STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	151511	A. BUILDING 00 B. WING	07/05/2017

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INDIANA UNIVERSITY HEALTH HOSPICE	950 NORTH MERIDIAN STREET, SUITE 700 INDIANAPOLIS, IN 46204

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L 0000 Bldg. 00	This survey was a federal and state complaint investigation. This was an extended survey. Complaint Number: IN00225849; Substantiated-deficiencies cited. Unrelated deficiencies cited. Facility #: 151511 Medicaid #: 200144910A Survey Dates: June 26, 27, 28, July 5; 2016 Hospice multiple site location in Bloomington offering inpatient services was in compliance with 42 CFR 418.110.	L 0000		
L 0503 Bldg. 00	418.52(a)(2) NOTICE OF RIGHTS AND RESPONSIBILITIES (2) The hospice must comply with the requirements of subpart I of part 489 of this chapter regarding advance directives. The hospice must inform and distribute written			

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	information to the patient concerning its policies on advance directives, including a description of applicable State law. Based on document review and policy review the agency failed to provide updated written information to patients regarding advance directives for 1 of 1 agency. Findings include: 1. The agency provided a hospice admission packet to surveyor on 6/28/17 at 2:45 PM. 2. The Indiana State Department of Health Advance Directives guide was in the admission packet which indicated dates, "March 1999 Revised May 2004." 3. The Indiana State Department of Health had an updated and revised Advance Directives packet dated July 2013 which is the current Advance Directives packet to be given to patients. The agency admission packet failed to evidence the most recent Advance Directives packet given to patients. 4. The agencies policy titled "PATIENT'S RIGHTS AND RESPONSIBILITIES," Policy #: EBR.P10 revised February 2015 stated	L 0503	**Summary statement:** The patients will receive the Indiana State Department of Health Advance Directive Guide in their agency admission packet provided at the time of admission. **Action Plan:** 1.The Agency has replaced the Advance Directive Forms in Agency's admission packet with The Indiana State Department of Health updated and revised Advance Directive Packet. 2.Provide Staff education before August 5, 2017, around the Advance Directive Packet and the need to replace in current admission packets and distribute to current patients. This education, provided via written educational materials and interactive discussion of the materials with clinical team members, is scheduled for completion by 8-5-17. 1.Education and discussion at each region location's staff meeting and completed by August 5th. **Prevention Plan:** ·The Agency's Clinical Director will annually review for any revisions and/or updates to the	08/05/2017

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	"Procedures: D ... 18. Receive written information about Advance Directives." 5. The agencies Job description titled "Director-Statewide Clinical Home Health and Hospice," dated April 14, 2016 stated, "Incumbent is responsible for maintaining compliance in process, policy and service for all Statewide Homecare and Hospice activities ... Acts as the CMS [Centers for Medicaid and Medicare] Administrator for Home Health and Hospice."		Indiana State Department of Health Advance Directive Guide. The Clinical Director will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur. **Completion Date:** August 5, 2017	
L 0512 Bldg. 00	418.52(c)(1) RIGHTS OF THE PATIENT The patient has a right to the following: (1) Receive effective pain management and symptom control from the hospice for conditions related to the terminal illness; Based on record review, policy review, and interview the agency failed to provide effective pain management and symptom control for 3 of 10 records reviewed (#1, 2, 9). Findings include: 1. The clinical record of patient #1 was reviewed and indicated a start of care date of 2/2/17. The record contained a plan of care dated 2/2/17-5/2/17, which	L 0512	**Summary statement:** The patients will receive effective pain management and symptom control from the hospice for conditions related to the terminal illness. **Action Plan:** 1.Policies CES.P10 Pain and Symptom Management and BR.P10 Patient Rights and Responsbilities were reviewed and no changes were recommended for this policy.	08/05/2017

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	indicated "SN [Skilled Nurse] 1-2 x [times] week x 13 weeks ... SN 5 PRN [as needed]: symptom management, patient comfort, family request. Instruct patient/caregiver on around the clock medication administration and maintenance of pain medication log, Assess/instruct patient/caregiver on medication administration, side effects, actions, and effectiveness ... AID 1-2 x week x 13 weeks ... Provide personal care and assistance with ADL's [Activities of daily living] ... SC [Spiritual Counselor] 8 PRN: Provide relation-based spiritual care ... SC 1 x day x 1 day." A. The Skilled Nursing Facility (SNF) that patient resided in provided resident progress notes and orders to surveyor upon visit to SNF on 6/27/17 at 9:45 AM. a. The SNF Resident Progress Note from the Registered Nurse (RN) on duty dated 2/10/17 at 12:37 AM indicated "At 9 PM resident daughter asked me to come in to assess her mother. Resident RR [Respiration Rate] increased to 32 and frothy bile colored secretions coming from resident mouth. Writer completed mouth care and administered another PRN Hyoscyamine and morphine 0.25 ml [milliliter]. Meds were ineffective.		1.Policy CES.P10 was developed February 2009 , last reviewed and updated on February 2015 and was designed to communicate effective pain management and symptom contract guidelines. 2.Policy BR.P10 was developed February 2009, last reviewed and updated on February 2015 and was designed to communicate patient rights and responsibility guidelines. 1.Provide Staff re-education around Policy CES.P10 Pain and Symptom Management and BR.P10 Patient Rights and Responsibilities before August 5, 2017, includes information around patient rights, pain and symptom management, and the job expectations of the Hospice RN. This education will become part of the new employee orientation. 1.This education, provided via written educational materials and interactive discussion of the materials with clinical team members, is scheduled for completion by 8-5-17. 2.Education and discussion will take place at each region location's staff meeting and completed by August 5th. **Prevention Plan:** ·The agency's Clinical Director will incorporate the education presentation into the new	

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	Writer called [hospice agency] ... On call hospice nurse stated that it sounds like re doing all that can be done. Writer responded ... residents daughter would like you or someone from the hospice to come in. [Hospice nurse] replied I will call the on call nurse and see if she can make a visit. No hospice nurse ever showed up and writer never received a call back from hospice." The record failed to evidence that symptoms were controlled and hospice failed to make a visit to assist with symptom management. b. The SNF medication orders for breakthrough symptom management which indicated, "Morphine concentrate 0.25 ml (5 mg) oral every 2 hours as needed for mild pain or air hunger ... Morphine concentrate 0.5 ml (10 mg) oral every 2 hours as needed for moderate pain or air hunger ... Hyoscyamine tablet 0.125 mg [milligram] sublingual 1-2 tabs every 4 hours PRN for secretions." The record failed to evidence that the hospice nurse guided the facility nurse over the phone in how to dose medications appropriately for symptom management. B. The agency medication list had the following orders for breakthrough symptom management which indicated, "Morphine Sulfate (Concentrate) by mouth solution 100 mg/5 ml Administer		employee orientation process. The Clinical Director will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur. **Completion Date:** August 5, 2017	

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	0.5 ml every hour as needed pain or breathlessness." The agency failed to ensure that this order was available to SNF as it was not on SNF medication orders. C. The Agency document titled "Home Health Certification and Plan of Care," indicated "May increase morphine administration frequency to every 30 minutes for uncontrolled shortness of breath or until patient appears comfortable ... Atropine Sulfate 1% Ophthalmic Drops: Administer 3 drops by mouth or under tongue every 30 minutes times 3 then every 2 hours as needed for excessive secretions." The agency failed to ensure that these orders were available to SNF as they were not on SNF medication orders. a. The agency document titled "Charts/Clinical Notes" indicated "Call from facility nurse that patient has copious secretions. Has given hyoscyamine and has scop patches on. Asked for atropine. Explained no longer on formulary. Orders given for mouth suctioning PRN." The agency failed to provide the atropine order to the facility per care plan orders for symptom management. 2. The clinical record of patient #2 was			

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	reviewed and indicated a start of care date of 1/20/17. The record contained a plan of care dated 1/20/17-4/19/17, which indicated "SN 1-2 x week x 1 week." A. The hospice document titled "Hospice v16.3 Initial visit-on 1-20-2017," indicated "Physical\Respiratory: Breathing labored with oxygen support, wheezing:bilat [bilateral] ... Dyspnea at rest ... No education this visit ... Actively dying-Symptoms: Dyspnea." The record failed to evidence any interventions by hospice nurse for symptom management or comfort at initial visit. B. The hospice document titled "Home Care & Hospice Customer Concern Form," was a complaint dated 2/20/17 from patient daughter that indicated "[Patient] ran out of morphine and suffered in pain at death ... Investigation results: Charting was reviewed ... admission nurse delivered written scripts of Morphine and Ativan to facility." The record failed to evidence documentation that scripts were taken to facility, only on the complaint form, and fails to evidence that the nurse completed an intervention on admission to provide symptom management. C. During an interview on 7/5/17 at 1:22 PM, the administrator stated that in			

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	such a short time we were unable to control patients pain. 3. The clinical record of patient #9 was reviewed and indicated a start of care date of 6/19/17. The record contained a plan of care dated 6/19/17-9/16/17, which indicated "SN 1-2 x week x 13 weeks ... MSS [Medical Social Services] 1-3 x month x 3 months ... AID 2 x week x 1 week ... SC 1-3 x month x 3 months." The agency failed to provide the SNF with medication orders for symptom management as ordered. A. The SNF that patient resided in provided the residents medication orders and written hospice progress notes from hospice staff to surveyor upon visit to SNF on 6/28/17 at 8:57 AM. a. The agency document titled "Patient Progress Notes," had an entry written on 6/20/17 that indicated "Pt [Patient] admitted to services 6/19. RN performed assessment. ... New orders received RVTO [Read back verified telephone order] from [Nurse Practitioner] ... Roxanol 5 mg Q [every] 1 hour SL [Sublingual] PRN for pain/SOB [shortness of breath], lorazepam intensol 0.5 mg Q 2 hours SL PRN for anxiety, & Atropine 3 gtts [drops] Q 1 hour for secretions."			

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	b. The SNF document titled "Physician Order Report," indicated "atropine drops 1%, 3 drops Q 1 hour for PRN secretions." The SNF medication orders failed to evidence the hospice provided Roxanol or Lorazepam orders to them. 4. The agencies policy titled "PAIN AND SYMPTOM MANAGEMENT," Policy #: CES.P10 revised February 2015 stated, "POLICY STATEMENTS: The interdisciplinary team ensures that patients receive effective pain management and symptom control from the hospice. PROCEDURES: D. If the patient is not receiving relief from the current pain medication or dosage, the nurse consults the contracted pharmacy, the hospice Medical Director, and/or attending physician, and carries out the recommended action(s) ordered by the physician." 5. The agencies Job description titled "Director-Statewide Clinical Home Health and Hospice," dated April 14, 2016 stated, "Incumbent is responsible for maintaining compliance in process, policy and service for all Statewide Homecare and Hospice activities ... Acts as the CMS [Centers for Medicaid and Medicare] Administrator for Home			

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	Health and Hospice." 6. The agencies Job description titled "RN-Hospice," dated September 15, 2014 stated, "Assumes responsibility for Hospice care as per Hospice policies and procedures. Maintains up to date patient records so that problems, plans, actions and goals are accurately and clearly stated and changes are reflected as they occur. ... Initiates communication with attending physicians. ... Demonstrates familiarity with policies of the agency and rules and regulations of state and federal bodies which relate to the delivery of hospice services. ... Assumes responsibility for evening and weekend on-call duty as scheduled and consistent with services policies." 7. During an interview on 6/8/17 at 1:50 PM, Employee C stated it is up to the Registered Nurse and/or the case manager to obtain prescription and get meds to the patient. 8. During an interview on 7/5/17 at 1:21 PM, the administrator stated she believes it would be best practice to obtain the meds wherever they could be gotten for the patients.			

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L 0522 Bldg. 00	418.54(a) INITIAL ASSESSMENT The hospice registered nurse must complete an initial assessment within 48 hours after the election of hospice care in accordance with §418.24 is complete (unless the physician, patient, or representative requests that the initial assessment be completed in less than 48 hours.)			
	Based on document review the agency failed to complete a thorough initial assessment for 1 of 10 records reviewed (#2). Findings include: 1. The clinical record of patient #2 was reviewed and indicated a start of care date of 1/20/17. The record contained a plan of care dated 1/20/17-4/19/17, which indicated "SN [Skilled Nursing] 1-2 x [times] week x 1 week." A. The hospice document titled "Hospice v16.3 Initial visit-on 1-20-2017," indicated "Vital signs Pulse 102 ... Respiration 22 ... Blood Pressure 103/47 ...Physical\Respiratory: Breathing labored with oxygen support, wheezing:bilat [bilateral] ... Dyspnea at rest ... No education this visit ... Physical\Skin\Evaluation Skin integrity: intact ... multiple bruising ... Extremities: Upper, Lower-Cyanotic nailbeds, Upper, Lower Cool ... End of Life Stage	L 0522	·Summary statement: The hospice registered nurse must complete an initial assessment within 48 hours after the election of hospice care in accordance with CFR 418.24 is complete (unless the physician, patient, or representative requests that the initial assessment be completed in less than 48 hours,) all of this per current policy Admission – Comprehensive Assessment Of The Patient PFC.A45 ·Action planned: ·Clinical leaders reviewed pertinent policy: Admission – Comprehensive Assessment Of The Patient PFC.A45 1.Policy PFC.A45 was developed February 2009, last reviewed and updated on February 2015 and was designed to ensure the hospice IDG conducts and documents a patient-specific comprehensive assessment that identifies the patient's need for hospice care, including but not limited to medical, nursing, psychosocial, emotional, and spiritual care. No changes were recommended for this policy. 2.Clinical leaders plan to	08/05/2017

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	Terminal illness ...Is the patient aware of prognosis?: Yes, Are significant others aware of prognosis?: Yes, Patient Coping: unknown ... Actively dying-Symptoms: Dyspnea ... Caregiver/family ... Accepting of death ... Environment\Safety: Fall risk assessment tool." The initial assessment failed to evidence patient's, psychosocial, emotional and spiritual status related to the terminal illness and related conditions 2. The agencies Job description titled "Director-Statewide Clinical Home Health and Hospice," dated April 14, 2016 stated, "Incumbent is responsible for maintaining compliance in process, policy and service for all Statewide Homecare and Hospice activities ... Acts as the CMS [Centers for Medicaid and Medicare] Administrator for Home Health and Hospice." 3. The agencies Job description titled "Manager-Clinical Operations," dated May 28, 2013 stated, "Assures the clinical competence of staff ... Maintains twenty four accountability for quality patient care ... Maintains knowledge of best practices in areas of clinical and organizational responsibility ... Assures unit compliance with all state and national regulatory standards. ... Accountable for daily unit operations.		re-educate Hospice staff on the inter-disciplinary requirements and time frames associated with comprehensive assessment. 3.Timely completion of the initial assessment by inter-disciplinary group to include medical, nursing, psychosocial, emotional, and spiritual assessments will be added to monthly chart audits. ·How the actions will improve the processes: Anticipated outcome of this education, and chart audits is that hospice staff will be fully aware and maintain compliance with the policy and expectations. ·Procedures for implementing the plan of correction for this deficiency: 1.This education, provided via written educational materials and interactive discussion of the materials with clinical team members, is scheduled for completion by 8-5-17. 2.Education and discussion will take place at each region location's staff meeting and completed by August 5th.	

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	4. The agencies Job description titled "RN-Hospice," dated September 15, 2014 stated, "Assumes responsibility for Hospice care as per Hospice policies and procedures. Maintains up to date patient records so that problems, plans, actions and goals are accurately and clearly stated and changes are reflected as they occur. ... Initiates communication with attending physicians. ... Demonstrates familiarity with policies of the agency and rules and regulations of state and federal bodies which relate to the delivery of hospice services. ... Assumes responsibility for evening and weekend on-call duty as scheduled and consistent with services policies."			
L 0530 Bldg. 00	418.54(c)(6) CONTENT OF COMPREHENSIVE ASSESSMENT [The comprehensive assessment must take into consideration the following factors:] (6) Drug profile. A review of all of the patient's prescription and over-the-counter drugs, herbal remedies and other alternative treatments that could affect drug therapy. This includes, but is not limited to, identification of the following: (i) Effectiveness of drug therapy (ii) Drug side effects (iii) Actual or potential drug interactions			

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	(iv) Duplicate drug therapy (v) Drug therapy currently associated with laboratory monitoring. Based on record review, policy review and interview, the agency failed to complete a current and accurate medication review for 5 of 10 records reviewed (#1, 5, 8, 9). Findings include: 1. The clinical record of patient #1 was reviewed and indicated a start of care date of 2/2/17. The record contained a plan of care dated 2/2/17-5/2/17, which indicated "SN [Skilled Nurse] 1-2 x [times] week x 13 weeks ... SN 5 PRN [as needed]: symptom management, patient comfort, family request. Instruct patient/caregiver on around the clock medication administration and maintenance of pain medication log, Assess/instruct patient/caregiver on medication administration, side effects, actions, and effectiveness ... Aid 1-2 x week x 13 weeks ... Provide personal care and assistance with ADL's [Activities of daily living] ... SC [Spiritual Counselor] 8 PRN: Provide relation-based spiritual care ... SC 1 x day x 1 day." The record showed discrepancies between the facility and hospice medication orders.	L 0530	·Summary statement: The agency ensures in writing a patient-specific comprehensive assessment that identifies the patient's needs for hospice cares, the need for physical, psychosocial, emotional, and spiritual care to the terminal illness that must be addressed in order to promote the hospice patient's well-being. The assessment includes all areas necessary for the palliation and management of the terminal illness and related conditions. The comprehensive assessment includes the following but not limited to: the nature and condition causing admission, complications and risk factors that affect care planning, functional status (including the patient's ability to understand and participate in his or her own care), imminence of death, severity of symptoms, and a review of all the patient's medications. The medication review includes all prescriptions, over- the- counter drugs, herbal remedies, and other alternative treatments that could affect drug therapy. Patient medications in the comprehensive assessment will be evaluated for effectiveness of drug therapy, drug side effects, actual or potential drug interactions, duplicate drug therapy, and drug therapy	08/05/2017

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	151511	A. BUILDING 00 B. WING	07/05/2017

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	A. The agency's document titled "Medication Status," indicated "Haloperidol Lactate By Mouth Concentrate 2 MG/ML [Milligrams per Milliliter]. Administer 0.5 ml (1 mg) by mouth or under tongue every 2 hours as needed for agitation." a. The facilities document titled "Order history," indicated "Haloperidol lactate concentrate 2 mg/ml; 1 ml Sublingual every 2 hours PRN for agitation." B. The agency document titled "Medication Status," indicated "Morphine Sulfate (Concentrate) By Mouth Solution 100 MG/5 ML 0.5 ml every hour as needed PRN pain or breathlessness per standing order set." b. The facilities document titled "Order history," indicated "Morphine solution 20 mg/ml; Give 0.5 ml every 2 hours for pain." c. The Agency document titled "Home Health Certification and Plan of Care," indicated "May increase morphine administration frequency to every 30 minutes for uncontrolled shortness of breath or until patient appears comfortable." The agency failed to		currently associated with laboratory monitoring. In addition, the comprehensive assessment must include data elements that allow for measurement of outcomes and is updated in the patient record assessment changes based on IDG discussion every 15 days, and as needed per current policy Admission- Comprehensive Assessment of The Patient PFC.A45. ·Action planned: 1.Clinical leaders reviewed pertinent policy: Admission- Comprehensive Assessment of The Patient PFC.A45, no changes were recommended for this policy. 1.Policy PFC.A45 was developed February 2009, last reviewed and updated on February 2015 and was designed to establish guidelines for a comprehensive assessment. 2.Clinical leaders provided education to Hospice staff on the procedures for the comprehensive assessment and complete medication review. 3.Random chart audit via clinical record review will be conducted to monitor compliance with policy Admission – Comprehension Assessment of The Patient PFC.A45 including the documentation within the EMR. ·How the actions will improve the processes: Anticipated outcome of this education, is that	

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	provide this order to the facility. 2. The clinical record of patient #5 was reviewed and indicated a start of care date of 9/30/16. The record contained a plan of care dated 5/28/17-7/26/17, which indicated "SN 1-3 x week x 9 weeks. Instruct patient/caregiver on around the clock medication administration and maintenance of pain medication log, Instruct patient/caregiver on reporting poorly controlled pain to Hospice, Assess/Instruct/monitor patient/caregiver on narcotic administration, side effects, actions, and effectiveness, Titrate medication dose for comfort per physician order ... AID 1-2 x week x 9 weeks Provide personal care and assistance with ADL's, Companionship." The record evidenced discrepancies of doses for Hyoscyamine and Robitussin. The record evidenced Miralax which the facility did not have as an order. The record evidenced tylenol as discontinued but was an active order at the facility, and the facility had an order for CBD which was not evidenced in hospice record. A. The agency document titled "Medication Status," indicated "Hyoscyamine Sulfate Sublingual tablet take 1-2 tablets under tongue every 4 hours as needed for excessive secretions ... Miralax by mouth packet daily PO {by		is that hospice staff will be fully aware and compliant with the policy and expectations. ·Procedures for implementing the plan of correction for this deficiency: 1.This education, provided via written educational materials and interactive discussion of the materials with clinical team members, is scheduled for completion by 8-5-17. 2.Education and discussion will take place at each region location's staff meeting and completed by August 5th. ·The Clinical Director will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	

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mouth] ... Robitussin Chest Congestion by Mouth Syrup 100 mg/5 ml 10 ml every hours as needed PO 10 ml q6h [every 6 hours] prn cough ...Tylenol by mouth tablet 325 mg 2 tablet three times a day PO Give 2 tablets (650 mg) by mouth three times a day end date: 4/27/17."

B. The facility document titled "Physician Order report," indicated "acetaminophen (OTC) 325 mg; 650 mg oral three times a day ...Hyoscyamine sulfate tablet sublingual 0.125 mg every 4 hours as needed for excessive secretions ... Robitussin Cough-Chest Congestion 10 ml Every 4 hours PRN cough/cold ... CBD oil 3 mg extra-strength, spray twice into mouth et [and] swallow as dietary supplement."

3. The clinical record of patient #8 was reviewed and indicated a start of care date of 3/31/17. The record contained a plan of care dated 3/31/17-6/28/17, which indicated "SN 1-2 x week x 14 weeks." The record evidenced discrepancies of doses for Oxygen, Tylenol, and Calcium Carbonate.

A. The agency document titled "Medication Status," indicated "Oxygen 3 liters/minute as needed for shortness of breath nasal cannula ... Calcium

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	Carbonate Antacid by mouth tablet Chewable 500 mg 1 tablet as needed PO PRN daily for indigestion ... Acetaminophen by mouth tablet 500 mg 2 Tablet every 6 hours as needed PO for mild pain." B. The facility document titled "Physician Order report," indicated "Acetaminophen 500 mg 2 tablets three times a day PRN ... Antacid (Calcium Carbonate) 2 tab once daily PRN for indigestion ... May titrate oxygen (1-4 liter/min) to maintain sats greater than 90% PRN." 4. The clinical record of patient #9 was reviewed and indicated a start of care date of 6/19/17. The record contained a plan of care dated 6/19/17-9/16/17, which indicated "SN 1-2 x week x 13 weeks ... MSS [Medical Social Services] 1-3 x month x 3 months ... AID 2 x week x 1 week ... SC 1-3 x month x 3 months." A. The agency document titled "Medication Status," indicated "Morphine Sulfate by mouth 20 mg/ml 0.25 ml every hour as needed PO for pain/shortness of breath ... Lorazepam Intensol by mouth concentrate 2 mg/ml 0.25 ml every 2 hours as needed PO for anxiety." These medication orders were not on the facility medication orders.			

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	B. The agency document titled "Patient progress Notes," dated 6/20/17 that was in the hospice folder in the facility indicated "New orders received RTVO [Received Telephone Verbal Order] from [ordering nurse practitioner] for Roxanol 5 mg Q1 hours SL[sublingual] PRN for pain/SOB [shortness of breath], lorazepam intensol 0.5 mg Q 2 hours SL PRN anxiety." The facility failed to have written orders for these medications. 5. The agencies policy titled "MEDICATION-MANAGEMENT," Policy #: CES.M35 revised February 2015 stated "POLICY STATEMENTS: The pharmaceutical needs of the hospice's patients are managed in a manner consistent with applicable State and Federal laws and accepted standards of practice. ... PROCEDURES: B. Medications are provided on a timely basis and are available 24 hours a day and seven days a week as needed. ... D. A drug profile is maintained for every patient and includes a listing of the current medication orders for each patient ... The RN Case Manger confirms the home medication profile is accurate at every patient visit. ... K. The patient's medication profile is reviewed and validated by the IDT to verify all the			

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	current known medications are listed accurately." 6. The agencies Job description titled "Director-Statewide Clinical Home Health and Hospice," dated April 14, 2016 stated, "Incumbent is responsible for maintaining compliance in process, policy and service for all Statewide Homecare and Hospice activities ... Acts as the CMS [Centers for Medicaid and Medicare] Administrator for Home Health and Hospice." 7. The agencies Job description titled "Manager-Clinical Operations," dated May 28, 2013 stated, "Assures the clinical competence of staff ... Maintains twenty four accountability for quality patient care ... Maintains knowledge of best practices in areas of clinical and organizational responsibility ... Assures unit compliance with all state and national regulatory standards. ... Accountable for daily unit operations. 8. The agencies Job description titled "RN-Hospice," dated September 15, 2014 stated, "Assumes responsibility for Hospice care as per Hospice policies and procedures. Maintains up to date patient records so that problems, plans, actions and goals are accurately and clearly stated and changes are reflected as they			

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	occur. ... Initiates communication with attending physicians. ... Demonstrates familiarity with policies of the agency and rules and regulations of state and federal bodies which relate to the delivery of hospice services. ... Assumes responsibility for evening and weekend on-call duty as scheduled and consistent with services policies."			
L 0543 Bldg. 00	418.56(b) PLAN OF CARE All hospice care and services furnished to patients and their families must follow an individualized written plan of care established by the hospice interdisciplinary group in collaboration with the attending physician (if any), the patient or representative, and the primary caregiver in accordance with the patient's needs if any of them so desire.			
	Based on document review, policy review, and interview the agency failed to establish an individualized written plan of care for 6 of 10 records reviewed (#2, 3, 4, 6, 8, 9). Findings include: 1. The clinical record of patient #2 was reviewed and indicated a start of care date of 1/20/17. The record contained a plan of care dated 1/20/17-4/19/17, which	L 0543	·Summary statement: The agency ensures the plan of care contains all services necessary for the palliation and management of the terminal illness and related conditions. The plan of care includes the following but not limited to: interventions to manage pain and symptoms, a detailed statement of the scope and the frequency of services necessary to meet the specific patient and family needs, measurable outcomes anticipated from implementing and coordinating the of care, drugs and treatments necessary to	08/05/2017

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	indicated "SN 1-2 x week x 1 week." The record failed to evidence individualization when building the careplan because it listed all the standing orders rather than ones the patient was utilizing. A. The Plan of care contained a full list of all the hospice standing orders and did not evidence individualization of standing orders based on needs of the patient. 2. The clinical record of patient #3 was reviewed and indicated a start of care date of 2/28/17. The record contained a plan of care dated 2/28/17-5/28/17, which indicated "SN 1-2 x week x 13 weeks ... MSS [Medical Social Services] 1 x week x 1 week, 4 PRN: Assess, changes and requests. Provide counseling, emotional support, unconditional positive regard ... AID 1 x week x 1 week, 3-4 x week x 12 weeks. SC 4 PRN: assessments, changes, requests." The record failed to evidence individualization when building the careplan because it listed all the standing orders rather than ones the patient was utilizing. A. The Plan of care contained a full list of all the hospice standing orders and did not evidence individualization of standing orders based on needs of the		meet the needs of the patient, medical supplies and appliances necessary to meet the needs of the patient, and documentation from the IDG of the patient or representative (level of understanding, involvement and agreement with the plan of care). Patient and family will participate in the development of the plan of care to individualize the patient need. In addition, interdisciplinary care team is required to document in the patient record updates to the plan of care as directed by the initial assessment, comprehensive assessment, updated patient assessment, changes based on IDG discussion every 15 days, and as needed per current policy Plan of Care PFC.P15. ·Action planned: 1.Clinical leaders reviewed pertinent policy: PFC.P15 Plan of Care, and no changes were recommended for this policy. 1.Policy PFC.P15 was developed February 2009, last reviewed and updated on February 2015 and was designed to establish guidelines for a comprehensive assessment. 2.Clinical leaders plan to educate Hospice staff on the procedures for the comprehensive assessment and complete medication review. 3.Random chart audit via clinical record review will be conducted to monitor compliance with policy PFC.P15 Plan of Care.	

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	patient. 3. The clinical record of patient #4 was reviewed and indicated a start of care date of 11/15/16. The record contained a plan of care dated 5/14/17-7/12/17, which indicated "SN 1 x week x 9 weeks ... MSS 4 PRN: Counseling, financial concerns, resource referrals, AID 2 x week x 9 weeks, SC 1-2 x month." The record failed to evidence individualization when building the careplan because it listed all the standing orders rather than ones the patient was utilizing. A. The Plan of care contained a full list of all the hospice standing orders and did not evidence individualization of standing orders based on needs of the patient. 4. The clinical record of patient #6 was reviewed and indicated a start of care date of 2/9/17. The record contained a plan of care dated 5/10/17-8/7/17, which indicated "SN 1 x week x 13 weeks ... AID 2 x week x 13 weeks provide personal care and assistance with ADL's." The record failed to evidence individualization when building the careplan because it listed all the standing orders rather than ones the patient was utilizing.		·How the actions will improve the processes: Anticipated outcome of this education is that is that hospice staff will be fully aware and compliant with the policy and expectations. ·Procedures for implementing the plan of correction for this deficiency: 1.This education, provided via written educational materials and interactive discussion of the materials with clinical team members, is scheduled for completion by 8-5-17. 2.Education and discussion will take place at each region location's staff meeting and completed by August 5th. ·The Clinical Director will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur. ·A quarterly clinical record review tool and shared visit tool has been developed for hospice and will begin now with these audits for second quarter 2017. ·Results of the Clinical Record Reviews will be documented and shared with clinical leaders to pass on to staff. Data and trends will be reviewed in the Agency's QAPI meetings.	

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	A. The Plan of care contained a full list of all the hospice standing orders and did not evidence individualization of standing orders based on needs of the patient. 5. The clinical record of patient #8 was reviewed and indicated a start of care date of 3/31/17. The record contained a plan of care dated 3/31/17-6/28/17, which indicated "SN 1-2 x week x 14 weeks." The record failed to evidence individualization when building the careplan because it listed all the standing orders rather than ones the patient was utilizing. A. The Plan of care contained a full list of all the hospice standing orders and did not evidence individualization of standing orders based on needs of the patient. 6. The clinical record of patient #9 was reviewed and indicated a start of care date of 6/19/17. The record contained a plan of care dated 6/19/17-9/16/17, which indicated "SN 1-2 x week x 13 weeks ... MSS 1-3 x month x 3 months ... AID 2 x week x 1 week ... SC 1-3 x month x 3 months." The record failed to evidence individualization when building the careplan because it listed all the standing			

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	orders rather than ones the patient was utilizing. A. The Plan of care contained a full list of all the hospice standing orders and did not evidence individualization of standing orders based on needs of the patient. 7. The agencies policy titled "PLAN OF CARE," Policy #: PFC.P15 revised October 2015 stated, "POLICY STATEMENTS: Hospice care and services provided to patients and their families are in accordance with an individualized, written plan of care established by the hospice IDG in collaboration with the patient's attending physician (if any) ... PROCEDURES: B. the patient's plan of care includes all services necessary for the palliation and management of the terminal illness and related conditions. ... H. The plan of care is reviewed and updated by the IDG every 15 days or more frequently if needed." 8. The agencies Job description titled "Director-Statewide Clinical Home Health and Hospice," dated April 14, 2016 stated, "Incumbent is responsible for maintaining compliance in process, policy and service for all Statewide Homecare and Hospice activities ... Acts			

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	as the CMS [Centers for Medicaid and Medicare] Administrator for Home Health and Hospice." 9. The agencies Job description titled "Manager-Clinical Operations," dated May 28, 2013 stated, "Assures the clinical competence of staff ... Maintains twenty four accountability for quality patient care ... Maintains knowledge of best practices in areas of clinical and organizational responsibility ... Assures unit compliance with all state and national regulatory standards. ... Accountable for daily unit operations. 10. The agencies Job description titled "RN-Hospice," dated September 15, 2014 stated, "Assumes responsibility for Hospice care as per Hospice policies and procedures. Maintains up to date patient records so that problems, plans, actions and goals are accurately and clearly stated and changes are reflected as they occur. ... Initiates communication with attending physicians. ... Demonstrates familiarity with policies of the agency and rules and regulations of state and federal bodies which relate to the delivery of hospice services. ... Assumes responsibility for evening and weekend on-call duty as scheduled and consistent with services policies."			

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	11. During an interview on 7/5/17 at 1:10 PM, the administrator stated that the standing orders are on the plan of care because it is their way of getting signatures up front from physicians. Stated that the standing order is pulled into a physicians order when it is utilized and that is how they show individualization.			
L 0545 Bldg. 00	418.56(c) CONTENT OF PLAN OF CARE The hospice must develop an individualized written plan of care for each patient. The plan of care must reflect patient and family goals and interventions based on the problems identified in the initial, comprehensive, and updated comprehensive assessments. The plan of care must include all services necessary for the palliation and management of the terminal illness and related conditions, including the following: Based on record review and interview the agency failed to develop a complete plan of care for 2 of 10 records reviewed (#2, 7). Findings include: 1. The clinical record of patient #2 was reviewed and indicated a start of care date of 1/20/17. The record contained a plan of care dated 1/20/17-4/19/17, which	L 0545	·Summary statement: The agency ensures the plan of care contains all services necessary for the palliation and management of the terminal illness and related conditions. The plan of care includes the following but not limited to: interventions to manage pain and symptoms, a detailed statement of the scope and the frequency of services necessary to meet the specific patient and family needs, measurable outcomes anticipated from implementing and	08/05/2017

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INDIANA UNIVERSITY HEALTH HOSPICE	950 NORTH MERIDIAN STREET, SUITE 700 INDIANAPOLIS, IN 46204

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	indicated "SN [Skilled Nursing] 1-2 x [times] week x 1 week." The initial assessment failed to evidence patient's, complete physical, psychosocial, emotional and spiritual status which led to an incomplete individualized plan of care. All components of plan of care were not completed. A. The agency's document titled "Home Health Certification and Plan of Care," indicated incomplete Nutritional Requirements, Allergies, Functional limitations, Activities permitted, Mental Status, and Prognosis. These areas were left blank on the plan of care and not addressed by the admitting nurse. B. During an interview on 7/5/17 at 1:25 PM, the administrator stated that the patient was admitted when actively dying and that was the focus and the reason there was missing info on the plan of care. 2. The clinical record of patient #7 was reviewed and indicated a start of care date of 6/19/17. The record contained a plan of care dated 6/19/17-9/16/17, which indicated "SN 1 x day x 13 days, 5 x week x 1 week ... MSS [Medical Social Services] 1-2 x week x 1 week ... SC [Spiritual Counselor] 2-4 x month x 3 months." The record failed to evidence		coordinating the of care, drugs and treatments necessary to meet the needs of the patient, medical supplies and appliances necessary to meet the needs of the patient, and documentation from the IDG of the patient or representative (level of understanding, involvement and agreement with the plan of care). In addition, interdisciplinary care team is required to document in the patient record updates to the plan of care as directed by the initial assessment, comprehensive assessment, updated patient assessment, changes based on IDG discussion every 15 days, and as needed per current policy Plan of Care PFC.P15. ·Action planned: 1.Clinical leaders reviewed pertinent policy: Plan of Care PFC.P15, no changes were recommended for this policy. 2.Policy PFC.P15 was developed February 2009, last reviewed and updated on February 2015 and was designed to establish guidelines for a comprehensive assessment. 3.Clinical leaders plan to educate Hospice staff on the procedures for the completeness of the plan of care. 4.Random chart audit via clinical record review will be conducted to monitor compliance with policy Admission – Plan of Care PFC.P15 including plan of care individualization.	

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	that the completing clinician signed and dated the created plan of care. A. The agency's document titled "Home Health Certification and Plan of Care," indicated incomplete Clinician's Signature as it was left blank on the plan of care and not addressed by the admitting nurse. B. During an interview on 7/5/17 at 2:07 PM, employee F stated that there was a box that was not checked on the plan of care that signs the document from completing clinician. C. During an interview on 7/5/17 at 2:08 PM, the administrator stated that this was missed by the auditor. 3. The agencies policy titled "PLAN OF CARE," Policy #: PFC.P15 revised October 2015 stated, "POLICY STATEMENTS: Hospice care and services provided to patients and their families are in accordance with an individualized, written plan of care established by the hospice IDG in collaboration with the patient's attending physician (if any) ... PROCEDURES: B. the patient's plan of care includes all services necessary for the palliation and management of the terminal illness and related conditions. ... H. The plan of care		·How the actions will improve the processes: Anticipated outcome of this education, is that is that hospice staff will be fully aware and compliant with the policy and expectations. ·Procedures for implementing the plan of correction for this deficiency: 1.This education, provided via written educational materials and interactive discussion of the materials with clinical team members, is scheduled for completion by 8-5-17. 2.Education and discussion will take place at each region location's staff meeting and completed by August 5th. ·The Clinical Director will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur. ·A quarterly clinical record review tool and shared visit tool has been developed for hospice and will begin now with these audits for second quarter 2017. ·Results of the Clinical Record Reviews will be documented and shared with clinical leaders to pass on to staff. Data and trends will be reviewed in the Agency's QAPI meetings.	

is reviewed and updated by the IDG every 15 days or more frequently if needed."

4. The agencies Job description titled "Director-Statewide Clinical Home Health and Hospice," dated April 14, 2016 stated, "Incumbent is responsible for maintaining compliance in process, policy and service for all Statewide Homecare and Hospice activities ... Acts as the CMS [Centers for Medicaid and Medicare] Administrator for Home Health and Hospice."

5. The agencies Job description titled "Manager-Clinical Operations," dated May 28, 2013 stated, "Assures the clinical competence of staff ... Maintains twenty four accountability for quality patient care ... Maintains knowledge of best practices in areas of clinical and organizational responsibility ... Assures unit compliance with all state and national regulatory standards. ... Accountable for daily unit operations.

6. The agencies Job description titled "RN-Hospice," dated September 15, 2014 stated, "Assumes responsibility for Hospice care as per Hospice policies and procedures. Maintains up to date patient records so that problems, plans, actions and goals are accurately and clearly

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	stated and changes are reflected as they occur. ... Initiates communication with attending physicians. ... Demonstrates familiarity with policies of the agency and rules and regulations of state and federal bodies which relate to the delivery of hospice services. ... Assumes responsibility for evening and weekend on-call duty as scheduled and consistent with services policies."			
L 0555 Bldg. 00	418.56(e)(2) COORDINATION OF SERVICES [The hospice must develop and maintain a system of communication and integration, in accordance with the hospice's own policies and procedures, to-] (2) Ensure that the care and services are provided in accordance with the plan of care.			
	Based on document review, policy review, and interview the agency failed to ensure that services provided were in accordance with plan of care for 1 of 10 records reviewed (#3). Findings include: 1. The clinical record of patient #3 was reviewed and indicated a start of care date of 2/28/17. The record contained a plan of care dated 2/28/17-5/28/17, which indicated "SN [Skilled Nursing] 1-2 x [times] week x 13 weeks ... MSS	L 0555	·Summary statement: The hospice must develop and maintain a system of communication and integration, in accordance with the hospice's own policies and procedures, to ensure that the care and services are provided in accordance with the plan of care per current policy HOSPICE CARE FOR NURSING FACILITY RESIDENTS – COORDINATION OF CARE PFC.H20 · Action planned: ·Clinical leaders reviewed pertinent policy: HOSPICE CARE FOR NURSING FACILITY	08/05/2017

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	[Medical Social Services] 1 x week x 1 week, 4 PRN: Assess, changes and requests. Provide counseling, emotional support, unconditional positive regard ... AID 1 x week x 1 week, 3-4 x week x 12 weeks. SC [Spiritual Counselor] 4 PRN [as needed]: assessments, changes, requests." The record failed to evidence an order for 6 mg of alprazalam as well as notification to the physician that patient received more alprazalam than physician ordered. A. The agency's document titled "Chart/Clinical Notes," dated 3/3/17 indicated, "CG [caregiver] gave 6 mg [milligram] alprazalam." B. The agency's document titled "Hospice v16.3 Oncall/Unscheduled visit - on 03-03-2017," indicated "pt [patient] became comfortable once bladder was drained and alprazalam dose 6 mg." C. The agency's document titled "Medication Status," indicated "Alprazalam by mouth tablet 2 MG. 1 tablet every 4 hours as needed PO [as needed] for anxiety." D. During an interview on 7/5/17 at 1:30 PM, the administrator stated agreement to medication error.		RESIDENTS – COORDINATION OF CARE PFC.H20 and no changes were recommended for this policy.s policy. 1.Policy PFC.H20 was developed February 2009, last reviewed and updated on March, 2015 and was designed to ensure that a written plan of care is established and maintained for each facility patient and is developed and coordinated with the hospice IDG in consultation with facility representatives and the patient's attending physician. 2.Clinical leaders plan to re-educate Hospice staff on requirement that all care provided to hospice patients in nursing facility must be in accordance with a coordinated hospice plan of care. 3.Random chart audit via clinical record review will be conducted to monitor for compliance with HOSPICE CARE FOR NURSING FACILITY RESIDENTS – **COORDINATION OF CARE PFC.H20** ·How the actions will improve the processes: Anticipated outcome of this education, and chart audits is that hospice staff will be fully aware and maintain compliance with the policy and expectations. ·Procedures for implementing the plan of correction for this deficiency: 1.This education, provided via written educational materials and interactive discussion of the	

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	2. The agencies policy titled "HOSPICE CARE FOR NURSING FACILITY RESIDENTS-COORDINATION OF CARE," Policy #: PFC.H20 revised February 2015 stated "POLICY STATEMENTS: [Agency] ensures that mechanisms are in place to provide for coordination of all hospice services provided to patients residing in facilities. ... PROCEDURES: C. The following information is provided to the facility: 1. The most recent hospice plan of care specific to each patient; 2. Hospice election form and any advance directives specific to each patient; Physician certification and recertification of the terminal illness specific to each patient; Names and contact information for hospice personnel involved in hospice care of each patient; 5. Instructions on how to access the hospice's 24 hour on-call system; 6. Hospice medication information specific to each patient; and 7. Hospice physician and attending physician (if any) orders specific to each patient." 3. The agencies Job description titled "Director-Statewide Clinical Home Health and Hospice," dated April 14, 2016 stated, "Incumbent is responsible for maintaining compliance in process, policy and service for all Statewide Homecare and Hospice activities ... Acts		materials with clinical team members, is scheduled for completion by 8-5-17. 2.Education and discussion provided at each region location's staff meeting and completed by August 5th. ·The Clinical Director will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur. ·A quarterly clinical record review tool has been developed for hospice and will begin now with these audits for second quarter 2017. Results of the Clinical Record Reviews will be documented and shared with clinical leaders to pass on to staff. Will also be reviewed in the Agency's QAPI monthly meetings.	

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	as the CMS [Centers for Medicaid and Medicare] Administrator for Home Health and Hospice." 4. The agencies Job description titled "Manager-Clinical Operations," dated May 28, 2013 stated, "Assures the clinical competence of staff ... Maintains twenty four accountability for quality patient care ... Maintains knowledge of best practices in areas of clinical and organizational responsibility ... Assures unit compliance with all state and national regulatory standards. ... Accountable for daily unit operations.			
L 0653 Bldg. 00	418.100(c)(2) SERVICES (2) Nursing services, physician services, and drugs and biologicals (as specified in §418.106) must be made routinely available on a 24-hour basis 7 days a week. Other covered services must be available on a 24-hour basis when reasonable and necessary to meet the needs of the patient and family.			
	Based on record review, policy review, and interview the agency failed to ensure that nursing serviced were made available on a 24-hour basis for 2 of 10 records reviewed (#1, 3). Findings include:	L 0653	Summary statement: The agency ensures that nursing is available on a 24 hour basis. Action planned: 1.Clinical leaders reviewed pertinent policy: PFC.A65 , no changes were recommended for	08/05/2017

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	1. The clinical record of patient #1 was reviewed and indicated a start of care date of 2/2/17. The record contained a plan of care dated 2/2/17-5/2/17, which indicated "SN [Skilled Nurse] 1-2 x [times] week x 13 weeks ... SN 5 PRN [as needed]: symptom management, patient comfort, family request. Instruct patient/caregiver on around the clock medication administration and maintenance of pain medication log, Assess/instruct patient/caregiver on medication administration, side effects, actions, and effectiveness ... Aid 1-2 x week x 13 weeks ... Provide personal care and assistance with ADL's [Activities of daily living] ... SC [Spiritual Counselor] 8 PRN: Provide relation-based spiritual care ... SC 1 x day x 1 day." A. The SNF Resident Progress Note from the Registered Nurse (RN) on duty dated 2/10/17 at 12:37 AM indicated "At 9 PM resident daughter asked me to come in to assess her mother. Resident RR [Respiration Rate] increased to 32 and frothy bile colored secretions coming from resident mouth. Writer completed mouth care and administered another PRN Hyoscyamine and morphine 0.25 ml [milliliter]. Meds were ineffective. Writer called [hospice agency] ... On call		this policy. 1.Policy PPFC.A65 was developed February 2009 , last reviewed and updated on March 2015, and was designed to communicate guidelines for availability 24/7. 2.Clinical leaders re-educated all Hospice staff on the policy and guidelines of on call and after hour nursing 24 hour availability. ·How the actions will improve the processes: Anticipated outcome of this education is that the hospice staff will be fully aware of the policy and expectations. ·Procedures for implementing the plan of correction for this deficiency: 1.Provide education to all Hospice Staff, provided via written educational materials and interactive discussion of the materials with clinical team members, is scheduled for completion by 8-5-17. 2.Education and discussion will take place at each region location's staff meeting and completed by August 5th. ·The Clinical Director will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	

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	hospice nurse stated that it sounds like re doing all that can be done. Writer responded ... residents daughter would like you or someone from the hospice to come in. [Hospice nurse] replied I will call the on call nurse and see if she can make a visit. No hospice nurse ever showed up and writer never received a call back from hospice." The record failed to evidence that symptoms were controlled and hospice failed to make a visit to assist with symptom management. 2. The clinical record of patient #3 was reviewed and indicated a start of care date of 2/28/17. The record contained a plan of care dated 2/28/17-5/28/17, which indicated "SN 1-2 x week x 13 weeks ... MSS [Medical Social Services] 1 x week x 1 week, 4 PRN: Assess, changes and requests. Provide counseling, emotional support, unconditional positive regard ... AID 1 x week x 1 week, 3-4 x week x 12 weeks. SC 4 PRN: assessments, changes, requests." The record failed to evidence that a SN was readily available to meet the patient/family needs. A. The agency's document titled "Chart/Clinical Notes," dated 3/5/17 and signed by RN at 3:13 PM indicated "Call from sister saying [sister] has not heard from nurse. Explained with another patient unable to urinate. Advised will			

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	come see them as soon as that is resolved. Not happy about having to wait." B. The agency's document titled "Chart/Clinical Notes," dated 3/5/17 and signed by RN at 3:40 PM indicated "Call from brother-in-law upset that it is taking so log for nurse to get there. Explained [nurse] was with another family, and will come as soon as she has finished with [patient] visit. Disputed the need to take so long. Explained [agency] have a duty to all of out patients to give them the time they need, and at times we have to ask some families to be patient to allow us to provide the care they would want us to provide them. Said [agency] is not meeting [families] needs. ... [Caller] said they would have gotten better care with another agency." C. The agency's document titled "Chart/Clinical Notes," dated 3/5/17 from the on call nurse visit indicated, "Family states being unhappy with hospice experience and patients sister asks for revocation forms as [sister] has already contacted another hospice company. Sister states that if pt [patient] alive in AM [morning] that will revoke and contact other hospice company." Documentation of note is signed 3/8/17 at 11:53 PM. It is not evidenced what			

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	time nurse arrived to home. D. During an interview on 7/5/17 at 1:32 PM, the administrator stated that the backup oncall nurse should have been sent out for this family. 3. The agencies policy titled "AVAILABILITY 24/7," Policy #: PFC.A65 revised February 3, 2015 stated "POLICY STATEMENTS: Care and services provided by [agency]are available 24 hours a day, 7 days a week, including holidays, as needed to meet the needs of patients and their caregivers. PROCEDURES: A. [Agency] assures that there is adequate staffing to meet the needs of patients. On-call services are provided to patients and their caregivers after business hours and on weekends and holidays for telephone consultation and visits as needed. ... E. Contractual agreements are maintained with pharmacies in the hospices service area to assure that medications are readily available." 4. The agencies Job description titled "Director-Statewide Clinical Home Health and Hospice," dated April 14, 2016 stated, "Incumbent is responsible for maintaining compliance in process, policy and service for all Statewide Homecare and Hospice activities ... Acts			

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	as the CMS [Centers for Medicaid and Medicare] Administrator for Home Health and Hospice." 5. The agencies Job description titled "Manager-Clinical Operations," dated May 28, 2013 stated, "Assures the clinical competence of staff ... Maintains twenty four accountability for quality patient care ... Maintains knowledge of best practices in areas of clinical and organizational responsibility ... Assures unit compliance with all state and national regulatory standards. ... Accountable for daily unit operations. 6. The agencies Job description titled "RN-Hospice," dated September 15, 2014 stated, "Assumes responsibility for Hospice care as per Hospice policies and procedures. Maintains up to date patient records so that problems, plans, actions and goals are accurately and clearly stated and changes are reflected as they occur. ... Initiates communication with attending physicians. ... Demonstrates familiarity with policies of the agency and rules and regulations of state and federal bodies which relate to the delivery of hospice services. ... Assumes responsibility for evening and weekend on-call duty as scheduled and consistent with services policies."			

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	7. During an interview on 6/28/17 at 3:27 PM the administrator stated that a clinical manager or team leader is backup for on call nurse and ultimately the administrator if needed for patient/family oncall needs. 8. During an interview on 6/28/17 at 3:28 PM the administrator stated that it is not the agencies practice to deny a visit if one is requested.			
L 0661 Bldg. 00	418.100(g)(1) TRAINING (1) A hospice must provide orientation about the hospice philosophy to all employees and contracted staff who have patient and family contact. Based on document review and interview the agency failed to ensure that all employees working in the hospice house were on the employee register and received orientation to the hospice philosophy for 4 active employees (G, H, I, J). Findings include: 1. On 6/28/17 at 2:50 PM, the agency provided surveyor with employee lists for all branches.	L 0661	·Summary statement: The agency ensures the all employees, contract staff, and volunteers, everyone who has patient and family contact will receive orientation about the hospice philosophy. ·Action planned: 1.An active employee list, including all volunteers, contract staff and management, will be maintained and updated with each new hire or termination of employment. 2.Clinical leaders reviewed pertinent policy: Competency Assessment for Staff HR.115 and was reviewed and revised, to	08/05/2017

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	2. The employee list for Bloomington Hospice House indicated 8 Registered Nurses, 3 Licensed Practical Nurses, and 5 Home Health Aides. The employee list indicated no other staff or management at the hospice house. 3. During interview on 6/29/17 at 11:20 AM, Employee H, Regional Director stated that employees at the hospice house have the same competencies as the hospital. 4. During interview on 6/29/17 at 12:30 PM, Employee H stated that the dietician comes from another office. 5. During interview on 6/29/17, at 10:20 AM Employee G, the maintenance tech stated that his records are stored at the hospital. 6. The agencies Job description titled "Director-Statewide Clinical Home Health and Hospice," dated April 14, 2016 stated, "Incumbent is responsible for maintaining compliance in process, policy and service for all Statewide Homecare and Hospice activities ... Acts as the CMS [Centers for Medicaid and Medicare] Administrator for Home Health and Hospice."		apply to all employees, volunteers and contracted staff, anyone that has patient and family contact. All employees, contracted staff, volunteers who have patient and family contact, will be required to receive orientation to the hospice philosophy at hire. ·How the actions will improve the processes: Anticipated outcome- all hospice staff all (including: employees, volunteers and contract staff, anyone with patient or family contact) will receive education on the hospice philosophy as part of our onboarding education, records of education will be maintained in each employee record. ·Procedures for implementing the plan of correction for this deficiency: 1.Leadership has been notified of the requirement to maintain an updated list of active employees, including anyone with patient or family contact, contract staff, volunteers. List is to be updated with each new hire and termination of employment and include all employees, volunteers and contract staff. 2.This education, provided via written educational materials and interactive discussion of the materials with clinical team members, is scheduled for completion by 8-5-17. 3.Education and discussion will take place at each region location's staff meeting and completed by August 5th.	

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	151511	A. BUILDING 00 B. WING	07/05/2017

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			4.Clinical staff will be required to sign a statement indicating he/she has reviewed the educational materials and understands the expectation of completing all the components of Hospice Philosophy education. ·The Clinical Director will be responsible for maintaining a current list of active employees, contract staff, and volunteers, ensuring they have received education on the hospice philosophy as part of their orientation. The Clinical Director will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	
L 0678 Bldg. 00	418.104(a)(7) CONTENT [Each patient's record must include the following:] (7) Physician orders. Based on record review and interview the agency failed to evidence a physicians order for medications given for 1 of 10 records reviewed (#3). Findings include: 1. The clinical record of patient #3 was reviewed and indicated a start of care date of 2/28/17. The record contained a plan of care dated 2/28/17-5/28/17, which	L 0678	·Summary statement: The agency ensures physician orders are obtained as needed and received from the physician within the time frame required by laws and regulations. The physician orders are for the following but not limited to: admit the patient to hospice services and to initially certify the patient’s terminal illness, new medications, change in medications, discontinuation of medication, change in visit frequency if not within the range	08/05/2017

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	indicated "SN [Skilled Nursing] 1-2 x [times] week x 13 weeks ... MSS [Medical Social Services] 1 x week x 1 week, 4 PRN: Assess, changes and requests. Provide counseling, emotional support, unconditional positive regard ... AID 1 x week x 1 week, 3-4 x week x 12 weeks. SC [Spiritual Counselor] 4 PRN [as needed]: assessments, changes, requests." The record failed to evidence an order for 6 mg of alprazalam as well as notification to the physician that patient received more alprazalam than physician ordered. A. The agency's document titled "Chart/Clinical Notes," dated 3/3/17 indicated, "CG [caregiver] gave 6 mg [milligram] alprazalam." B. The agency's document titled "Hospice v16.3 Oncall/Unscheduled visit - on 03-03-2017," indicated "pt [patient] became comfortable once bladder was drained and alprazalam dose 6 mg." C. The agency's document titled "Medication Status," indicated "Alprazalam by mouth tablet 2 MG. 1 tablet every 4 hours as needed PO [as needed] for anxiety." 2. The agencies Job description titled "Manager-Clinical Operations," dated		specified in the patient's plan of care, dressing changes, wound care, and/or added disciplines or services or equipment to meet the needs of the patient. Documentation of receipt of the verbal order and of the written are sent to the physician for signature are maintained in patient's medical record per current policy Physician Orders WE.P30. ·Action planned: 1.Clinical leaders reviewed pertinent policy: Physician Orders WE.P30, no changes were recommended for this policy. 2.Policy WE.P30 was developed February 2009, last reviewed and updated on February 2015 and was designed to communicate guidelines for physician orders. 3.Clinical leaders plan to educate hospice staff on the procedure for physician orders. 4.The Agency's Statewide Medical Director plan to educate medical director staff on the procedures for physician orders. 5.Random chart audits will be conducted to monitor compliance with policy WE.P30 including the documentation within the EMR. ·How the actions will improve the processes: Anticipated outcome of this education, and chart audits is that hospice staff will be fully aware and compliant with the policy and expectations. ·Procedures for implementing	

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	May 28, 2013 stated, "Assures the clinical competence of staff ... Maintains twenty four accountability for quality patient care ... Maintains knowledge of best practices in areas of clinical and organizational responsibility ... Assures unit compliance with all state and national regulatory standards. ... Accountable for daily unit operations.		the plan of correction for this deficiency: 1.This education, provided via written educational materials and interactive discussion of the materials with clinical team members, is scheduled for completion by 8-5-17. 2.Education and discussion will take place at each region location's staff meeting and completed by August 5th. ·The Clinical Director will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur. ·A quarterly clinical record review and shared visit tool has been developed for hospice and will begin now with these audits for second quarter 2017. ·Results of the Clinical Record Reviews will be documented and shared with clinical leaders to share with staff. Data and trends will be reviewed in the Agency's QAPI meetings.	
L 0680 Bldg. 00	418.104(c) PROTECTION OF INFORMATION The clinical record, its contents and the information contained therein must be safeguarded against loss or unauthorized use. The hospice must be in compliance with the Department's rules regarding personal health information as set out at 45 CFR parts 160 and 164. Based on record review, policy review,	L 0680	**Summary Statement: The**	08/05/2017

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	and interview the agency failed to protect and safeguard records against loss for 1 of 10 records reviewed (#1). Findings include: 1. The clinical record of patient #1 was reviewed and indicated a start of care date of 2/2/17. The record contained a plan of care dated 2/2/17-5/2/17, which indicated "SN [Skilled Nurse] 1-2 x [times] week x 13 weeks ... SN 5 PRN [as needed]: symptom management, patient comfort, family request. Instruct patient/caregiver on around the clock medication administration and maintenance of pain medication log, Assess/instruct patient/caregiver on medication administration, side effects, actions, and effectiveness ... Aid 1-2 x week x 13 weeks ... Provide personal care and assistance with ADL's [Activities of daily living] ... SC [Spiritual Care] 8 PRN: Provide relation-based spiritual care ... SC 1 x day x 1 day." The hospice failed to safeguard and protect hospice records against loss, from facility where patient resided, after patient passed away. The facility nor the hospice could locate patients hospice records from hospice binder. A. During an interview on 6/28/17 at		**agency will protect and safeguard records against loss. (1 or 10 records reviewd)** **Action Planned:** **·The agency Leadership reviewed policies CES.C15 Clinical Records, and PFC.H20 Hospice Care For Nursing Facility Residents-Coordination of Care, No suggestions for revisions were made for CES.C15. Suggestions made to revise policy PFC.H20 to include provision that written documentation left in facility is considered to be part of hospice Clinical Record and will be picked up by Hospice Agency Staff upon death or discharge of patient and that this documentation will be scanned into the Hospice Agency's EMR.** ·Policy CES.C15 was developed February 2009, last reviewed and updated April 2015, and was designed to communicate guidelines for clinical records. ·PRC.H20 was developed February 2009, last reviewed and updated on February 2015 and was designed to communicate guidelines for coordination of care, including Hospice medical records in a facility. Policy revised	

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	11:00 AM, Employee A, the administrator, stated that the hospice records within the binders at facilities are the property of the facility since it is on site at the facility. B. During an interview on 6/27/17 at 12:12 PM, Employee AA, the Director of Nursing at the facility where patient resided, stated that the facility medical records department called the hospice inquiring where the hospice documentation was from the hospice binder. Stated the hospice instructed that after patient death that the binder is picked up and the records are shredded. C. During an interview on 6/28/17 at 12:06 PM, the administrator stated that when facility called hospice in regards to records employee K told facility that the binder is picked up after death. D. During an interview on 6/28/17 at 12:07 PM, the administrator stated that the hospice gives the facility the option to keep the records from the hospice binder. If facility does not want the records then it will be scanned into the hospice records. Also stated that there is no records from the facility scanned into patients hospice record. E. During interview on 6/27/17 at		to include provision that written documentation left in the facility is considered part of the Hospice Clinical Record and will be picked up by Hospice Agency Staff at discharge of or death of patient and will be scanned into the EMR. ·Provide Staff education before August 5, 2017, around the facility record considered part of the Hospice Clinical Record and will be picked up by Hospice Agency staff upon death or discharge of the patient, then scanned into the Hospice Agency's EMR. ·**Random** shared visits will be conducted with leadership visiting patients in facilities at each location to assess and monitor compliance with policy CES.C15 Clinical Records and PFC.H20 Hospice Care for Nursing Facility Residents, including the documentation within the EMR. ·How the actions will improve the processes: Anticipated outcome of this education, shared visits and chart audits is that hospice staff will be fully aware of the policy and expectations. ·Procedures for implementing the plan of correction for this deficiency: 1.Clinical Leaders will provide education via written educational materials and interactive discussion of the materials with clinical team members, is scheduled for completion by 8-5-17. 2.Education and discussion	

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	11:45 AM, Employee AA stated that hospice documentation is usually sent to facilities medical records and then scanned into the patients chart. F. During interview on 6/27/17 at 12:13 PM, Employee AA stated that there is no hospice documentation in the facilities records for this patient. 2. The agencies policy titled "PROTECTION/STORAGE/DESTRUCTION OF CLIENT RECORDS," Policy #: RC.101 revised March 2017 stated "SCOPE: This policy applies to all paper and electronic client records. ... POLICY STATEMENTS: [Agency] is responsible for the protection of client records and the storage of those records once the patient has been discharged or is no longer receiving services from [agency]. ... Client record information is safeguarded against loss ... All records shall be maintained for ten (10) years from the dates of service or record creation." 3. The agencies Job description titled "Director-Statewide Clinical Home Health and Hospice," dated April 14, 2016 stated, "Incumbent is responsible for maintaining compliance in process, policy and service for all Statewide Homecare and Hospice activities ... Acts		will take place at each region location's staff meeting and completed by August 5th. ·The Clinical Director will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur. ·A quarterly clinical record review tool has been developed for hospice and will include this information for second quarter 2017. ·Results of the Clinical Record Reviews will be documented and shared with clinical leaders to discuss with staff. Data and trends will be reviewed in the Agency's QAPI meetings.	

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	as the CMS [Centers for Medicaid and Medicare] Administrator for Home Health and Hospice."			
L 0681 Bldg. 00	418.104(d) RETENTION OF RECORDS Patient clinical records must be retained for 6 years after the death or discharge of the patient, unless State law stipulates a longer period of time. If the hospice discontinues operation, hospice policies must provide for retention and storage of clinical records. The hospice must inform its State agency and its CMS Regional office where such clinical records will be stored and how they may be accessed.			
	Based on record review, policy review, and interview the agency failed to retain written hospice records from a skilled nursing facility for 1 of 10 records reviewed (#1). Findings include: 1. The clinical record of patient #1 was reviewed and indicated a start of care date of 2/2/17. The record contained a plan of care dated 2/2/17-5/2/17, which indicated "SN [Skilled Nurse] 1-2 x [times] week x 13 weeks ... SN 5 PRN [as needed]: symptom management, patient comfort, family request. Instruct patient/caregiver on around the clock medication administration and	L 0681	Summary Statement: The agency will retain written hospice records from a skilled nursing facility. (1 or 10 records reviewed) Action Planned: ·The agency Leadership reviewed policies CES.C15 Clinical Records, and PFC.H20 Hospice Care For Nursing Facility Residents-Coordination of Care, No suggestions for revisions were made for CES.C15. Suggestions made to revise policy PFC.H20 to include provision that written documentation left in facility is considered to be part of hospice Clinical Record and will be picked up by Hospice Agency Staff upon death or discharge of patient and	08/05/2017

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	maintenance of pain medication log, Assess/instruct patient/caregiver on medication administration, side effects, actions, and effectiveness ... Aid 1-2 x week x 13 weeks ... Provide personal care and assistance with ADL's [Activities of daily living] ... SC [Spiritual Care] 8 PRN: Provide relation-based spiritual care ... SC 1 x day x 1 day." The hospice failed to retain hospice records from facility where patient resided, after patient passed away. The facility nor the hospice could locate patients hospice records from hospice binder. A. During an interview on 6/28/17 at 11:00 AM, Employee A, the administrator, stated that the hospice records within the binders at facilities are the property of the facility since it is on site at the facility. B. During an interview on 6/27/17 at 12:12 PM, Employee AA, the Director of Nursing at the facility where patient resided, stated that the facility medical records department called the hospice inquiring where the hospice documentation was from the hospice binder. Stated the hospice instructed that after patient death that the binder is picked up and the records are shredded.		that this documentation will be scanned into the Hospice Agency's EMR. Hospice staff will discontinue the practice of leaving their written documentation (in the form of communication notes, progress notes, etc.,) ·Policy CES.C15 was developed February 2009, last reviewed and updated April 2015, and was designed to communicate guidelines for clinical records. ·PRC.H20 was developed February 2009, last reviewed and updated on February 2015 and was designed to communicate guidelines for coordination of care, including Hospice medical records in a facility.Policy revised to include provision that written documentation left in the facility is considered part of the Hospice Clinical Record and will be picked up by Hospice Agency Staff at discharge of or death of patient and will be scanned into the EMR. ·Provide Staff education before August 5, 2017, around the facility record considered part of the Hospice Clinical Record and will be picked up by Hospice Agency staff upon death or discharge of the patient, then scanned into the Hospice Agency's EMR. **·Clinical Leaders will perform random shared visits will be conducted with staff visiting patients in facilities at each location to assess and monitor**compliance with policy	

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	C. During an interview on 6/28/17 at 12:06 PM, the administrator stated that when facility called hospice in regards to records employee K told facility that the binder is picked up after death. D. During an interview on 6/28/17 at 12:07 PM, the administrator stated that the hospice gives the facility the option to keep the records from the hospice binder. If facility does not want the records then it will be scanned into the hospice records. Also stated that there is no records from the facility scanned into patients hospice record. E. During interview on 6/27/17 at 11:45 AM, Employee AA stated that hospice documentation is usually sent to facilities medical records and then scanned into the patients chart. F. During interview on 6/27/17 at 12:13 PM, Employee AA stated that there is no hospice documentation in the facilities records for this patient. 2. The agencies Job description titled "Director-Statewide Clinical Home Health and Hospice," dated April 14, 2016 stated, "Incumbent is responsible for maintaining compliance in process, policy and service for all Statewide Homecare and Hospice activities ... Acts		CES.C15 Clinical Records and PFC.H20 Hospice Care for Nursing Facility Residents, including the documentation within the EMR. ·How the actions will improve the processes: Anticipated outcome of this education, shared visits and chart audits is that hospice staff will be fully aware of the policy and expectations. ·Procedures for implementing the plan of correction for this deficiency: 1.Clinical Leaders will provide education via written educational materials and interactive discussion of the materials with clinical team members, is scheduled for completion by 8-5-17. 2.Education and discussion will take place at each region location's staff meeting and completed by August 5th. ·The Clinical Director will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur. ·A quarterly clinical record review tool has been developed for hospice and will include this information for second quarter 2017. ·Results of the Clinical Record Reviews will be documented and shared with clinical leaders to discuss with staff. Data and trends will be reviewed in the Agency's QAPI meetings.	

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	as the CMS [Centers for Medicaid and Medicare] Administrator for Home Health and Hospice."			
L 0684 Bldg. 00	418.104(e)(3) DISCHARGE OR TRANSFER OF CARE (3) The hospice discharge summary required by (e)(1) and (e)(2) of this section must include- (i) A summary of the patient's stay including treatments, symptoms and pain management; (ii) The patient's current plan of care; (iii) The patient's latest physician orders; and (iv) Any other documentation that will assist in post-discharge continuity of care or that is requested by the attending physician or receiving facility.			
	Based on record review and interview the agency failed to ensure that the discharge summary was complete with all required information for 1 of 10 records reviewed (#1). Findings include: 1. The clinical record of patient #1 was reviewed and indicated a start of care date of 2/2/17. The record contained a plan of care dated 2/2/17-5/2/17, which indicated "SN [Skilled Nurse] 1-2 x [times] week x 13 weeks ... SN 5 PRN [as needed]: symptom management,	L 0684	Summary statement: The agency ensures that the discharge summary is complete with all required information. Action planned: 1.Clinical leaders reviewed pertinent policy: CES.D15 Discharge from Hospice Care and no changes were recommended for this policy. 1.Policy CES.D15 Discharge from Hospice Care was developed February 2009 , last reviewed and updated on February 2015, and was designed to communicate guidelines for	08/05/2017

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	patient comfort, family request. Instruct patient/caregiver on around the clock medication administration and maintenance of pain medication log, Assess/instruct patient/caregiver on medication administration, side effects, actions, and effectiveness ... Aid 1-2 x week x 13 weeks ... Provide personal care and assistance with ADL's [Activities of daily living] ... SC [Spiritual Care] 8 PRN: Provide relation-based spiritual care ... SC 1 x day x 1 day." The record failed to evidence a complete and accurate discharge summary. A. The agency's document titled "Agency Discharge summary as of 7/5/2017," indicated "Services Provided, Goals/Expected Health Status Evaluation." The record failed to evidence a summary of the patient's stay including treatments, symptoms and pain management; the patients current plan of care; and the patient's latest physician orders. 2. The agencies Job description titled "Director-Statewide Clinical Home Health and Hospice," dated April 14, 2016 stated, "Incumbent is responsible for maintaining compliance in process, policy and service for all Statewide Homecare and Hospice activities ... Acts		discharging a hospice patient, including required information for the discharge summary. 2.Clinical leaders re-educated all Hospice staff on the policy and guidelines of required information for a discharge summary. ·How the actions will improve the processes: Anticipated outcome of this education is that the hospice staff will be fully aware and compliant with the policy and expectations. ·Procedures for implementing the plan of correction for this deficiency: 1.Provide education to all Hospice Staff, provided via written educational materials and interactive discussion of the materials with clinical team members, is scheduled for completion by 8-5-17. 2.Education and discussion will take place at each region location's staff meeting and completed by August 5th. ·The Clinical Director will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur. ·A quarterly clinical record review tool has been developed for hospice and will include this information for second quarter 2017. ·Results of the Clinical Record Reviews will be documented and shared with clinical leaders to discuss with staff. Data and	

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	as the CMS [Centers for Medicaid and Medicare] Administrator for Home Health and Hospice." 3. During an interview on 7/5/17 at 12:54 PM, the administrator stated that the Agency discharge summary is the only thing that is sent to the physician upon discharge or patient death.		trends will be reviewed in the Agency's QAPI meetings.	
L 0778 Bldg. 00	418.112(e)(1)(i) COORDINATION OF SERVICES [The designated interdisciplinary group member is responsible for:] (i) Providing overall coordination of the hospice care of the SNF/NF or ICF/MR resident with SNF/NF or ICF/MR representatives; Based on record review, policy review, and interview the agency failed to ensure that coordination of care was established with facility staff with every nursing visit for 4 of 9 records reviewed receiving hospice in Skilled Nursing Facilities (SNF) (1, 4, 5, 6). Findings include: 1. The clinical record of patient #1 was	L 0778	·Summary statement: The agency ensures the staff is providing the following for each specific patient: most recent hospice plan of care, hospice election form, any advance directives, physician certification and recertification of the terminal illness, names and contact information for hospice personnel involved in the care, instructions on how to access the hospice's 24 hour on call system, hospice medication information, and	08/05/2017

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	reviewed and indicated a start of care date of 2/2/17. The record contained a plan of care dated 2/2/17-5/2/17, which indicated "SN [Skilled Nurse] 1-2 x [times] week x 13 weeks ... SN 5 PRN [as needed]: symptom management, patient comfort, family request. Instruct patient/caregiver on around the clock medication administration and maintenance of pain medication log, Assess/instruct patient/caregiver on medication administration, side effects, actions, and effectiveness ... Aid 1-2 x week x 13 weeks ... Provide personal care and assistance with ADL's [Activities of daily living] ... SC [Spiritual Counselor] 8 PRN: Provide relation-based spiritual care ... SC 1 x day x 1 day." A. In the agency's document titled "Hospice v16.3 Initial Visit- on 02-02-2017, the care management section of assessment indicated "Case Coordination: List all communication with other disciplines, agencies and vendors today." None." The record failed to evidence any care coordination between the hospice nurse and the facility staff or family. B. In the agency's document titled "Hospice v16.3 Routine Visit- on 02-04-2017, the assessment contains no mention of care coordination. The record		hospice physician and attending physician (if any) orders specific to the patient. In addition, documenting coordination of care in the patient record all of this per current policy Coordination of Care PRC.H20. ·Action planned: 1.Clinical leaders reviewed pertinent policy: Hospice Care for Nursing Facility Residents – Coordination of Care PRC.H20, no changes were recommended for this policy. 1.Policy PRC.H20 was developed February 2009, last reviewed and updated on February 2015 and was designed to communicate guidelines for coordination of care in a facility. 2.Clinical leaders Re-education of Hospice staff on the procedure for providing the facility with the aforementioned documents and correctly documenting coordination of care within the assessment. 3.Random Shared visits will be conducted with staff visiting patients in facilities at each location to assess and monitor compliance with policy Coordination of Care PRC.H20 including the documentation within the EMR. ·How the actions will improve the processes: Anticipated outcome of this education, shared visits and chart audits is that hospice staff will be fully aware of the policy and expectations. ·Procedures for implementing	

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	failed to evidence any care coordination between the hospice nurse and the facility staff or family. 2. The clinical record of patient #4 was reviewed and indicated a start of care date of 11/15/16. The record contained a plan of care dated 5/14/17-7/12/17, which indicated "SN 1 x week x 9 weeks ... MSS [Medical Social Services] 4 PRN: Counseling, financial concerns, resource referrals, AID 2 x week x 9 weeks, SC 1-2 x month." A. In the agency's document titled "Hospice v16.3 Routine Visit- on 05-15-2017, the care management section of assessment indicated "Case Coordination: List all communication with other disciplines, agencies and vendors today." None." The record failed to evidence any care coordination between the hospice nurse and the facility staff or family. B. In the agency's document titled "Hospice v16.3 Routine Visit- on 05-22-2017, the care management section of assessment indicated "Case Coordination: List all communication with other disciplines, agencies and vendors today." None." The record failed to evidence any care coordination between the hospice nurse and the facility staff or family.		the plan of correction for this deficiency: 1.This education, provided via written educational materials and interactive discussion of the materials with clinical team members, is scheduled for completion by 8-5-17. 2.Education and discussion will take place at each region location's staff meeting and completed by August 5th. 3.Clinical staff will be required to sign a statement indicating he/she has reviewed the educational materials and understands the expectation of completing all the components of care coordination. ·The Clinical Director will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur. ·A quarterly clinical record review tool has been developed for hospice and will include this information for second quarter 2017. ·Results of the Clinical Record Reviews will be documented and shared with clinical leaders to discuss with staff. Data and trends will be reviewed in the Agency's QAPI meetings.	

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	C. In the agency's document titled "Hospice v16.3 Routine Visit- on 06-12-2017, the care management section of assessment indicated "Case Coordination: List all communication with other disciplines, agencies and vendors today." None." The record failed to evidence any care coordination between the hospice nurse and the facility staff or family. D. In the agency's document titled "Hospice v16.3 Routine Visit- on 06-19-2017, the care management section of assessment indicated "Case Coordination: List all communication with other disciplines, agencies and vendors today." None." The record failed to evidence any care coordination between the hospice nurse and the facility staff or family. 3. The clinical record of patient #5 was reviewed and indicated a start of care date of 9/30/16. The record contained a plan of care dated 5/28/17-7/26/17, which indicated "SN 1-3 x week x 9 weeks. Instruct patient/caregiver on around the clock medication administration and maintenance of pain medication log, Instruct patient/caregiver on reporting poorly controlled pain to Hospice, Assess/Instruct/monitor patient/caregiver on narcotic administration, side effects, actions, and effectiveness, Titrate medication dose for comfort per			

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	physician order ... AID 1-2 x week x 9 weeks Provide personal care and assistance with ADL's, Companionship." A. In the agency's document titled "Hospice v16.3 Routine Visit- on 06-01-2017, the care management section of assessment indicated "Case Coordination: List all communication with other disciplines, agencies and vendors today." None." The record failed to evidence any care coordination between the hospice nurse and the facility staff or family. B. During visit to the facility on 6/27/17 at 9:45 AM, the surveyor observed that the Hospice Binder contained no consents, certificate of terminal illness or recertifications, hospice staff contact information, 24 hour call info, medication list, or physicians orders. 4. The clinical record of patient #6 was reviewed and indicated a start of care date of 2/9/17. The record contained a plan of care dated 5/10/17-8/7/17, which indicated "SN 1 x week x 13 weeks ... AID 2 x week x 13 weeks provide personal care and assistance with ADL's." A. In the agency's document titled "Hospice v16.3 Routine Visit- on 06-13-2017, the care management section of			

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	assessment indicated "Case Coordination: List all communication with other disciplines, agencies and vendors today." None." The record failed to evidence any care coordination between the hospice nurse and the facility staff or family. B. In the agency's document titled "Hospice v16.3 Routine Visit- on 06-20-2017, the care management section of assessment indicated "Case Coordination: List all communication with other disciplines, agencies and vendors today." None." The record failed to evidence any care coordination between the hospice nurse and the facility staff or family. 5. The clinical record of patient #8 was reviewed and indicated a start of care date of 3/31/17. The record contained a plan of care dated 3/31/17-6/28/17, which indicated "SN 1-2 x week x 14 weeks." A. During visit to the facility on 6/28/17 at 8:30 AM, the surveyor observed that the Hospice Binder contained no consents, certificate of terminal illness or recertifications, or physicians orders. 6. The clinical record of patient #9 was reviewed and indicated a start of care date of 6/19/17. The record contained a plan of care dated 6/19/17-9/16/17, which			

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	indicated "SN [Skilled Nurse] 1-2 x [times] week x 13 weeks ... MSS 1-3 x month x 3 months ... AID 2 x week x 1 week ... SC 1-3 x month x 3 months." A. During visit to the facility on 6/28/17 at 8:57 AM, the surveyor observed that the Hospice Binder which was not present. There was a folder present that contained only progress note papers within it. The folder contained no consents, plan of care, certificate of terminal illness or recertifications, hospice staff contact information, 24 hour call info, medication list, or physicians orders. 7. The agencies Job description titled "Director-Statewide Clinical Home Health and Hospice," dated April 14, 2016 stated, "Incumbent is responsible for maintaining compliance in process, policy and service for all Statewide Homecare and Hospice activities ... Acts as the CMS [Centers for Medicaid and Medicare] Administrator for Home Health and Hospice." 8. The agencies Job description titled "Manager-Clinical Operations," dated May 28, 2013 stated, "Assures the clinical competence of staff ... Maintains twenty four accountability for quality patient care ... Maintains knowledge of			

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	best practices in areas of clinical and organizational responsibility ... Assures unit compliance with all state and national regulatory standards. ... Accountable for daily unit operations. 9. The agencies Job description titled "RN-Hospice," dated September 15, 2014 stated, "Assumes responsibility for Hospice care as per Hospice policies and procedures. Maintains up to date patient records so that problems, plans, actions and goals are accurately and clearly stated and changes are reflected as they occur. ... Initiates communication with attending physicians. ... Demonstrates familiarity with policies of the agency and rules and regulations of state and federal bodies which relate to the delivery of hospice services. ... Assumes responsibility for evening and weekend on-call duty as scheduled and consistent with services policies."			