/19 (benefit period 6), the skilled nurse failed to provide wound measurements to assess the patient's progress, specifically document how the treatments were provided, the patient's tolerance to treatments, and failed to include a temperature upon the assessment as evidenced by the following:

The Hospice Nursing Visit/ Assessment Update Note for 1/14/19 indicated the patient had 3 pressure ulcers. The Note lacked measurements (length, width, depth) for all 3 pressure ulcers and specific anatomical locations of each wound (#1 wound unstageable, #2 wound Stage 2, #3 wound Stage 3). The record evidenced the appearance of each of the wound beds as black, excoriated, and pink/yellow slough. The surrounding skin of each wound was described as red or WNL. All wounds were cleaned, dried, and treated with Flagyl and Tegaderm. No temperature recorded.

The Hospice Nursing Visit/ Assessment Update Note for 1/16/19 lacked measurements for all 3 pressure ulcers and specific anatomical locations of each wound (#1 wound unstageable, #2 wound

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Stage 2, #3 wound Stage 3). The record evidenced the appearance of each of the wound beds as black, excoriated, and pink/ yellow slough. The surrounding skin of each wound was described as red or WNL. The record indicated that Tegaderm, Flagyl [changed] to #1 and #3 and that Tegaderm was intact to #2 wound. The summary of visit note states, " ... Skin breakdown on buttocks increasing in spite of treatment & turning." No temperature recorded.

The Hospice Nursing Visit/ Assessment Update Note for 1/18/19 lacked measurements for all 3 pressure ulcers and specific anatomical locations of each wound (#1 wound Stage 2, #2 wound unstageable, #3 wound unstageable). The record evidenced the appearance of each of the wound beds as (#1) closed/excoriated, (#2) black/ yellow, and (#3) black eschar. The surrounding skin of each wound was described as red or WNL. The record indicated that "wound was cleaned, dried, Flagyl, Tegaderm". The record indicated the patient was regularly incontinent, wears diapers. No temperature recorded.

The Hospice Nursing Visit/ Assessment Update Note for 1/21/19 lacked measurements for all 3 pressure ulcers and specific anatomical locations of each wound (#1 wound Stage 2, #2 wound unstageable, #3 wound Stage 3). The record evidenced the appearance of each of the wound beds as black, excoriated, and pink/yellow slough. The surrounding skin of each wound was described as WNL. The record indicated that Tegaderm was intact to #1 and #2 wounds and that #3 wound was cleaned with wound cleaner and Flagyl cream and Tegaderm applied. The summary of visit note states, " ... seems to have forgotten how to void when he sits her on the

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toilet. We continue to treat multiple wounds ..."
No temperature recorded.

The Hospice Nursing Visit/ Assessment Update Note for 1/23/19 lacked measurements for all 3 pressure ulcers and specific anatomical locations of each wound (#1 wound Stage 2, #2 wound unstageable, #3 wound Stage 3). The record evidenced the appearance of each of the wound beds as excoriated/ closed, yellow/ dark, and eschar. The surrounding skin of each wound was described as WNL or red. The record indicated that "Soiled dressing removed/ disposed of properly, wound cleansed, dried, Flagyl, Tegaderm". No temperature recorded.

The Hospice Nursing Visit/ Assessment Update Note for 1/25/19 lacked measurements for all 3 pressure ulcers and specific anatomical locations of each wound (#1 wound Stage 2, #2 wound unstageable, #3 wound Stage 3). The record evidenced the appearance of each of the wound beds as excoriated/ red, yellow/ pink, and eschar/ dry. The surrounding skin of each wound was described as WNL or red. The record indicated that "#1, #3 Tegaderm intact, wound cleaner, dried, Flagyl cr & Tegaderm to #2". No temperature recorded.

The Hospice Nursing Visit/ Assessment Update Note for 1/28/19 lacked measurements for all 3 pressure ulcers and specific anatomical locations of each wound (#1 wound Stage 2, #2 wound unstageable, #3 wound Stage 3). The record evidenced the appearance of each of the wound beds as red/ dry, excoriated/ black, and pink/ yellow. The surrounding skin of each wound was described as WNL or red. The record indicated that "wound cleanser & Flagyl cr & Tegaderm

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changed - all wounds". The summary of visit note stated that the physician visited for re-certification visit. No temperature recorded.

The Hospice Nursing Visit/ Assessment Update Note for 1/31/19 lacked measurements for all 3 pressure ulcers and specific anatomical locations of each wound (#1 wound Stage 2, #2 wound unstageable, #3 wound unstageable). The record evidenced the appearance of each of the wound beds as excoriated/ superficial, eschar, and slough/ yellow/ red. The surrounding skin of each wound was described as WNL or red. The record indicated that "wound cleaned, dried, Tegaderm with Flagyl". No temperature recorded.

The Hospice Nursing Visit/ Assessment Update Note for 2/4/19 lacked measurements for all 3 pressure ulcers and specific anatomical locations of each wound (#1 wound Stage 2, #2 wound unstageable, #3 wound unstageable). The record evidenced the appearance of each of the wound beds as excoriated/ dry, slough/ red, and eschar. The surrounding skin of each wound was described as WNL or red. The record indicated that "wound cleaned, dried, Tegaderm, Flagyl". No temperature recorded.

The Hospice Nursing Visit/ Assessment Update Note for 2/6/19 lacked measurements for all 3 pressure ulcers and specific anatomical locations of each wound (#1 wound Stage 2, #2 wound Stage 3, #3 wound unstageable). The record evidenced the appearance of each of the wound beds as superficial/red, yellow/pink/black, and eschar. The surrounding skin of each wound was described as WNL or red. The record indicated that "Tegaderm [changed] to all areas Flagyl cr applied". The summary of visit note stated " ...O2

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L 533	Continued From page 17 sat @ 77% on R/A, but no resp distress ...". Patient on Omnicef (antibiotic). No temperature recorded. The Hospice Nursing Visit/ Assessment Update Note for 2/8/19 lacked measurements for all 3 pressure ulcers and specific anatomical locations of each wound (#1 wound Stage 2, #2 wound Stage 3, #3 wound unstageable). The record evidenced the appearance of each of the wound beds as dry/excoriated, black/ slough, and eschar. The surrounding skin of each wound was described as WNL or red. The record indicated that "wound cleansed, dried, Flagyl, Tegaderm". No temperature recorded. The Hospice Nursing Visit/ Assessment Update Note for 2/11/19 lacked measurements for all 3 pressure ulcers and specific anatomical locations of each wound (#1 wound Stage 2, #2 wound Stage 3, #3 wound unstageable). The record evidenced the appearance of each of the wound beds as dry/ excoriated, slough/ yellow/ pink, and eschar. The surrounding skin of each wound was described as red. The record indicated that "Soiled dressing removed/ disposed of properly, wound cleansed with wound cleanser, Flagyl & Tegaderm #2, Tegaderm intact to #1 & #3". The patient's O2 sat was 92% on R/A. No temperature recorded. The Hospice Nursing Visit/ Assessment Update Note for 2/13/19 lacked measurements for all 3 pressure ulcers and specific anatomical locations of each wound (#1 wound Stage 2, #2 wound Stage 3, #3 wound unstageable). The record evidenced the appearance of each of the wound beds as red, pink/ yellow/ black, and eschar. The surrounding skin of each wound was described	L 533		

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as WNL or red. The record indicated that "Soiled dressing removed/ disposed of properly, wounds #2 & #3 Tegaderm removed area cleaned [with] bathfoam. Flagyl & Tegaderm re-applied". The summary visit note states, " ... The large decubitous #2 appears to be getting deeper [with] more necrosis - we continue Flagyl cream & Tegaderm ...". No temperature recorded.

The Hospice Nursing Visit/ Assessment Update Note for 2/15/19 lacked measurements for all 3 pressure ulcers and specific anatomical locations of each wound (#1 wound unstageable, #2 unstageable, #3 wound Stage 2) and failed to specify a skin tear location. The record evidenced the appearance of each of the wound beds as black/ slough, eschar, and excoriated. The skin tear size was 0 (zero) and dry. The surrounding skin of each wound was described as [decrease] red, red or WNL. The record indicated that "Soiled dressing removed/ disposed of properly, wound cleaned (specify)". The summary visit note lacked evidence as to how the skin tear occurred. No temperature recorded.

The Hospice Nursing Visit/ Assessment Update Note for 2/18/19 lacked measurements for all 3 pressure ulcers and specific anatomical locations of each wound (#1 wound unstageable, #2 unstageable, #3 wound Stage 2) and failed to specify an anatomical location of the skin tear. The record evidenced the appearance of each of the wound beds as dry/ excoriated, eschar, and necrotic/ slough. The skin tear size was dry, no measurements recorded. The surrounding skin of each wound was described as WNL and red. The record indicated that "Soiled dressing removed/ disposed of properly, wound cleaned, dried Flagyl Tegaderm". No temperature

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recorded.

The Hospice Nursing Visit/ Assessment Update Note for 2/20/19 lacked measurements for all 3 pressure ulcers and specific anatomical locations of each wound (#1 wound unstageable, #2 unstageable, #3 wound Stage 2) and failed to specify an anatomical location of the skin tear. The record evidenced the appearance of wound #1 was dry excoriated. The record lacked documentation of the appearance of wound bed's #2, #3 and the skin tear. The surrounding skin of each wound was described as WNL and red. The record indicated that "Soiled dressing removed/ disposed of properly, Tegaderm [changed] & Flagyl cr to #3" The record lacked documentation if wounds #1, #2 and the skin tear was cleaned and treated. No temperature recorded.

The Hospice Nursing Visit/ Assessment Update Note for 2/22/19 lacked measurements for all 3 pressure ulcers and specific anatomical locations of each wound (#1 wound unstageable, #2 unstageable, #3 unstageable) and lacked documentation if the skin tear was healed. The record evidenced the appearance of wound #1 was dry excoriated, #2 was necrotic/ slough, #3 was eschar. The surrounding skin of each wound was described as WNL and red. The record indicated that "Soiled dressing removed/ disposed of properly, wound cleansed, dried, Flagyl, Tegaderm".

The Hospice Nursing Visit/ Assessment Update Note for 2/25/19 lacked measurements for all 3 pressure ulcers and specific anatomical locations of each wound (#1 wound Stage 2, #2 unstageable, #3 unstageable). The record evidenced the appearance of wound #1 was dry

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excoriated, #2 was slough/ necrotic, #3 was eschar. The surrounding skin of each wound was described as WNL, red and pink. The record indicated there was thin serosanguinous drainage to #2 and #3 wounds. The record indicated that "Soiled dressing removed/disposed of properly, wound cleansed, dried, Flagyl, Tegaderm" The summary visit note states, " ...Walking better this visit [with] max assist ..."

The Hospice Nursing Visit/ Assessment Update Note for 2/27/19 lacked measurements for all 3 pressure ulcers and specific anatomical locations of each wound (#1 wound Stage 2, #2 unstageable, #3 unstageable). The record evidenced the appearance of wound #1 was dry excoriated, #2 was slough/ necrotic, #3 was eschar. The surrounding skin of each wound was described as WNL and red. The record indicated there was thin serosanguinous drainage to #2 and #3 wounds. The record indicated that "Soiled dressing removed/disposed of properly, wound cleansed, dried, Flagyl, Tegaderm applied"

The Hospice Nursing Visit/ Assessment Update Note for 3/1/19 lacked measurements for all 3 pressure ulcers and specific anatomical locations of each wound (#1 wound Stage 2, #2 unstageable, #3 unstageable). The record evidenced the appearance of wound #1 was dry excoriated, #2 was slough, #3 was necrotic. The surrounding skin of each wound was described as WNL and red/pink. The record indicated there was thin serosanguinous drainage to #2 wound. The record indicated that "Soiled dressing removed/ disposed of properly, wound cleansed, dried, Flagyl, Tegaderm applied" No temperature recorded.

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The Hospice Nursing Visit/ Assessment Update Note for 3/4/19 lacked measurements for all 3 pressure ulcers and specific anatomical locations of each wound (#1 wound Stage 2, #2 unstageable, #3 unstageable). The record evidenced the appearance of wound #1 was dry excoriated, #2 was eschar, #3 was slough/ necrotic. The surrounding skin of each wound was described as WNL and red/ pink. The record indicated there was thin serosanguinous drainage to #3 wound. The record indicated that "Soiled dressing removed/ disposed of properly, wound cleansed, dried, Flagyl, Tegaderm" The summary visit note states, " ...Wounds cont. 0 [zero] improvement ..." No temperature recorded.

The Hospice Nursing Visit/ Assessment Update Note for 3/6/19 lacked measurements for all 3 pressure ulcers and specific anatomical locations of each wound (#1 wound Stage 2, #2 unstageable, #3 Stage 3). The record evidenced the appearance of wound #1 was red, #2 left blank, #3 yellow-pink. The surrounding skin of each wound was described as WNL. The record indicated there was thick serosanguinous drainage to #3 wound. The record indicated that "Soiled dressing removed/disposed of properly, #3 Tegaderm changed - Wound cleansed - Flagyl & Tegaderm re-applied" No temperature recorded.

The Hospice Nursing Visit/ Assessment Update Note for 3/8/19 lacked measurements for all 3 pressure ulcers and specific anatomical locations of each wound (#1 wound Stage 2, #2 unstageable, #3 Stage 3). The record evidenced the appearance of wound #1 was red, #2 eschar, #3 yellow/moist. The surrounding skin of each wound was described as WNL and red. The

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record indicated there was thick serosanguinous drainage to #3 wound. The record indicated that "Soiled dressing removed/disposed of properly, Tegaderm changed - Wound cleansed, Flagyl & Tegaderm re-applied" No temperature recorded.

The Hospice Nursing Visit/ Assessment Update Note for 3/11/19 lacked measurements for all 3 pressure ulcers and specific anatomical locations of each wound (#1 wound Stage 2, #2 unstageable, #3 unstageable). The record evidenced the appearance of wound #1 was dry, #2 slough/necrotic, #3 eschar. The surrounding skin of each wound was described as WNL and pink. The record indicated there was thin serosanguinous drainage to #1 and #2 wound. The record indicated that "Soiled dressing removed/ disposed of properly, Tegaderm changed - Wound cleansed, dried, Flagyl & Tegaderm" No temperature recorded.

The Hospice Nursing Visit/ Assessment Update Note for 3/13/19 lacked measurements for all 3 pressure ulcers and specific anatomical locations of each wound (#1 wound Stage 2, #2 wound Stage 4, #3 unstageable). The record evidenced the appearance of wound #1 "Tegaderm", #2 "intact", #3 yellow/ pink/ slough. Tunneling (destruction of tissue which results in a narrow passageway)/ undermining (erosion of wound edges) for wound #2 "?". The surrounding skin of each wound was described as WNL and pink. The record indicated there was a large amount of thick serosanguinous drainage to #3 wound. The record indicated that "Soiled dressing removed/ disposed of properly, Aloe bath wash, dried, Medihoney gel & alginate & Tegarderm to #2 - #1 & #3 Tegaderm intact" The record failed to measure (probe is gently inserted into the

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passageway until resistance is felt) tunneling/ undermining for wound #2. No temperature recorded.

The Hospice Nursing Visit/ Assessment Update Note for 3/15/19 lacked measurements for all 3 pressure ulcers and specific anatomical locations of each wound (#1 wound Stage 2, #2 wound Stage 4, #3 unstageable). The record evidenced the appearance of wound #1 "necrosis/open/dry", #2 slough/necrosis, #3 eschar. Tunneling/ undermining for wound #2 "?". The surrounding skin of each wound was described as red, pink and WNL. The record indicated there was a large amount of thick serosanguineous drainage to #3 wound. The record indicated that "Soiled dressing removed/disposed of properly, cleansed, dried, skin prep, Medihoney, drsg, Tegaderm" The summary visit note states, " ...Wounds [with] little to 0 [no] improvement - Area to back is worse. New tx. initiated this shift" The record failed to measure tunneling/undermining for wound #2. No temperature recorded.

The Hospice Nursing Visit/ Assessment Update Note for 3/18/19 lacked measurements for all 4 pressure ulcers and specific anatomical locations of each wound (#1 wound Stage 2, #2 wound Stage 1, #3 Stage 4, #4 wound unstageable). The record evidenced the appearance of wound #1 red, #2 red, #3 slough/red/yellow/black and #4 eschar. Tunneling/undermining for wound #2 "?". The surrounding skin of each wound was described as red or WNL. The record indicated there was a large amount of thick serosanguineous drainage to #3 wound. The record indicated that "Wound cleanser Tegaderm [changed] - Medihoney, drsg, #1, #3 -Tegaderm to new area #2" The summary visit note states, "

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L 533	Continued From page 24 ...Wounds [with] little to 0 [no] improvement - Area to back is worse. New tx. initiated this shift" The summary visit note states, " ...we continue to treat decubities with Medihoney alginate drsg - perhaps slight improvement noted of Stage 4 sacral wound." The record evidenced the patient acquired a new pressure injury. The record failed to measure tunneling/undermining for wound #2. No temperature recorded. The Hospice Nursing Visit/ Assessment Update Note for 3/20/19 lacked measurements for all 4 pressure ulcers and specific anatomical locations of each wound (#1 wound Stage 2, #2 wound unstageable, #3 Stage 4). The record evidenced the appearance of wound #1 dry, excoriated, #2 eschar, #3 moist/slough/necrotic. Tunneling/undermining for wound #3 "?". The surrounding skin of each wound was described as WNL or slight red-pink. The record indicated there was a large amount of thick serosanguinous drainage to #3 wound. The record indicated that "Soiled dressing removed/ disposed of properly. Wound cleansed, dried, Medihoney,Tegaderm" The summary visit note states, "Pt continuous [with] wounds. Tx in place. [increase] drainage" No temperature recorded. The record failed to evidence the 4th pressure ulcer was treated or healed and failed to measure tunneling/undermining for wound #3. The Hospice Nursing Visit/ Assessment Update Note for 3/22/19 lacked measurements for all 4 pressure ulcers and specific anatomical locations of each wound (#1 wound unstageable, Stage 2, #2 did not indicate a Stage, #3 wound unstageable, #4 wound Stage 4). The record evidenced the appearance of wound #1 eschar, #2 "intact drsg", #3 "intact drsg" #4 pink, necrotic	L 533		

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edge. Tunneling/ undermining for wound #4 "?". The surrounding skin of each wound was described as WNL or slight red-pink. The record indicated there was a large amount of thin tan drainage to #4 wound. The record indicated that "Soiled dressing removed/disposed of properly. Wound cleansed, dried, Medihoney,Tegaderm" No temperature recorded.

The Hospice Nursing Visit/ Assessment Update Note for 3/25/19 lacked measurements for all 4 pressure ulcers and specific anatomical locations of each wound (#1 wound unstageable, #2 wound Stage 2, #3 wound unstageable, #4 wound Stage 4). The record evidenced the appearance of wound #1 eschar, #2 red, #3 eschar, #4 pink, necrosis. Tunneling/ undermining for wound #4 "?". The surrounding skin of each wound was described as WNL or slight red-pink. The record indicated there was a small amount of thin seroussanguineouslarge drainage #1 and #2 wounds and a large amount of thick seroussangious drainage to #4 wound. The record indicated that "Soiled dressing removed/ disposed of properly. Wound cleansed, dried, Medihoney,Tegaderm" No temperature recorded.

The Hospice Nursing Visit/ Assessment Update Note for 3/27/19 lacked measurements for all 4 pressure ulcers and specific anatomical locations of each wound (#1 wound unstageable, #2 wound Stage 2, #3 wound unstageable, #4 wound Stage 4). The record lacked evidence the appearance of all wounds were assessed. Tunneling/undermining for wound #4 "?". The surrounding skin of each wound was described as WNL or slight red-pink. The record indicated there was a small amount of thin tan drainage #3 and #4 wounds. The record indicated that "Soiled

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dressing removed/ disposed of properly. Wound cleaned [with] wound cleanser, dried, Medihoney,Tegaderm" No temperature recorded.

The Hospice Nursing Visit/ Assessment Update Note for 3/29/19 lacked measurements for all 4 pressure ulcers and specific anatomical locations of each wound (#1 wound unstageable, #2 wound unstageable, #3 wound Stage 4, #4 did not address). The record lacked evidence the appearance of all wounds were assessed. Tunneling/ undermining for wound #4 "?". The surrounding skin of each wound was described as WNL or slight red-pink. The record indicated there was a small amount of thin tan drainage #3 and #4 wounds. The record indicated that "Soiled dressing removed/disposed of properly. Wound cleaned [with] wound cleanser, dried, Medihoney,Tegaderm" The record lacked evidence if #4 wound to [right upper back] was being treated or healed. No temperature recorded. The summary visit note states, " ...pt appears to be actively dying at this time ..."

The Hospice Nursing Visit/ Assessment Update Note for 4/1/19 lacked measurements for all 4 pressure ulcers and specific anatomical locations of each wound. No staging of wounds recorded. Tunneling/ undermining for wound #4 "?". The surrounding skin of each wound was described as WNL or slight red-pink. The record indicated there was a small amount of thin tan drainage #3 and #4 wounds and that wound #4 had an odor. The record indicated that "Soiled dressing removed/disposed of properly. Wound cleansed, Flagyl, Tegaderm" No temperature recorded and unable to obtain a blood pressure. The summary visit note states, "Pt ashen in color, cool to touch, Mottling to toes ... Discomfort noted [with] turning

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on side. Dressings [changed] odor noted. Applied Flagyl ... pt non-responsive ... "

5. The clinical record of patient #6, election date 6/28/18, included an initial plan of care for the benefit period 6/28/19 to 9/25/18, with orders for vital signs per protocol and prn. This record was reviewed on 4/17/19. The patient's diagnosis was Malignant Melanoma right lower leg. The skilled nurse failed to appropirately assess the patient and failed to include a temperature at the following visits when the patient was experiencing pain and mental changes, and when the patient was started on antibiotic therapy as evidenced by the following.:

The Hospice Nursing Visit/ Assessment Update Notes for 7/6, 7/9, 7/13, 7/16 of 2018 lacked documentation that the agency was monitoring patient #6's temperature. On 7/6/18 the record states, "Large tumor on LRE firm, tender, & warm to touch ... Her V/S [vital signs] all WNL [within normal limits]" On 7/16/18 the patient was experiencing pain to he/she's right lower leg site of the melanoma.

The Hospice Nursing Visit/ Assessment Update Notes for 7/18/18 stated that patient #6 was confused at times. No temperature recorded.

The Hospice Nursing Visit/ Assessment Update Notes for 7/19/18 states, "lethargy, confusion, et that patient had been crawling on floor last evening ... [increased] confusion noted. General malaise ... Pt. did report "burning when urination started" et some side pain when questioned r/t [related to] s/s [signs and symptoms]." No temperature recorded.

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The Hospice Nursing Visit/ Assessment Update Notes for 7/20/18 states, "Started today Cipro 500mg 1 [every] 12 hours x 3 [days] " The patient was diagnosed with a UTI (urinary tract infection). The patient had problems remembering and seems more forgetful, slightly confused at times. The patient often stares with a blank look on her face. No temperature recorded.

The Hospice Nursing Visit/ Assessment Update Notes for 7/23/18 failed to indicate the patient's temperature was recorded.

The Hospice Nursing Visit/ Assessment Update Notes for 7/25/18 indicated that patient #6 was started on Pen VK (antibiotic) 500mg 1 BID (twice a day) x 10 [days] for UTI after finishing 3 day treatment of Omnicef (antibiotic).

The Hospice Nursing Visit/ Assessment Update Notes for 7/27/18 indicated the primary care giver reported some confusion at times. Antibiotic therapy continues. No temperature recorded.

The Hospice Nursing Visit/ Assessment Update Notes for 7/30/18 "ice pack applied to tumor site for 20 min intermittently to relieve throbbing pain ... V/S WNL ..." No specific temperature recorded.

The Hospice Nursing Visit/ Assessment Update Notes for 8/1/18 stated that patient #6 reported pain 8/10 (10 worst pain) to leg. No temperature recorded.

The Hospice Nursing Visit/ Assessment Update Notes for 8/3/18 stated that patient #6 had no signs of UTI and had completed the antibiotic. No temperature recorded.

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The Hospice Nursing Visit/ Assessment Update Notes for 8/4/18 stated that patient #6 may have recurrent UTI and that both antibiotics were refilled. Temperature 97.4.

The Hospice Nursing Visit/ Assessment Update Notes for 8/6/18 states, "Patient states has had burning with urination. Antibiotic restarted for UTI." No temperature recorded.

The Hospice Nursing Visit/ Assessment Update Notes for 8/8/18 stated that patient #6 continues with Pen VK and Cipro and that "V/S WNL". No specific temperature recorded.

The Hospice Nursing Visit/ Assessment Update Notes for 8/8/18 failed to indicate the patient's temperature was recorded.

The Hospice Nursing Visit/ Assessment Update Notes for 8/8/18 stated that patient #6 was somewhat confused. Temp 98.6 t.a.

During an interview on 4/17/19 at 2 p.m. the Administrator stated the agency did not routinely measure wounds nor did the agency have a specific wound protocol. stated the agency did not routinely take temperatures on all visits and indicated the nurses could tell by touch if the patient had a fever.At 2:36 p.m. the Administrator provided a copy of the unofficial certificate of death which indicated that patient #5's cause of death was dementia.

6. Patient 1's Clinical Record was reviewed on 4/15/19 at 11:08 a.m. and contained an initial Plan of Treatment for the benefit period of 12/6/18 to 3/6/19, with orders for skilled nursing to assess VS (vital signs) and all body systems, and ADL (Activities of Daily Living). The skilled

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L 533	Continued From page 30 nurse failed to assess the patient's termperature, as evidenced by the following: Patient 1's Initial and Comprehensive Hospice Assessment, dated 12/7/18, failed to evidence documentation of a temperature assessed. Patient 1's Hospice Nursing Visit/ Assessment Update, dated 12/10/18, failed to evidence documentation of a temperature assessed. 7. Patient 4's clinical record was reviewed on 4/17/19 at 9:34 a.m. and contained an initial Plan of Treatment for the benefit period of 5/15/17 to 8/12/17, orders for skilled nursing to assess VS and all body systems. The skilled nurse failed to assess the patient's termperature, as evidenced by the following: Patient 4's Hospice Nursing Visit/ Assessment Updates failed to evidence documentation of a temperature, assessed for 13 of 15 nursing visits during the certification period of 5/15/17 to 8/12/17 - on 5/19/17, 5/22/17, 5/24/17, 5/26/17, 5/31/17, 6/2/17, 6/7/17, 6/19/17, 6/12/17, 6/14/17, 6/16/17, 6/19/17, and 6/21/17.	L 533		
L 536	IDG, CARE PLANNING, COORDINATION OF SERVICES CFR(s): 418.56 This CONDITION is not met as evidenced by: Based on record review and interview, the agency failed to ensure visits were provided, including holidays, as ordered and failed to ensure care were provided per the plan of care (See tag L543); failed to ensure specific measurable outcomes and goals regarding	L 536		

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L 536	Continued From page 31 pressure ulcers were established (See tag L548); failed to ensure the updated plan of care included meausures to be put into place to ensure a patient with skin impairments does not deteriorate, failed to put measures in place to ensure the patient does not develop more wounds, and failed to include the patient's progress toward outcomes and goals regarding skin integumentary issues. (See tag L553). The cumulative effect of these systemic problems resulted in the hospice's inability to be in compliance the Condition of Participation: 42 CFR 418.56 Interdisicplinary Group, Care Planning and Coordination of Services	L 536		
L 543	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 patient's needs if any of them so desire. This STANDARD is not met as evidenced by: Based on record review and interview, the agency failed to ensure visits were provided, including holidays, as ordered and failed to ensure care were provided per the plan of care for 6 of 8 patient records reviewed. (Patients 1, 2, 3, 4, 5, 6) Findings include:	L 543		

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1. An undated policy, titled, "Clinical Records," was provided by the Administrator on 4/18/19 at 1:47 p.m. The policy indicated, but was not limited to, "1. Entries are made in the clinical record for all services provided (both those services provided directly and through contracted providers) in a standardized format and are legible, clear and complete and signed and dated by the person providing the services."

2. An undated policy, titled, "Plan of Care," was provided by the Administrator on 4/18/19 at 1:47 p.m. The policy included, but was not limited to, "1. The patient's plan of care specifies the care and services necessary to meet the needs of the patient/caregiver as identified in the initial, comprehensive, and updated assessments of the patient."

3. Patient 1's Clinical Record was reviewed on 4/15/19 at 11:08 a.m. and contained an initial Plan of Treatment for the benefit period of 12/6/18 to 3/6/19, with orders for skilled nursing to assess VS (vital signs) and all body systems, and ADL (Activities of Daily Living) interventions included to provide hospice nurse personal care, twice weekly.

Patient 1's Initial and Comprehensive Hospice Assessment, dated 12/7/18, lacked documentation of a temperature assessed.

Patient 1's Hospice Nursing Visit/ Assessment Update, dated 12/10/18, lacked documentation of a temperature, weight, and/or mid-arm circumference assessed.

Patient 1's Initial Plan of Care and Updates,

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included "Self-care Deficit Related to Activity Intolerance," dated 12/6/18, with an intervention for the nurse to visit three times a week on Monday, Wednesday, and Friday to provide personal care. Patient 1's visit notes from 12/6/18 to 3/6/19 lacked documentation of specific personal care provided.

4. Patient 2's Clinical Record was reviewed on 4/15/19 at 2:14 p.m. and contained an Initial Plan of Care and Updates, which included "Self-care Deficit Related to Activity Intolerance," dated 5/25/18, with an intervention for the nurse to visit three times a week on Monday, Wednesday, and Friday to provide nursing and personal care.

Patient 2's visit notes from 11/20/18 to 1/18/19 lacked documentation of specific personal care provided.

Patient 2's Clinical Record lacked documentation of a visit, missed visit, and/or order change for visits on Monday 12/24/18 (Christmas Eve), and Monday 12/31/18 (New Year's Eve).

5. Patient 3's Clinical Record was reviewed on 4/6/19 at 11:00 a.m. and contained an Initial Plan of Care and Updates, which included Self-care Deficit Related to Activity Intolerance, dated 4/30/18, with an intervention for the nurse to visit three times a week on Monday, Wednesday, and Friday to provide nursing and personal care.

Patient 3's visit notes from 4/30/18 to 7/28/18 lacked documentation of specific personal care provided.

Patient 3's Clinical Record lacked documentation of a visit, missed visit, and/or order change for

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visits on Monday 12/31/18 (New Year's Eve), Wednesday 1/30/19, Friday 2/1/19, and Monday 2/18/19 (President's Day).

6. Patient 4's Clinical Record was reviewed on 4/17/19 at 9:34 a.m. and contained an initial Plan of Treatment for the benefit period of 5/15/17 to 8/12/17, orders for skilled nursing to assess VS and all body systems, and ADL interventions to provide hospice nurse personal care on Monday and Friday, and Hospice Skilled Nurse care three times weekly on Monday, Wednesday, and Friday.

Patient 4's Hospice Nursing Visit/Assessment Updates lacked documentation of a temperature, weight, and/or mid-arm circumference assessed for 13 of 15 nursing visits during the certification period of 5/15/17 to 8/12/17 - on 5/19/17, 5/22/17, 5/24/17, 5/26/17, 5/31/17, 6/2/17, 6/7/17, 6/19/17, 6/12/17, 6/14/17, 6/16/17, 6/19/17, and 6/21/17, .

Patient 4's Initial Plan of Care and Updates, included Self-care Deficit Related to Activity Intolerance, dated 6/14/1, with an intervention for the nurse to visit two times per week to provide personal care.

Patient 4's visit notes from 5/15/17 to 8/12/17 lacked documentation of specific personal care provided.

Patient 4's Clinical Record lacked documentation of a visit, missed visit, and/or order change for a visit on Monday, 5/29/17 (Memorial Day).
7. The clinical record #5 with an election date of 12/11/17, benefit period 12/11/17 to 3/10/18, was reviewed on 4/15/19. Patient 5's initial "Plan of

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Treatment" contained orders for skilled nursing to assess VS and the "Interventions: a. Vital signs per protocol and prn."

Patient 5's Hospice Nursing Visit/ Assessment Updates failed to evidence documentation of a temperature for on 1/17, 1/19, 1/22, 1/24, 1/26,1/31, 2/2, 2/5, 2/9, 2/16, 2/19, 2/21 of 2018. The patient was on an antibiotic for a wound infection.

8. The clinical record #6 with an election date 6/28/18, benefit period 6/28/19 to 9/25/18, was reviewed on 4/17/19. Patient 6's initial "Plan of Treatment" contained orders for skilled nursing to assess VS and the "Interventions: a. Vital signs per protocol and prn."

Patient 6's Hospice Nursing Visit/ Assessment Updates failed to evidence documentation of a temperature on 7/18, 7/19, 7/20, 7/23, 7/27, 7/30, 8/1, 8/3, 8/6, 8/8 of 2018. The patient was on an antibiotic for a urinary tract infection.

9. During an interview on 4/17/19 at 11:25 a.m., the Administrator indicated the agency does not complete aide care plans for patients, but will be on the plan of care. The administrator indicated when the nursing staff completed personal care visits, they should have documented on their nurses notes in the narrative section. The Administrator indicated a MAC (mid arm circumference) should be done monthly, and they would not routinely check a temperature because they could feel the patient with their hand to know if they were warm. The Administrator indicated if a holiday falls on a Monday, Wednesday, or Friday they will not do routine visits or reschedule. The office is closed on holidays as well and the

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L 543	Continued From page 36 Administrator is on call.	L 543		
L 548	CONTENT OF PLAN OF CARE CFR(s): 418.56(c)(3) [The plan of care must include all services necessary for the palliation and management of the terminal illness and related conditions, including the following:] (3) Measurable outcomes anticipated from implementing and coordinating the plan of care. This STANDARD is not met as evidenced by: Based on record review and interview, the agency failed to ensure specific measurable outcomes and goals regarding pressure ulcers were established for 1 of 3 patients with skin integumentary issues. (Patient 5) Findings include: An undated policy, titled, "Plan of Care," was provided by the Administrator on 4/18/19 at 1:47 p.m. The policy included, but was not limited to, "1. The patient's plan of care specifies the care and services necessary to meet the needs of the patient/caregiver as identified in the initial, comprehensive, and updated assessments of the patient." A 2014 article titled "Prevention and Treatment of Pressure Ulcers: Quick Reference Guide" states, "Pressure Ulcer Assessment 1. Assess the pressure ulcer initially and re-assess it at least weekly... 1. Document the results of all wound assessments ... A two-week period is recommended for evaluating progress toward healing. However, weekly assessments provide	L 548		

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L 548	Continued From page 37 an opportunity for the health professional to assess the ulcer more regularly, detect complications as early as possible, and adjust the treatment plan accordingly." The clinical record of patient #5, Election date 12/11/17, benefit period 12/11/17 to 3/10/18, was reviewed on 4/15/19. The patient's diagnosis was Alzheimer's with a history of sacral decubs. Review of the Initial Plan of Care and Updates for said benefit period stated, "Actual Skin Breakdown/ Pressure Related To:... Goal:... a. Area of breakdown/ pressure will reduce in size/ stage and/or will resolve with interventions. b. Area of breakdown/ pressure will be free of infections." Review of the Hospice Nursing Visit/ Assessment Update Notes from 12/11/17 to 2/9/18 indicated patient 5's wound was measured 3 out of 29 visits. The record lacked consistent measurements each week and indicated the wound was getting worse. The agency failed to set specific measurable goals regarding the patient's wounds. During an interview on 4/17/19 at 2 p.m. the Administrator stated the agency does not routinely measure wounds nor does the agency have a specific wound protocol. The Administrator stated the agency has standing orders for Tegaderm and skin barrier cream upon admission.	L 548		
L 553	REVIEW OF THE PLAN OF CARE CFR(s): 418.56(d) A revised plan of care must include information from the patient's updated comprehensive	L 553		

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assessment and must note the patient's progress toward outcomes and goals specified in the plan of care.

This STANDARD is not met as evidenced by:
Based on record review and interview, the Interdisciplinary Group (IDG) failed to ensure the updated plan of care included meausures to be put into place to ensure a patient with skin impairments does not deteriorate, failed to put measures in place to ensure the patient does not develop more wounds, and failed to include the patient's progress toward outcomes and goals regarding skin integumentary issues for 1 of 3 patient with skin integumentary issues. (Patient 5)

Findings include:

1. An undated policy titled, "Comprehensive Assessment of the Patient", was provided by the Administrator on 4/18/19 at 2 p.m The policy indicated, but was not limited to "The hospice IDG conducts and documents a patient-specific comprehensive assessment that identifies the patient's need for hospice care, including medical, nursing ..."

2. An undated policy titled, "Standards of Practice", was provided by the Administrator on 4/18/19 at 2 p.m. The policy indicated, but was not limited to "... provides care and services according to accepted standards of practice and State and Federal laws and regulations ... 2. All care is provided according to the patient's plan of care established by the hospice IDG ..."

3. The clinical record for patient #5, election date 12/11/17, benefit period 12/11/17 to 3/10/18, was

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reviewed on 4/16/19. The patient's diagnosis was Alzheimer's. The IDG group meeting note failed to be specific and failed to evidence the patient's progress toward an outcome and goal as evidenced by the following:

The Hospice Nursing Visit/ Assessment Update Note for 12/15/17 indicated a 3 cm [centimeters] Stage 1 pressure area to the patient's right buttock that was red and non-blanchable.

The Hospice Nursing Visit/ Assessment Update Note for 1/3/18 indicated a 2 x 2 cm Stage 2 pressure area to the patient's right buttock with a black wound bed. Tegaderm was changed and reapplied.

Review of an IDG meeting note dated 1/10/18 states, "Pt has decubitus sacral area - Tegaderm in use - changing position [every 3-4 hrs]." The note lacked the patient's progress toward an outcome and goal.

The Hospice Nursing Visit/ Assessment Update Note dated 1/14/18 indicated a 2 cm x 2.5 cm unstageable pressure ulcer to the patient's sacrum with a black wound bed and red surrounding skin.

Review of an IDG meeting note dated 1/24/18 states, "Unstageable area cont. to sacral area. Pt [patient] lies side to side between meals Tx. [treatment] cont." The note failed to be specific and failed to evidence the patient's progress toward an outcome and goal. The note also failed to indicate what measures were put into place to ensure no further deterioration of wound and prevention of further skin breakdown.

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The record included documentation on 1/29/18 that a low air bed/ mattress was on order and initiated on 1/31/18, 47 days after a Stage 1 pressure ulcer was identified. The record failed to evidence consistent wound measurements.

Review of an IDG meeting note dated 2/7/18 states, "Recently finished Atb.[antibiotic] Mod. [moderate] odorous drainage. Low air loss mattress in place. T [temperature] cont. [continued] Pt T & R [respiratations] frequently." The note failed to be specific and failed to evidence the patient's progress toward an outcome and goal.

Review of an IDG meeting note dated 1/9//19 states, "Continue c [with] Flagyl cream & Tegaderm to pressure areas - Has developed 3 more areas ..." The IDG group meeting note failed to be specific and failed to evidence the patient's progress toward an outcome and goal as evidenced by the following:

The Hospice Nursing Visit/ Assessment Update Note for 1/14/19 indicated the patient had 3 pressure ulcers. The Note lacked measurements (length, width, depth) for all 3 pressure ulcers and specific anatomical locations of each wound (#1 wound unstageable, #2 wound Stage 2, #3 wound Stage 3). The record evidenced the appearance of each of the wound beds as black, excoriated, and pink/yellow slough. The surrounding skin of each wound was described as red or WNL. All wounds were cleaned, dried, and treated with Flagyl and Tegaderm. No temperature recorded.

The Hospice Nursing Visit/ Assessment Update Note for 1/16/19 lacked measurements for all 3

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pressure ulcers and specific anatomical locations of each wound (#1 wound unstageable, #2 wound Stage 2, #3 wound Stage 3). The record evidenced the appearance of each of the wound beds as black, excoriated, and pink/ yellow slough. The surrounding skin of each wound was described as red or WNL. The record indicated that Tegaderm, Flagyl [changed] to #1 and #3 and that Tegaderm was intact to #2 wound. The summary of visit note states, " ... Skin breakdown on buttocks increasing in spite of treatment & turning." No temperature recorded.

The Hospice Nursing Visit/ Assessment Update Note for 1/18/19 lacked measurements for all 3 pressure ulcers and specific anatomical locations of each wound (#1 wound Stage 2, #2 wound unstageable, #3 wound unstageable). The record evidenced the appearance of each of the wound beds as (#1) closed/ excoriated, (#2) black/ yellow, and (#3) black eschar. The surrounding skin of each wound was described as red or WNL. The record indicated that "wound was cleaned, dried, Flagyl, Tegaderm". The record indicated the patient was regularly incontinent, wears diapers. No temperature recorded.

The Hospice Nursing Visit/ Assessment Update Note for 1/21/19 lacked measurements for all 3 pressure ulcers and specific anatomical locations of each wound (#1 wound Stage 2, #2 wound unstageable, #3 wound Stage 3). The record evidenced the appearance of each of the wound beds as black, excoriated, and pink/ yellow slough. The surrounding skin of each wound was described as WNL. The record indicated that Tegaderm was intact to #1 and #2 wounds and that #3 wound was cleaned with wound cleaner and Flagyl cream and Tegaderm applied. The

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summary of visit note states, " ... seems to have forgotten how to void when he sits her on the toilet. We continue to treat multiple wounds ..." No temperature recorded.

The Hospice Nursing Visit/ Assessment Update Note for 1/23/19 lacked measurements for all 3 pressure ulcers and specific anatomical locations of each wound (#1 wound Stage 2, #2 wound unstageable, #3 wound Stage 3). The record evidenced the appearance of each of the wound beds as excoriated/ closed, yellow/ dark, and eschar. The surrounding skin of each wound was described as WNL or red. The record indicated that "Soiled dressing removed/ disposed of properly, wound cleansed, dried, Flagyl, Tegaderm". No temperature recorded.

Review of an IDG meeting note dated 1/23/19 states, "Has multiple decubii - we continue to treat ..." The IDG group meeting note failed to be specific and failed to evidence the patient's progress toward an outcome and goals.

The Hospice Nursing Visit/ Assessment Update Note for 1/25/19 lacked measurements for all 3 pressure ulcers and specific anatomical locations of each wound (#1 wound Stage 2, #2 wound unstageable, #3 wound Stage 3). The record evidenced the appearance of each of the wound beds as excoriated/ red, yellow/ pink, and eschar/ dry. The surrounding skin of each wound was described as WNL or red. The record indicated that "#1, #3 Tegaderm intact, wound cleaner, dried, Flagyl [cream] & [and] Tegaderm to #2". No temperature recorded.

The Hospice Nursing Visit/ Assessment Update Note for 1/28/19 lacked measurements for all 3

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pressure ulcers and specific anatomical locations of each wound (#1 wound Stage 2, #2 wound unstageable, #3 wound Stage 3). The record evidenced the appearance of each of the wound beds as red/ dry, excoriated/black, and pink/ yellow. The surrounding skin of each wound was described as WNL or red. The record indicated that "wound cleanser & Flagyl cr & Tegaderm changed - all wounds". The summary of visit note stated that the physician visited for re-certification visit. No temperature recorded.

The Hospice Nursing Visit/ Assessment Update Note for 1/31/19 lacked measurements for all 3 pressure ulcers and specific anatomical locations of each wound (#1 wound Stage 2, #2 wound unstageable, #3 wound unstageable). The record evidenced the appearance of each of the wound beds as excoriated/ superficial, eschar, and slough/ yellow/ red. The surrounding skin of each wound was described as WNL or red. The record indicated that "wound cleaned, dried, Tegaderm with Flagyl". No temperature recorded.

The Hospice Nursing Visit/ Assessment Update Note for 2/4/19 lacked measurements for all 3 pressure ulcers and specific anatomical locations of each wound (#1 wound Stage 2, #2 wound unstageable, #3 wound unstageable). The record evidenced the appearance of each of the wound beds as excoriated/ dry, slough/ red, and eschar. The surrounding skin of each wound was described as WNL or red. The record indicated that "wound cleaned, dried, Tegaderm, Flagyl". No temperature recorded.

The Hospice Nursing Visit/ Assessment Update Note for 2/6/19 lacked measurements for all 3 pressure ulcers and specific anatomical locations

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of each wound (#1 wound Stage 2, #2 wound Stage 3, #3 wound unstageable). The record evidenced the appearance of each of the wound beds as superficial/red, yellow/pink/black, and eschar. The surrounding skin of each wound was described as WNL or red. The record indicated that "Tegaderm [changed] to all areas Flagyl cr applied". The summary of visit note stated " ...O2 sat @ 77% on R/A, but no resp distress ...". Patient on Omnicef (antibiotic). No temperature recorded.

Review of the IDG meeting note dated 2/6/19 states, "Pressure areas continue [with] treatment. Atb therapy started r/t wound infection ..." The IDG group meeting note failed to be specific and failed to evidence the patient's progress toward an outcome and goals.

The Hospice Nursing Visit/ Assessment Update Note for 2/8/19 lacked measurements for all 3 pressure ulcers and specific anatomical locations of each wound (#1 wound Stage 2, #2 wound Stage 3, #3 wound unstageable). The record evidenced the appearance of each of the wound beds as dry/ excoriated, black/ slough, and eschar. The surrounding skin of each wound was described as WNL or red. The record indicated that "wound cleansed, dried, Flagyl, Tegaderm". No temperature recorded.

The Hospice Nursing Visit/ Assessment Update Note for 2/11/19 lacked measurements for all 3 pressure ulcers and specific anatomical locations of each wound (#1 wound Stage 2, #2 wound Stage 3, #3 wound unstageable). The record evidenced the appearance of each of the wound beds as dry/ excoriated, slough/yellow/pink, and eschar. The surrounding skin of each wound was

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described as red. The record indicated that "Soiled dressing removed/ disposed of properly, wound cleansed with wound cleanser, Flagyl & Tegaderm #2, Tegaderm intact to #1 & #3". The patient's O2 sat was 92% on R/A. No temperature recorded.

The Hospice Nursing Visit/ Assessment Update Note for 2/13/19 lacked measurements for all 3 pressure ulcers and specific anatomical locations of each wound (#1 wound Stage 2, #2 wound Stage 3, #3 wound unstageable). The record evidenced the appearance of each of the wound beds as red, pink/ yellow/ black, and eschar. The surrounding skin of each wound was described as WNL or red. The record indicated that "Soiled dressing removed/ disposed of properly, wounds #2 & #3 Tegaderm removed area cleaned [with] bathfoam. Flagyl & Tegaderm re-applied". The summary visit note states, " ... The large decubitous #2 appears to be getting deeper [with] more necrosis - we continue Flagyl cream & Tegaderm ...". No temperature recorded.

The Hospice Nursing Visit/ Assessment Update Note for 2/15/19 lacked measurements for all 3 pressure ulcers and specific anatomical locations of each wound (#1 wound unstageable, #2 unstageable, #3 wound Stage 2) and failed to specify a skin tear location. The record evidenced the appearance of each of the wound beds as black/slough, eschar, and excoriated. The skin tear size was 0 (zero) and dry. The surrounding skin of each wound was described as [decrease] red, red or WNL. The record indicated that "Soiled dressing removed/disposed of properly, wound cleaned (specify)". The summary visit note lacked evidence as to how the skin tear occurred. No temperature recorded.

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L 553	Continued From page 46 The Hospice Nursing Visit/ Assessment Update Note for 2/18/19 lacked measurements for all 3 pressure ulcers and specific anatomical locations of each wound (#1 wound unstageable, #2 unstageable, #3 wound Stage 2) and failed to specify an anatomical location of the skin tear. The record evidenced the appearance of each of the wound beds as dry/excoriated, eschar, and necrotic/ slough. The skin tear size was dry, no measurements recorded. The surrounding skin of each wound was described as WNL and red. The record indicated that "Soiled dressing removed/ disposed of properly, wound cleaned, dried Flagyl Tegaderm". No temperature recorded. The Hospice Nursing Visit/ Assessment Update Note for 2/20/19 lacked measurements for all 3 pressure ulcers and specific anatomical locations of each wound (#1 wound unstageable, #2 unstageable, #3 wound Stage 2) and failed to specify an anatomical location of the skin tear. The record evidenced the appearance of wound #1 was dry excoriated. The record lacked documentation of the appearance of wound bed's #2, #3 and the skin tear. The surrounding skin of each wound was described as WNL and red. The record indicated that "Soiled dressing removed/ disposed of properly, Tegaderm [changed] & Flagyl cr to #3" The record lacked documentation if wounds #1, #2 and the skin tear was cleaned and treated. No temperature recorded. Review of the IDG meeting note dated 2/20/19 states, "Wounds continue. [no] improvement. Atb therapy ineffective. Nutrition Fair." The IDG group meeting note failed to be specific and failed to evidence the patient's progress toward an	L 553		

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outcome and goals.

The Hospice Nursing Visit/ Assessment Update Note for 2/22/19 lacked measurements for all 3 pressure ulcers and specific anatomical locations of each wound (#1 wound unstageable, #2 unstageable, #3 unstageable) and lacked documentation if the skin tear was healed. The record evidenced the appearance of wound #1 was dry excoriated, #2 was necrotic/ slough, #3 was eschar. The surrounding skin of each wound was described as WNL and red. The record indicated that "Soiled dressing removed/ disposed of properly, wound cleansed, dried, Flagyl, Tegaderm".

The Hospice Nursing Visit/ Assessment Update Note for 2/25/19 lacked measurements for all 3 pressure ulcers and specific anatomical locations of each wound (#1 wound Stage 2, #2 unstageable, #3 unstageable). The record evidenced the appearance of wound #1 was dry excoriated, #2 was slough/necrotic, #3 was eschar. The surrounding skin of each wound was described as WNL, red and pink. The record indicated there was thin serosanguinous drainage to #2 and #3 wounds. The record indicated that "Soiled dressing removed/disposed of properly, wound cleansed, dried, Flagyl, Tegaderm" The summary visit note states, " ...Walking better this visit [with] max assist ..."

The Hospice Nursing Visit/ Assessment Update Note for 2/27/19 lacked measurements for all 3 pressure ulcers and specific anatomical locations of each wound (#1 wound Stage 2, #2 unstageable, #3 unstageable). The record evidenced the appearance of wound #1 was dry excoriated, #2 was slough/ necrotic, #3 was

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eschar. The surrounding skin of each wound was described as WNL and red. The record indicated there was thin serosanguinous drainage to #2 and #3 wounds. The record indicated that "Soiled dressing removed/disposed of properly, wound cleansed, dried, Flagyl, Tegaderm applied"

The Hospice Nursing Visit/ Assessment Update Note for 3/1/19 lacked measurements for all 3 pressure ulcers and specific anatomical locations of each wound (#1 wound Stage 2, #2 unstageable, #3 unstageable). The record evidenced the appearance of wound #1 was dry excoriated, #2 was slough, #3 was necrotic. The surrounding skin of each wound was described as WNL and red/ pink. The record indicated there was thin serosanguinous drainage to #2 wound. The record indicated that "Soiled dressing removed/disposed of properly, wound cleansed, dried, Flagyl, Tegaderm applied" No temperature recorded.

The Hospice Nursing Visit/ Assessment Update Note for 3/4/19 lacked measurements for all 3 pressure ulcers and specific anatomical locations of each wound (#1 wound Stage 2, #2 unstageable, #3 unstageable). The record evidenced the appearance of wound #1 was dry excoriated, #2 was eschar, #3 was slough/ necrotic. The surrounding skin of each wound was described as WNL and red/pink. The record indicated there was thin serosanguinous drainage to #3 wound. The record indicated that "Soiled dressing removed/ disposed of properly, wound cleansed, dried, Flagyl, Tegaderm" The summary visit note states, " ...Wounds cont. 0 [zero] improvement ..." No temperature recorded.

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Note for 3/6/19 lacked measurements for all 3 pressure ulcers and specific anatomical locations of each wound (#1 wound Stage 2, #2 unstageable, #3 Stage 3). The record evidenced the appearance of wound #1 was red, #2 left blank, #3 yellow-pink. The surrounding skin of each wound was described as WNL. The record indicated there was thick serosanguinous drainage to #3 wound. The record indicated that "Soiled dressing removed/disposed of properly, #3 Tegaderm changed - Wound cleansed - Flagyl & Tegaderm re-applied" No temperature recorded.

Review of an IDG meeting note dated 3/6/19 states, "Wounds continue. Nutrition fair. Takes Ensure clear." The IDG group meeting note failed to be specific and failed to evidence the patient's progress toward an outcome and goals.

The Hospice Nursing Visit/ Assessment Update Note for 3/8/19 lacked measurements for all 3 pressure ulcers and specific anatomical locations of each wound (#1 wound Stage 2, #2 unstageable, #3 Stage 3). The record evidenced the appearance of wound #1 was red, #2 eschar, #3 yellow/ moist. The surrounding skin of each wound was described as WNL and red. The record indicated there was thick serosanguinous drainage to #3 wound. The record indicated that "Soiled dressing removed/disposed of properly, Tegaderm changed - Wound cleansed, Flagyl & Tegaderm re-applied" No temperature recorded.

The Hospice Nursing Visit/ Assessment Update Note for 3/11/19 lacked measurements for all 3 pressure ulcers and specific anatomical locations of each wound (#1 wound Stage 2, #2 unstageable, #3 unstageable). The record

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evidenced the appearance of wound #1 was dry, #2 slough/ necrotic, #3 eschar. The surrounding skin of each wound was described as WNL and pink. The record indicated there was thin serosanguinous drainage to #1 and #2 wound. The record indicated that "Soiled dressing removed/ disposed of properly, Tegaderm changed - Wound cleansed, dried, Flagyl & Tegaderm" No temperature recorded.

The Hospice Nursing Visit/ Assessment Update Note for 3/13/19 lacked measurements for all 3 pressure ulcers and specific anatomical locations of each wound (#1 wound Stage 2, #2 wound Stage 4, #3 unstageable). The record evidenced the appearance of wound #1 "Tegaderm", #2 "intact", #3 yellow/ pink/ slough. Tunneling (destruction of tissue which results in a narrow passageway)/ undermining (erosion of wound edges) for wound #2 "?". The surrounding skin of each wound was described as WNL and pink. The record indicated there was a large amount of thick serosanguinous drainage to #3 wound. The record indicated that "Soiled dressing removed/ disposed of properly, Aloe bath wash, dried, Medihoney gel & alginate & Tegarderm to #2 - #1 & #3 Tegaderm intact" The record failed to measure (probe is gently inserted into the passageway until resistance is felt) tunneling/undermining for wound #2. No temperature recorded.

The Hospice Nursing Visit/ Assessment Update Note for 3/15/19 lacked measurements for all 3 pressure ulcers and specific anatomical locations of each wound (#1 wound Stage 2, #2 wound Stage 4, #3 unstageable). The record evidenced the appearance of wound #1 "necrosis/open/dry", #2 slough/necrosis, #3 eschar. Tunneling/

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undermining for wound #2 "?". The surrounding skin of each wound was described as red, pink and WNL. The record indicated there was a large amount of thick serosanguineous drainage to #3 wound. The record indicated that "Soiled dressing removed/disposed of properly, cleansed, dried, skin prep, Medihoney, drsg, Tegaderm" The summary visit note states, " ...Wounds [with] little to 0 [no] improvement - Area to back is worse. New tx. initiated this shift" The record failed to measure tunneling/ undermining for wound #2. No temperature recorded.

The Hospice Nursing Visit/ Assessment Update Note for 3/18/19 lacked measurements for all 4 pressure ulcers and specific anatomical locations of each wound (#1 wound Stage 2, #2 wound Stage 1, #3 Stage 4, #4 wound unstageable). The record evidenced the appearance of wound #1 red, #2 red, #3 slough/red/yellow/black and #4 eschar. Tunneling/undermining for wound #2 "?". The surrounding skin of each wound was described as red or WNL. The record indicated there was a large amount of thick serosanguineous drainage to #3 wound. The record indicated that "Wound cleanser Tegaderm [changed] - Medihoney, drsg, #1, #3 -Tegaderm to new area #2" The summary visit note states, " ...Wounds [with] little to 0 [no] improvement - Area to back is worse. New tx. initiated this shift" The summary visit note states, " ...we continue to treat decubities with Medihoney alginate drsg - perhaps slight improvement noted of Stage 4 sacral wound." The record evidenced the patient acquired a new pressure injury. The record failed to measure tunneling/ undermining for wound #2. No temperature recorded.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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Note for 3/20/19 lacked measurements for all 4 pressure ulcers and specific anatomical locations of each wound (#1 wound Stage 2, #2 wound unstageable, #3 Stage 4). The record evidenced the appearance of wound #1 dry, excoriated, #2 eschar, #3 moist/ slough/ necrotic. Tunneling/undermining for wound #3 "?". The surrounding skin of each wound was described as WNL or slight red-pink. The record indicated there was a large amount of thick serosanguinous drainage to #3 wound. The record indicated that "Soiled dressing removed/disposed of properly. Wound cleansed, dried, Medihoney,Tegaderm" The summary visit note states, "Pt continuous [with] wounds. Tx in place. [increase] drainage" No temperature recorded. The record failed to evidence the 4th pressure ulcer was treated or healed and failed to measure tunneling/undermining for wound #3.

Review of an IDG meeting note dated 3/20/19 states, "Wounds continue. Has 4 areas now. Using Medihoney drsg & there may be slight improvement of most severe decubitus. Will continue to monitor closely." The IDG group meeting note failed to be specific and failed to evidence the patient's progress toward an outcome and goals.

The Hospice Nursing Visit/ Assessment Update Note for 3/22/19 lacked measurements for all 4 pressure ulcers and specific anatomical locations of each wound (#1 wound unstageable, Stage 2, #2 did not indicate a Stage, #3 wound unstageable, #4 wound Stage 4). The record evidenced the appearance of wound #1 eschar, #2 "intact drsg", #3 "intact drsg" #4 pink, necrotic edge. Tunneling/ undermining for wound #4 "?". The surrounding skin of each wound was

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described as WNL or slight red-pink. The record indicated there was a large amount of thin tan drainage to #4 wound. The record indicated that "Soiled dressing removed/disposed of properly. Wound cleansed, dried, Medihoney,Tegaderm" No temperature recorded.

The Hospice Nursing Visit/ Assessment Update Note for 3/25/19 lacked measurements for all 4 pressure ulcers and specific anatomical locations of each wound (#1 wound unstageable, #2 wound Stage 2, #3 wound unstageable, #4 wound Stage 4). The record evidenced the appearance of wound #1 eschar, #2 red, #3 eschar, #4 pink, necrosis. Tunneling/ undermining for wound #4 "?". The surrounding skin of each wound was described as WNL or slight red-pink. The record indicated there was a small amount of thin seroussanguineouslarge drainage #1 and #2 wounds and a large amount of thick seroussangious drainage to #4 wound. The record indicated that "Soiled dressing removed/disposed of properly. Wound cleansed, dried, Medihoney,Tegaderm" No temperature recorded.

The Hospice Nursing Visit/ Assessment Update Note for 3/27/19 lacked measurements for all 4 pressure ulcers and specific anatomical locations of each wound (#1 wound unstageable, #2 wound Stage 2, #3 wound unstageable, #4 wound Stage 4). The record lacked evidence the appearance of all wounds were assessed. Tunneling/ undermining for wound #4 "?". The surrounding skin of each wound was described as WNL or slight red-pink. The record indicated there was a small amount of thin tan drainage #3 and #4 wounds. The record indicated that "Soiled dressing removed/disposed of properly. Wound

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cleaned [with] wound cleanser, dried, Medihoney,Tegaderm" No temperature recorded.

The Hospice Nursing Visit/ Assessment Update Note for 3/29/19 lacked measurements for all 4 pressure ulcers and specific anatomical locations of each wound (#1 wound unstageable, #2 wound unstageable, #3 wound Stage 4, #4 did not address). The record lacked evidence the appearance of all wounds were assessed. Tunneling/undermining for wound #4 "?". The surrounding skin of each wound was described as WNL or slight red-pink. The record indicated there was a small amount of thin tan drainage #3 and #4 wounds. The record indicated that "Soiled dressing removed/ disposed of properly. Wound cleaned [with] wound cleanser, dried, Medihoney,Tegaderm" The record lacked evidence if #4 wound to [right upper back] was being treated or healed. No temperature recorded. The summary visit note states, " ...pt appears to be actively dying at this time ..."

The Hospice Nursing Visit/Assessment Update Note for 4/1/19 lacked measurements for all 4 pressure ulcers and specific anatomical locations of each wound. No staging of wounds recorded. Tunneling/ undermining for wound #4 "?". The surrounding skin of each wound was described as WNL or slight red-pink. The record indicated there was a small amount of thin tan drainage #3 and #4 wounds and that wound #4 had an odor. The record indicated that "Soiled dressing removed/ disposed of properly. Wound cleansed, Flagyl, Tegaderm" No temperature recorded and unable to obtain a blood pressure. The summary visit note states, "Pt ashen in color, cool to touch, Mottling to toes ... Discomfort noted [with] turning on side. Dressings [changed] odor noted. Applied

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L 553	Continued From page 55 Flagyl ... pt non-responsive ... " During an interview on 4/17/19 at 2 p.m. the Administrator stated the agency does not routinely measure wounds nor does the agency have a specific wound protocol. The Administrator stated the agency did not routinely take temperatures on all visits and that the nurses could tell by touch if the patient had a fever.At 2:36 p.m. the Administrator provided a copy of the unofficial certificate of death which indicated that patient #5's cause of death was dementia.	L 553		
L 562	PROGRAM SCOPE CFR(s): 418.58(a)(2) (2) The hospice must measure, analyze, and track quality indicators, including adverse patient events, and other aspects of performance that enable the hospice to assess processes of care, hospice services, and operations. This STANDARD is not met as evidenced by: Based on record review and interview, the agency failed to ensure all infections and all skin impairments were measured, analyzed, tracked, and incorporated into the Quality Assessment and Performance Improvement Program for 1 of 1 agency. Findings include: 1. An undated policy titled, "Quality Assessment and Performance Improvement Program", states, " ... 1. The QAPI program includes processes for measuring, analyzing, and tracking quality indictors, including adverse patient events, and other aspects of performance that enable the hospice to assess processes of care, services	L 562		

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L 562	Continued From page 56	L 562		

and operations. 2. The hospice collects data that is used to monitor the effectiveness and safety of services and quality of care and identify opportunities for improvement....4. Performance improvement activities track adverse patient events, analyze their cause an implement preventive actions and mechanisms ..."

2. An undated policy titled, "Adverse Events" states, "... Examples of reportable incidents include , but are not limited to: a. adverse outcomes ... 9. The Administrator and/or CCC, in collaboration with the QAPI Committee, tracks and trends all reports of adverse events in order to analyze their causes, implement preventative actions and mechanisms that include feedback and learning throughout the hospice."

3. The clinical record of patient #5, benefit period 12/11/17 to 3/10/18, was reviewed on 4/15/19. Review of the "Initial and Comprehensive Hospice Assessment" dated 12/11/17, indicated the patient was started on a new antibiotic for recurrent urinary tract infection.

The clinical record of patient #5, benefit period 12/6/18 to 2/3/19, was reviewed on 4/17/19. The clinical record contained IDG (Interdisciplinary Group) Meeting Notes that indicated the following:

2/6/19 - "Pressure areas continue [with] treatment. Atb therapy started r/t wound infection ..."

2/20/19 - "Wounds continue. [no] improvement. Atb therapy ineffective. Nutrition Fair."

4. The clinical record of patient #6, benefit period

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L 562	Continued From page 57 6/28/19 to 9/25/18, was reviewed on 4/17/19. During this benefit period, the clinical record indicated the patient was being treated with antibiotics for a urinary tract infection. 5. Review of the 2018 and 2019 quality assessment and performance improvement failed to track infections and all skin impairments. 6. During an interview on 4/22/19 at 11 a.m. the Administrator stated the agency did not track infections and wounds in the agency's QAPI program.	L 562		
L 663	TRAINING CFR(s): 418.100(g)(3) (3) A hospice must assess the skills and competence of all individuals furnishing care, including volunteers furnishing services, and, as necessary, provide in-service training and education programs where required. The hospice must have written policies and procedures describing its method(s) of assessment of competency and maintain a written description of the in-service training provided during the previous 12 months. This STANDARD is not met as evidenced by: Based on record review and interview, the agency failed to ensure all individuals furnishing care, including volunteers, were provided in-service training and education programs for 6 out of 9 employees. (Employees A, F, G, H, I, and J) Findings include: An undated policy, title, "Staff Education," was	L 663		

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L 663	Continued From page 58	L 663		

provided by the Administrator on 4/18/19 at 1:47 p.m. The policy indicated, but was not limited to, "Spencer County Hospice provides on-going educational opportunities to its staff and volunteers that support staff development, maintaining and improving competencies and lifelong learning. 1. The learning needs of the hospice staff are assessed annually. 2. A schedule of in-service training is developed annually based upon assessed needs. 3. Learning opportunities may include, but are not limited to: a. attendance at audio conferences; b. online educational opportunities; c. in-services provided by the Medical Director and other internal staff; d. in-services provided by outside speakers."

During a review the In-service Binder on 4/22/19 at 10:36 a.m. contained the following in-services:

An in-service on 2/19/19 on Pain Management, attended by Employees C, a Licensed Practical Nurse and D, a Registered Nurse.

An in-service on the Afterlife, attended on 3/9/18 by Employee D and on 3/12 (no year noted) by Employee C and the Administrator, who is also a RN.

An in-service on Dying in Peace, attended on 3/2/18 by Employees C and D and on 3/5/18 by the Administrator.

An in-service on Choosing the Appropriate Dressings, attended on 2/19/18 by the Administrator and Employee D and on 2/21/18 by Employee C.

An in-service on Wounds, attended on 1/5/18 by

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L 663	Continued From page 59 Employees C and D. An in-service on Lewy Body Dementia, attended on 1/10/18 by Employees C and D. An in-service on Disposal of Drugs, attended on 1/17/18 by Employees C and D. The agency lacked documentation of any yearly in-services provided to the Social Worker, Medical Director, Dietician, Spiritual Care Coordinator, Volunteer Coordinator, or Volunteers. The only in-services provided were to the nurses of the agency. During an interview on 4/18/19 at 11:00 a.m., the Administrator indicated the only in-services completed were with the three nurses of the agency and any other information would be discussed informally during Interdisciplinary Team Meetings which were not documented anywhere.	L 663		
L 678	CONTENT CFR(s): 418.104(a)(7) [Each patient's record must include the following:] (7) Physician orders. This STANDARD is not met as evidenced by: Based on record review and interview, the agency failed to ensure patients had initial hospice orders for 6 of 8 patients reviewed (Patients 1, 4, 5, 6, 7, 8) and failed to ensure the plan of care contained instructions for medications necessary to meet the patient's needs regarding skin integumentary issues for 1 of 3 patients with skin integumentary issues. (Patient 5)	L 678		

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Findings include:

1. An undated policy, titled, "Admission to Hospice Care," was provided by the Administrator on 4/18/19 at 1:47 p.m. The policy included, but was not limited to, "4. The hospice obtains orders from a physician according to law and regulation and professional standards of practice before providing care."

2. Patient 1's clinical record was reviewed on 4/15/19 at 11:08 a.m., and lacked an initial order from a physician to admit to hospice care.

3. Patient 4's clinical record was reviewed on 4/17/19 at 9:34 a.m., and lacked an initial order from a physician to admit to hospice care.
4. The clinical record #5 with a start of care and election date 12/11/17, benefit period 12/11/17 to 3/10/18, was reviewed 4/15/19. The clinical record for patient #5 lacked an initial order from a physician to admit to hospice care.

Review of the Initial and Comprehensive Hospice Assessment for 12/11/17 indicated the patient had a history of sacral decubitus ulcers that were treated previously by a home health agency.

A physician telephone order for 2/2/18 states, "Flagyl 250 mg (milligram) as directed to decubitous #14 - may continue if effective. May use Flagyl cr. if more effective". The order lacked specific instructions such as frequency, route, stop date, and anatomical location for topical medication.

A physician telephone order for 2/12/18 states, "May use Alginate dressing to decubitus on

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L 678	Continued From page 61 sacrum. Change prn". The order lacked specific instructions such as frequency, stop date, or whether to continue Flagyl as previously ordered. A physician telephone order for 3/6/19 states, "May try Medihoney alginate dressing to pressure sores as directed". The order lacked specific instructions such as amount, frequency, stop date, and anatomical location as to where the medication would be applied. During an interview on 4/18/19 at 2 p.m. inquired as to why Medihoney did not have specific directions for use. The Administrator stated that Medihoney was a new treatment to them. 5. The clinical record for patient #6 lacked an initial order from a physician to admit to hospice care. 6. The clinical record for patient #7 lacked an initial order from a physician to admit to hospice care. 7. The clinical record for patient #8 lacked an initial order from a physician to admit to hospice care. 8. During an interview on 4/16/19 at 2:25 p.m., the Administrator indicated they do not acquire a hospice order prior to receiving the certification.	L 678		
L 679	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.	L 679		

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L 679	Continued From page 62 This STANDARD is not met as evidenced by: Based on record review and interview, the agency failed to ensure clinical record documents were signed/authenticated for 2 of 4 clinical records reviewed. (Patients 2, 3) Findings include: 1. An undated policy, titled, "Clinical Records," was provided by the Administrator on 4/18/19 at 1:47 p.m. The policy indicated, but was not limited to, "1. Entries are made in the clinical record for all services provided (both those services provided directly and through contracted providers) in a standardized format and are legible, clear and complete and signed and dated by the person providing the services." 2. Patient 2's Clinical Record was reviewed on 4/15/19 at 2:15 p.m., and contained a Physician's Certification for Medicare Hospice Benefit, dated 8/22/18 to 11/19/18, which lacked the attending physician's signature. Patient 2's Physician Order, dated 1/15/19, to continue skilled Physical Therapy times 30 days, lacked a physician's signature. 3. Patient 3's Clinical Record was reviewed on 4/16/19 at 11:00 a.m., and contained a Physician's Certification for Medicare Hospice Benefit, dated 7/29/18 to 10/26/18, which lacked the attending physician's signature. 4. During an interview on 4/16/19 at 2:25 p.m., the Administrator indicated when continuing physical therapy, the agency did not get a new order from the doctor so the order would not have	L 679		

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L 679	Continued From page 63 gone to the physician for signature. 5. During an interview on 4/18/19 at 2:00 p.m., the Administrator indicated certifications should be signed by the physicians.	L 679		