STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	151599	A. BUILDING 00 B. WING	10/01/2020

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PREMIER HOSPICE & PALLIATIVE CARE - INDIANA LLC	11550 N MERIDIAN STREET, SUITE 375 CARMEL, IN 46032

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L 0000 Bldg. 00	This visit was for a Federal Complaint survey of a Deemed Hospice provider. Survey Dates: 09/30 to 10/01/2020 CCN: 151599 Facility: 007409 Complaint #: IN00337284: Substantiated. Deficiencies related and unrelated to the complaint were cited. Records Reviewed: 3 Quality Review completed on 10/29/2020 A4	L 0000	**L 000** This Plan of Correction constitutes **PREMIER HOSPICE & PALLIATIVE CARE - INDIANA LLC's** written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and/or federal law.	
L 0515 Bldg. 00	418.52(c)(4) RIGHTS OF THE PATIENT [The patient has a right to the following:] (4) Choose his or her attending physician; Based on record review and interview, the agency failed to ensure patients were informed of their right to choose his or her attending physician in 3 of 4 interviews conducted. (Patients #1, 3, 9) Findings include: 1. Review of the agency's document titled "Hospice Election of Benefit Statement" revealed a section titled "Right to choose an attending physician" which indicated "I understand that I have a right to choose my attending physician to oversee my care .... " 2. Review of the admission packet which	L 0515	**L 515** 418.52(c)(4) RIGHTS OF THE PATIENT [The patient has a right to the following:] (4) Choose his or her attending physician. **How are you going to correct the deficiency? If already corrected, include the following steps and state date of correction.** From 10/8/20-10/9/20, all Community Liaison staff were In-serviced on the following *Premier Hospice & Palliative Care CHAP Hospice Policy and Procedure Manual*, 2020 policies,	10/30/2020

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

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	contained the patient rights, a section on page 14 titled "Decision Making - You have the right to", indicated the patient has the right to choose their attending physician and other health care providers and communicate with these providers. 3. Review of the agency's active client roster and discharge report that was provided on 09/30/2020, revealed 25 out of 30 active client roster and 20 out of 27 discharged patients had the hospice medical director as their primary physician. 4. The family member for patient #1 was interviewed on 09/30/20 at 9:20 a.m., and indicated while the patient was at the hospital, a hospice liaison visited and was told that they could not use their own MD and had to use the hospice Medical Director, as well as what they could and could not do, would "get rid" of the patient's medications and provide only comfort medications, no emergency room visits, no reaching to their primary care physician, and they could only reach out to the hospice physician. 5. The family member for patient #3 was interviewed on 10/01/20 at 9:40 a.m., and indicated during their admission, they were not provided with an option to keep their primary care physician but was instructed that the Medical Director would be their primary physician while on service. 6. The family member for patient #9 was interviewed on 09/30/2020 at 4:43 p.m., and indicated during their admission, they were not provided with an option to keep their primary care physician. When asked about the consents that were signed indicating their understanding of patient rights and if these rights were explained in full detail, the family member indicated the person		and rules: 1.ADMISSION CRITERIA AND PROCESS- INDIANA, Policy No. 1-009; 2.HOSPICE ELECTION STATEMENT, Policy No. 1-031; 3.§418.52 Condition of Participation: Patient's Rights. Involved staff acknowledged this in-service re-training in writing. Organization policies set forth that the patient has the right to be informed of his or her rights, and the hospice shall protect and promote the exercise of these rights. The patient has the right to choose his or her attending physician and to have this person involved in their medical care in all hospice settings as long as the attending physician, in turn, undertakes to provide care for the patient. **How are you going to prevent the deficiency from recurring in the future, even if already corrected?** 1.100% focused chart audit for 90 days on Admissions, then ongoing, 10% review each quarter to ensure patients were informed they have the right to choose their attending physician, as evidenced by patient or representative placing their initials next to the statement "YOU HAVE THE RIGHT TO: choose your attending physician.." education on Page 14 of the *Patient Hospice Admission*	

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	who had them sign the admission documents reviewed "main topics", told them where to sign, gave them "stuff to read" and was told they couldn't see their primary care physician. 7. During an interview on 09/30/2020 at 4:55 p.m., and when queried if patients are allowed to choose their own physician for hospice services, the Administrator stated patients could "elect who-ever, 100% their choice." 8. The above findings were reviewed with the Regional Director of Compliance, Director of Nursing, Patient Care Manager of the Bloomington Branch, and Administrator on 10/01/2020 at 1:20 p.m.. in which they responded that the patients/ caregivers signed the consents upon admission, therefore, they knew they had a choice. When asked how certain they were that their clinicians and liaisons were thoroughly reviewing patient rights and consents upon admission when 3 out of 4 people indicated they were told they must use the Medical Director, they had no other response.		*Booklet*. Nurses shall securely submit a copy of the initialed page to the office for chart attachments. Nurses shall report any Complaints related to Liaison misinformation/misunderstanding to the agency Administrator who will interview the beneficiary and/or caregivers; 2.Patient Care Managers/Designee(s) shall phone survey all new Admissions to verify patient/representative understanding of education on Patient's Rights including patient's right to choose their attending physician; 3.Thresholds for focused audits and phone surveys are 100% with evidence patients/representatives were informed and understood their right to choose their attending physician. If threshold not met, Patient Care Managers will re-educate involved staff, progressively, involving human resources for discipline, if needed. **Who is going to be responsible for prevention above: i.e., director, supervisor, etc.?** Patient Care Managers (PCMs) are responsible for audits, surveys and staff correction. PCMs will be overseen by Director(s) of Clinical Services (DCS) who report to the Administrator. The Administrator shall report Focus audit and Patient survey results to the QAPI Committee and then the Governing	

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			Body for three consecutive quarters. **By what date are you going to have the deficiency corrected?** 10/30/20. Liaisons completed re-education by 10/9/20. Nurses completed education on their role in compliance by 10/30/20. By no later than 10/30/20, the organization will have implemented 100% Focus audits and Surveys.	
L 0525 Bldg. 00	418.54(c)(1) CONTENT OF COMPREHENSIVE ASSESSMENT The comprehensive assessment must take into consideration the following factors: (1) The nature and condition causing admission (including the presence or lack of objective data and subjective complaints). Based on record review and interview, the agency failed to ensure comprehensive assessments were complete and included assessments of bruising, location of diminished breath sounds, past medical histories/ medication use of anti-seizure, anti-anxiety, muscle relaxant, and pain medications, as well as ensuring wound measurements were accurate for 2 of 3 records reviewed. (Patient #1, 2) Findings include: 1. Review of an agency's policy titled	L 0525	**L 525** 18.54(c)(1) CONTENT OF COMPREHENSIVE ASSESSMENT The comprehensive assessment must take into consideration the following factors: (1) The nature and condition causing admission (including the presence or lack of objective data and subjective complaints). **How are you going to correct the deficiency? If already corrected, include the**	10/30/2020

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	"Comprehensive Assessment Policy No. 1-014.1" dated 5/11/20, indicated " ... 1. During the comprehensive assessment, all baseline data and other relevant information will be documented in the patient's clinical record ... B. ... 2. Restlessness, anxiety ... 4. Skin Integrity ... E. Alleviating and exacerbating factors for physical symptoms. F. Current treatment and patient response to that treatment. I. A physical assessment, including ... skin ... N. Patients past and present medical and psychiatric history including any pertinent diagnosis and any co-morbid conditions .... " 2. According to an article titled "Table 2, [National Pressure Ulcer Staging System] at https://www.ncbi.nlm.nik.gov, described a deep tissue injury as a "pressure-related injury to subcutaneous tissues under intact skin.. Initially, these lesions have the appearance of a deep bruise ... purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/ or sheer." A Stage 2 pressure wound is described as a "partial thickness loss or dermis presenting as a shallow open ulcer with a red, pink wound bed without slough. May also present as an intact or open/ruptured serum-filled blister. Presents as a shiny or dry shallow ulcer without slough or bruising." A Stage 3 pressure wound is described as a "full thickness tissue loss. Subcutaneous fat may be visible, but bone, tendon, or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling." A Stage 4 pressure wound is described as a full thickness tissue loss; extensive destruction; with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes		**following steps and state date of correction.** From 10/14/20-10/30/20, all Registered Nurses were In-serviced on the following *Premier Hospice & Palliative Care CHAP Hospice Policy and Procedure Manual*, 2020 policies, and wound assessment and care guidelines: 1.COMPREHENSIVE ASSESSMENT, Policy No. 1-014 2.PAIN ASSESSMENT, Policy No. 1-018; 3.WOUND CARE, Policy No. 2-035.A; 4.SKIN AND WOUNDCARE QUICK REFERENCE/GUIDELINE; National Pressure Ulcer Advisory Panel (NPUAP) Staging System. Involved staff acknowledged this in-service re-training in writing. Organization policies set forth that complete comprehensive assessment includes assessments of bruising, location of diminished breath sounds, acceptable pain range, past medication histories/medication use of anti-seizure, anti-anxiety, muscle relaxant, as well as ensuring wound measurements are accurate and wounds are staged according to the NPUAP Staging System. The hospice will conduct and document in writing a patient-specific comprehensive assessment that identifies the patient's need for hospice care and services, and the patient's	

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	undermining and tunneling. An Unstageable wound is described as a "full thickness tissue loss in which actual depth of the ulcer is completely obscured by slough (yellow, tan, gray, green, or brown) and / or eschar (tan, brown or black) in the wound bed. Until enough slough and/ or eschar is removed to expose the base of the wound, the true depth and stage cannot be determined .... " 3. Review of clinical record #1, Election date of 08/06/2020, revealed the patient had bruising. The assessment failed to evidence the size, description, and location of the bruises. 4. The clinical record for patient #2, Election date 9/10/20, included history and physical from an entity dated 8/14/20, which stated the patient has a history of C6 spinal cord injury after a motor vehicle accident in 2002 that resulted in the patient becoming a paraplegic, has sacral/ ischial and heel wounds. The patient was admitted prior to this hospitalization for sepsis related to wound infections. The patient underwent debridement and antibiotic therapy. The patient returned to the hospital due to unresponsiveness and fever. The patient was treated again for recurrent sepsis and ended up having 3 seizures during their hospital stay. The clinical record also contained notes from a skilled nursing facility that the patient was sent to after hospitalization for wound treatment with a wound vac (a type of device that decreases air pressure on the wound to help it heal), IV (intravenous) antibiotics for sepsis, and seizures. A 9/5/20 note indicated the patient's sacral wound increased in size from 7 to 10 cm (centimeter) due to loose stools, causing further infection to the sacral wound. The note also indicated the patient had a diagnosis of an anxiety disorder. On 9/1,		need for physical, psychosocial, emotional, and spiritual care. This assessment will include all areas of hospice care related to the palliation and management of the terminal illness and related conditions. During the comprehensive patient assessment, all baseline data and other relevant information will be documented in the patient's clinical record, including at least the following information, as relevant: A. An assessment of pain, including the origin, location, duration, severity, and relief measures. [Nurses will document pain and symptom assessments and reassessments as required. When pain is identified, a more comprehensive pain assessment will be completed. Pain assessments will facilitate regular reassessment and follow-up by clinicians.] 1.B. An assessment of severity of secondary symptoms, such as: 1.1. Dyspnea, nausea, vomiting, constipation, respiratory distress, and nutritional status 2.2. Restlessness, anxiety, emotional distress 3.3. Sleep Disorders 4.4. Skin Integrity 5.5. Confusion 1.C. An assessment of the need for a bowel regimen, esp.	

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	the note indicated the patient had a deep tissue injury to the right heel possibly measuring 2.6 x 5 cm (centimeters), a wound to the right trochanter measuring 2 x 0.8 x 0.1 cm, left heel measuring was described as an unstageable deep tissue injury measuring 2.5 x 6 cm, Stage IV left trochanter measured 3.5 x 3.5 x 0.4 cm on 8/28/20. During the patient's stay, the patient had critical labs and refused further treatment and hospice was presented. Review of the plan of care for the benefit period of 09/10/20 to 12/8/20. The medication list on the plan of care indicated the patient was prescribed and taking Alprazolam (Xanax) 0.5 mg (milligrams) every 6 hours as needed for anxiety, Baclofen 20 mg twice a day for muscle relaxant, levetiracetam 500 mg and Vimpat 100 mg twice a day for seizures, and Norco 5 mg-325 mg tablet every 6 hours as needed for pain. Review of the start of care comprehensive assessment dated 9/10/20, failed to include an acceptable pain range. The assessment failed to include any information/ assessment of the patient's need for anti-anxiety medication, muscle relaxant, anti-seizure medication, pain medication, right heel and right trochanter. Review of the wound assessment indicated the patient had a stage 3 wound to the left greater trochanter that measured 10 (L) x 8.5 (W) x 0.5 (D) centimeters (cm); the sacral wound was stage 4 wound that measured 18 x 25 x 1.5 cm; and a stage 2 wound to the left heel that measured 7.6 x 7.6 x 0.1 cm. The narrative note indicated the right heel was unblancheable and boggy. The wound assessment failed to include a full assessment with measurements of the right heel, failed to identify the left heel accurately according to professional wound standards; failed to be		when the patient is prescribed opioids. 2.D. Nature and condition causing admission 3.E. Alleviating and exacerbating factors for physical symptoms 1. Effectiveness drug therapy 2. Unwanted side and toxic effects 3. Drug interactions (actual or potential) 4. Duplicate drug therapy F. Current treatment and patient response to that treatment G. An assessment of the patient's response to palliative treatment H. An assessment of the patient's well-being, comfort and dignity throughout the dying process. I. A physical assessment, including blood pressure, temperature, pulse, respiration, skin, and other relevant data related to pertinent physical findings and the patient's terminal illness J. Imminence of death K. Patient's functional status including, but not limited to, the degree of self-care and the amount and level of assistance needed L. Patient's cognitive status including the ability to understand and participate in his or her own care Complication and risk factors that affect care planning M. Complication and risk factors that affect care planning, including drug diversion N. Patient's past and present	

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	consistent with the patient's stay at the facility and failed to be consistent with ongoing assessments as evidenced by the following: Review of the updated comprehensive assessment dated 9/14/20, indicated the left trochanter measured 3.5 x 5 x 1 cm, the sacral wound measured 8.5 x 9 x 3 cm, and the left heel measured 4 x 3.5 x 0 cm. Review of the updated comprehensive assessment dated 9/23/20, indicated the left trochanter measured 5 x 5 x 0.5 cm, the sacral wound measured 5 x 9 x 1.5 cm, and the left heel measured 5 x 6 x 0.1 cm. During an interview on 9/30/20 at 5:00 p.m., when asked about the inconsistent measurements of the patient wounds, the Patient Care Manager acknowledged the discrepancy. During an interview on 10/1/20 at 9:14 a.m., the patient's caregiver stated the patient had been on Xanax for years for anxiety and the patient had horrible dysreflexia, which caused his legs to spasm, and did have pain and discomfort, and utilized the Baclofen routinely and Norco as needed. 5. The above findings were reviewed with the Regional Director of Compliance, Director of Nursing, Patient Care Manager of the Bloomington Branch, and Administrator on 10/01/2020 at 1:20 p.m., in which no further information or documentation was provided.		medical, psychiatric history, pertinent diagnosis, co-morbid conditions O. Name and address of the patient's attending physician P. Name of hospital, other agencies, persons involved in the past & present care of the patient Q. An evaluation of the home environment and assessment of emergency preparedness R. Presence of any Advance Directives for care and/or discussions with patient and family/caregiver regarding the withholding/withdrawal of resuscitative services or treatment S. Equipment presently in home and potentially needed by patient T. Review of current and related past medications, including prescription and over-the-counter medications, supplements, herbal remedies, alternative treatments, allergy history and other medication information U. Patient and family/caregiver support systems and the care the family/caregiver is available, capable, and willing to provide, including applicable strengths of patient, physical, psychosocial, and/or spiritual resources available V. The patient's psychosocial status, including emotional barriers to treatment, cognitive limitations, memory and orientation, family relationships, social history, source and adequacy of environmental and	

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			other resources, coping mechanisms, and the patient's and family/caregiver's reaction to illness. W. An assessment of the patient's and family/caregiver's spiritual orientation, including, as appropriate, any involvement in a religious group such as a church or synagogue or a support group such as Alcoholics Anonymous and spiritual concerns or needs such as despair, suffering, guilt, etc. X. Involvement of family/caregiver, neighbors, and/or other individuals/organizations, including involvement in any support groups Y. An assessment of the need for volunteer services to offer support or respite to the patient and family/caregiver Z. A bereavement assessment of the needs of the patient's family and other individuals AA. Laboratory results BB. Medical, alcohol, and other drug history CC. TB screening DD. Specific, individualized patient needs/problems pertinent to the hospice care being provided EE. Past medical and surgical care, including dates of onset/exacerbation FF. The patient's and family/caregiver's educational needs, abilities, motivation, and readiness to learn. GG. The need for referrals and	

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			further evaluation by appropriate health professionals 1.The assessment should determine: Probable prognosis of six (6) months or less; Patient problems and needs related to the terminal illness; Patient goals related to the terminal illness. During each wound care visit, nurse to review prior wound assessment, note significant discrepancies from prior to current wound assessment, communicate to manager and to the physician, and resolve discrepancy in the medical record documentation. Wound care will be evaluated and reviewed at least weekly in response to treatment. All wound care will be performed in accordance with physician orders and practice standards. The physician will be updated regarding a patient's wound status on an ongoing basis. The organization will notify the physician immediately if there are signs and symptoms of wound deterioration, including infection, significant bleeding, or enlargement. If there is no improvement in a wound after two weeks of a treatment, the physician will be consulted to determine if a change in wound care is appropriate. **How are you going to prevent the deficiency from recurring in the future, even if already**	

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			corrected? 1.100% focused chart audit for 90 days on Admissions, then ongoing, 10% each quarter to ensure nursing comprehensive assessment; 2.100% focused wound care audit for 90 days on all Wound care patients, then ongoing, 10% each quarter to ensure pressure ulcer assessment according to NPUAC Staging System; 3.Threshold for focused audits is 100% compliance with comprehensive assessment and wound staging. If threshold not met, Patient Care Managers will re-educate involved staff, progressively, involving human resources for work plans, if needed. **Who is going to be responsible for prevention above: i.e., director, supervisor, etc.?** Patient Care Managers (PCMs) are responsible for audits and staff correction. PCMs will be overseen by Director(s) of Clinical Services (DCS) who report to the Administrator. The Administrator shall report Focus audit results to the QAPI Committee and then the Governing Body for three consecutive quarters. **By what date are you going to have the deficiency corrected?** 10/30/20. Nurses completed re-education by	

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			10/30/20. By no later than 10/30/20, the organization will have implemented 100% Focus audits on Comprehensive Assessment at Admission and ongoing for Wounds.	
L 0533 Bldg. 00	418.54(d) UPDATE OF COMPREHENSIVE ASSESSMENT The update of the comprehensive assessment must be accomplished by the hospice interdisciplinary group (in collaboration with the individual's attending physician, if any) and must consider changes that have taken place since the initial assessment. It must include information on the patient's progress toward desired outcomes, as well as a reassessment of the patient's response to care. The assessment update must be accomplished as frequently as the condition of the patient requires, but no less frequently than every 15 days. Based on record review and interview, the agency failed to ensure the updated comprehensive assessment included accurate and consistent information on the patient's symptoms, progress toward desired outcomes, and patient's response to care for 2 of 3 records reviewed. (Patients #1, 2) Findings include: 1. Review of an agency policy titled "Ongoing Comprehensive Assessment Policy No. 1-015.1" dated 5/11/20, indicated " ... During each home visit, the Case Manager or other discipline will evaluate the patient according to the problems identified during the initial assessment and	L 0533	**L 533** 418.54(d) UPDATE OF COMPREHENSIVE ASSESSMENT The update of the comprehensive assessment must be accomplished by the hospice interdisciplinary group (in collaboration with the individual's attending physician, if any) and must consider changes that have taken place since the initial assessment. It must include information on the patient's progress toward desired outcomes, as well as a reassessment of the patient's	10/30/2020

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	thereafter the comprehensive assessment .... " 2. Review of an agency policy titled "Patient Education Process Policy No. 2-025.1-3" dated 5/11/20, indicated " ... Procedure ... 6. ... the patient and family/ caregiver will receive verbal, and as appropriate, written instructions on: ... B. The patient's disease process C. The medical regimen D. Medication management and administration ... G. Prescribed treatments ... 7. Documentation of patient and family/ caregiver education will consist of: A. Describing what was taught to the patient ... B. Describing the patient's response to the teaching, including level of understanding and the ability to repeat or demonstrate what was taught. C. Describing any additional learning needs not currently met ... 11. The patient's and family/caregiver's knowledge, skills, and behaviors will be assessed during hospice visits. Re-education, when appropriate, will be provided .... " 3. Review of an agency policy titled "Pain Management Education Policy No. 2-026.1" dated 5/11/20, indicated " ... 3. Documentation of patient and family/ caregiver instruction and understanding in the clinical record will include: A. Information taught B. Patient and family/ caregiver understanding C. Response to teaching .... " 4. Review of an agency policy titled "Pain assessment Policy No. 1-018.1" dated 5/11/20, indicated " ... Pain assessments will be appropriate to the patient's age and will be documented to facilitate regular reassessment and follow-up by clinicians ... 2. ... the following in-depth pain assessment information will be obtained whenever possible: ... G. Pain management history, to include a medication history, presence of common		response to care. The assessment update must be accomplished as frequently as the condition of the patient requires, but no less frequently than every 15 days. **How are you going to correct the deficiency? If already corrected, include the following steps and state date of correction.** From 10/14/20-10/30/20, all Nursing staff were In-serviced on the following *Premier Hospice & Palliative Care CHAP Hospice Policy and Procedure Manual*, 2020 policies and wound assessment guidelines: 1.ONGOING COMPREHENSIVE ASSESSMENT, Policy No. 1-015; 1.PATIENT EDUCATION PROCESS, Policy No. 2-025; 2.PAIN MANAGEMENT EDUCATION, Policy No. 2-026; 3.PAIN ASSESSMENT, Policy No. 1-018; 4.WOUND CARE, Policy No. 2-035.A; 5.SKIN AND WOUNDCARE QUICK REFERENCE/GUIDELINE; National Pressure Ulcer Advisory Panel (NPUAP) Staging System. Involved staff acknowledged this in-service re-training in writing: Organization policies set forth the organization shall ensure updates to the comprehensive assessment includes accurate and consistent information on the patient's	

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	barriers to reporting pain and using analgesics, past interventions and response ... I. The patient's pain goal, including pain intensity goals related to function, activities, and quality of life ... Pain Management ... 2. Non-pharmacological interventions will be considered for the treatment of pain ... 4. Patient and family / caregiver education will focus on the use and side effects of analgesic and/ or adjuvant medications, expected responses to therapy, and the importance of administering medications according to prescribed dosage and frequency." 5. According to an article titled "Table 2, [National Pressure Ulcer Staging System] at https://www.ncbi.nlm.nik.gov, described a deep tissue injury as a "pressure-related injury to subcutaneous tissues under intact skin.. Initially, these lesions have the appearance of a deep bruise ... purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/ or sheer." A Stage 2 pressure wound is described as a "partial thickness loss or dermis presenting as a shallow open ulcer with a red, pink wound bed without slough. May also present as an intact or open/ruptured serum-filled blister. Presents as a shiny or dry shallow ulcer without slough or bruising." A Stage 3 pressure wound is described as a "full thickness tissue loss. Subcutaneous fat may be visible, but bone, tendon, or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling." A Stage 4 pressure wound is described as a full thickness tissue loss; extensive destruction; with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling. An Unstageable		symptoms, progress toward desired outcomes, and patient's response to care. The ongoing comprehensive assessment will be updated as frequently as the condition of the patient warrants. Each visit, the nurse will assess/data collect for: 1.A. Pain, including the origin, location, duration, severity, and relief measures 2.B. Symptoms such as, nausea, vomiting, respiratory distress, patient's response to care 3.C. Factors that alleviate or exacerbate physical symptoms 4.D. Current treatment related to the identified symptoms and the patient’s response 5.E. Vital signs appropriate to the patient’s condition 6.F. Breath sounds 7.G. Skin integrity 8.H. Bowel sounds, elimination (urinary and bowel) 9.I. Mental status 10.J. Appetite/diet, nutritional status 11.K. Functional status 12.L. Safety/home environment 13.M. Patient and family/caregiver support 14.N. Progress toward hospice goals and patient needs and problems 15.O. Compliance with treatments and medication regimen	

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	wound is described as a "full thickness tissue loss in which actual depth of the ulcer is completely obscured by slough (yellow, tan, gray, green, or brown) and / or eschar (tan, brown or black) in the wound bed. Until enough slough and/ or eschar is removed to expose the base of the wound, the true depth and stage cannot be determined .... " 6. According to an article titled "Assessment and Documentation of Pressure Ulcers" at https://healthinsight.org/Internal/events/Nursing_Home/Assessment_and_Documentation_Pressure_Ulcers%20_0110719_Color.pdf described epithelialization as a "process by which the wound surface is covered by new epithelium, this begins when the wound has filled with granulation tissue. The tissue is pink, almost white, and only occurs on top of healthy granulation tissue." Slough is described as "the presence of devitalized yellowish tissue is observed and is formed by an accumulation of dead cells. Must not be confused with the presence of pus." Necrotic tissue is described as a "wound containing dead tissue. The wound may appear hard, dry and black. Dead connective tissue may appear gray. The presence of dead tissue in a wound prevents healing." 7. The clinical record for patient #1, start of care 8/6/20, was reviewed and included a plan of care for the benefit period of 8/6/20 to 10/4/20. The plan of care included, but was not limited to, goals of "Patient, family, caregivers are knowledgeable and involved in hospice plan of care for patient ... pt/cg (patient/ caregiver) will verbalize understanding of indications, uses, and side effects of each medication and administer medications as prescribed as evidenced by no adverse effects from medication error, narcotic counts will be correct each visit through next		16.[Narcotic Counts including Quantity of medication used since last count and Reason is a required ongoing assessment] 17.P. The need for an alternative setting or level of care 18.Ongoing comprehensive assessments should focus on progress toward goals: 19.A. Patient's response to care 20.B. Changes in patient condition, level of deterioration 21.C. Changes in patient diagnoses/prognosis 22.D. Changes in the patient's care environment or support systems 23.E. Well-being 24.F. Comfort 25.G. Dignity throughout the dying process 26.Based on the assessments, the plan of care—including problems, needs, goals, and outcomes—will be reviewed and updated by the interdisciplinary group members responsible for the case. Change/verbal orders will be entered immediately and forwarded to the physician. Patients and family/caregivers will receive information regarding pain and the management of pain as an integral part of hospice care. The patient and family/caregiver will receive verbal or written instructions, as appropriate, regarding:	

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	benefit period ... Anxiety/ agitation/ restlessness will be managed with use prn [as needed] lorazepam as ordered through next benefit period ... Patient/ caregiver will be able to verbalize measures to promote comfort related to respiratory system in the terminal patient through next benefit period .... " Review of the 8/7/20 IDG (interdisciplinary group) note indicated the education provided were safety and comfort medication. Narcotic count indicated: Norco 12 tabs (tablets), Roxanol 30 ml (milliliters), and Lorazepam 10 tabs. Patient and/or caregiver understand the appropriate use, use of side rails and returns demonstration, and dexamethasone was called into the patients pharmacy. Review of the skilled nursing visit note dated 8/7/20 indicated the only interventions/ goals achieved was pain management and safety. The updated comprehensive assessment/ skilled nursing visit notes failed to evidence the patient's/ caregiver progress towards the goals related to the specific medication that was educated and patient/ caregiver understanding of each medication and progress towards understanding/ verbalization of measures to promote comfort related to respiratory system. Review of the 8/8/20 IDG note indicated "N/A" to education provided. Narcotic count indicated: Norco 12 tabs, Morphine (Roxanol) 30 ml, and Lorazepam 20 tabs. Patient and/ or caregiver understand the appropriate use of side rails and returns demonstration. Respirations even but slightly labored at rest at times and the patient denied a need for intervention, no edema, and DME (durable medical equipment) concerns. Review of the skilled nursing visit note dated 8/8/20 indicated the only interventions/ goals achieved was pain management and safety. The		1.A. The pain process 2.B. The risk for pain 3.C. The pain assessment process 4.D. The importance of effective pain management 5.E. Methods for pain management, when identified as part of treatment 6.F. Potential limitations of pain management modalities 7.G. Side effects of pain treatment 8.Documentation of patient and family/caregiver instruction and understanding in the clinical record will include: A. Specific information taught; B. Patient and family/caregiver specific understanding; C. Response to teaching; D. Additional learning needs. Nurses will document pain and symptom assessments and reassessments as required. When pain is identified, a more comprehensive pain assessment will be completed. Pain assessments facilitate reassessment and follow-up. During wound care visits, nurse to review prior wound assessment, note significant discrepancies from prior to current wound assessment, communicate to manager and to the physician, and resolve discrepancy in the medical record documentation. Wound care will be evaluated and reviewed at least weekly. All wound care will be performed in	

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	updated comprehensive assessment/ skilled nursing visit notes failed to evidence the patient's/ caregiver progress towards the goals related to the specific medication that was educated and patient/ caregiver understanding of each medication and progress towards understanding/ verbalization of measures to promote comfort related to respiratory system. The clinical record also failed to evidence the accuracy of the narcotic count/ if Lorazepam was ordered the previous day or if there was a miscount due to previous days count indicated 10 tabs. Review of the 8/9/20 IDG note indicated "N/A" to education provided. Narcotic count indicated: Norco 12 tabs, Morphine (Roxanol) 29.5 ml, and Lorazepam 20 tabs. Patient and/ or caregiver understand the appropriate use of side rails and returns demonstration. Over the counter eye drops used and spouse instructed on hospice not delivering medications. Review of the skilled nursing visit note dated 8/9/20 indicated the only interventions/ goals achieved was pain management and safety. The updated comprehensive assessment/ skilled nursing visit notes failed to evidence the patient's/ caregiver progress towards the goals related to the specific medication that was educated and patient/ caregiver understanding of each medication and progress towards understanding/ verbalization of measures to promote comfort related to respiratory system. The visit note also failed to evidence an assessment of when the patient used the Roxanol and reason for use. Review of the 8/10/20 IDG note indicated the education provided was on safety and comfort medication. Narcotic count indicated: Norco 12 tabs, Roxanol 28 ml, Lorazepam 21 tabs. Patient		accordance with physician orders and practice standards. The physician will be updated regarding a patient's wound status on an ongoing basis. The organization will notify the physician immediately if there are signs and symptoms of wound deterioration, including infection, significant bleeding, or enlargement. If there is no improvement in a wound after two weeks of a treatment, the physician will be consulted to determine if a change in wound care is appropriate. **How are you going to prevent the deficiency from recurring in the future, even if already corrected?** 1.100% focused chart audit for 90 days on Update of Comprehensive Assessment prior to each Interdisciplinary Group Meeting/IDG, then ongoing, 10% each quarter to ensure update to the comprehensive assessment; 2.100% focused wound care audit for 90 days on all Wound care patients, then ongoing, 10% each quarter to ensure pressure ulcer assessment according to NPUAC Staging System; 3.Threshold for focused audits is 100% compliance with update to comprehensive assessment and wound staging. If threshold not met, Patient Care Managers will re-educate involved staff,	

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	and/ or caregiver understand the appropriate use of side rails and returns demonstration. Shortness of breath at baseline. Concerns and request for a trapeze for the patient's bed. Review of the skilled nursing visit note indicated the only interventions/ goals achieved was pain management and safety. The updated comprehensive assessment/ skilled nursing visit notes failed to evidence the patient's/ caregiver progress towards the goals related to the specific medication that was educated and patient/ caregiver understanding of each medication and progress towards understanding/ verbalization of measures to promote comfort related to respiratory system. The visit note also failed to evidence an assessment of when the patient used the Roxanol and the accuracy of the narcotic count since Lorazepam was counted at 20 tabs on 8/9/20. Review of the 8/13/20 IDG note indicated the education provided were safety and comfort medication. Narcotic count indicated: Norco 12 tabs, Roxanol 28 ml, Lorazepam 20 tabs. Patient and/ or caregiver understand the appropriate use of side rails and returns demonstration. Shortness of breath at baseline. Spouse requests a bariatric bed extender and was advised that it was not available. Review of the skilled nursing visit note indicated the only interventions/ goals achieved was pain management and safety. The updated comprehensive assessment/ skilled nursing visit notes failed to evidence the patient's/ caregiver progress towards the goals related to the specific medication that was educated and patient/ caregiver understanding of each medication and progress towards understanding/ verbalization of measures to promote comfort related to respiratory system. The visit note also failed to evidence an assessment of when the patient used		progressively, involving human resources for work plans, if needed. **Who is going to be responsible for prevention above: i.e., director, supervisor, etc.?** Patient Care Managers (PCMs) are responsible for audits and staff correction. PCMs will be overseen by Director(s) of Clinical Services (DCS) who report to the Administrator. The Administrator shall report Focus audit results to the QAPI Committee and then the Governing Body for three consecutive quarters. **By what date are you going to have the deficiency corrected?** 10/30/20. Nurses completed re-education by 10/30/20. By no later than 10/30/20, the organization will have implemented 100% Focus audits on Update of Comprehensive Assessment prior to each IDG and Wounds ongoing.	

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	the Lorazepam. Review of the 8/17/20 IDG note indicated the education provided were safety and comfort medication. Narcotic count indicated: Norco 12 tabs, Roxanol 28 ml, Lorazepam 21 tabs. No falls and caregiver understands the appropriate use of side rails and returns demonstration. The patient had tachycardia with an irregular heart rate of 140-160, new order for cardizem 120 mg daily was called into the pharmacy. No shortness of breath above baseline. Review of the skilled nursing visit note indicated the only interventions/ goals achieved was pain management and safety. The updated comprehensive assessment/ skilled nursing visit notes failed to evidence the patient's/ caregiver progress towards the goals related to the specific medication that was educated and patient/ caregiver understanding of each medication and progress towards understanding/ verbalization of measures to promote comfort related to respiratory system. The visit note also failed to evidence an accurate narcotic count since Lorazepam was counted at 20 tabs on 8/13/20. 8. The clinical record for patient #2, start of care 9/10/20, was reviewed and included start of care comprehensive assessment dated 9/10/20, failed to include an acceptable pain range. Review of the wound assessment indicated the patient had a stage 3 wound to the left greater trochanter that measured 10 (L) [length] x 8.5 (W) [width] x 0.5 (D) [depth] centimeters (cm), with < 25 % (less than 25 percent) granulation tissue and 51-75% necrotic tissue; the sacral wound was stage 4 wound that measured 18 x 25 x 1.5 cm, depth description indicated a full thickness wound with 25 - 50 % necrosis and 26 - 50% necrotic tissue slough; and a stage 2 wound to the left heel that measured 7.6			

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	x 7.6 x 0.1 cm, depth description indicated a partial thickness wound with 100% epithelialization and 0-25 % necrotic tissue slough and eschar. The narrative note indicated the patient had a right heel wound that was non-blanchable and boggy but unopened. Review of the plan of care for the benefit period of 9/10/20 to 12/8/20. The medication list indicated the patient was prescribed Xanax 0.5 mg every 6 hours as needed for anxiety, Baclofen 20 mg tablets 2 times daily for muscle relaxant, Lorazepam 1 mg tablet every 4 hours as needed for anxiety, agitation, and restlessness, Norco 5 mg - 325 mg tablet 1 every 6 hours as needed for pain, and Morphine concentrate 100 mg/ 5 ml (20 mg/ml) oral solution give 0.25 ml every 4 hours as needed for pain or air hunger. The interventions indicated the hospice nurse to obtain blood sugar readings from the patient/ caregiver at each visit, wound treatment to 3 pressure ulcers (located at the left trochanter, sacral, and left heel), hospice nurse to monitor pain level and report changes in pain level to physician, and failed to evidence a goal of what is an acceptable level of pain. The plan of care revealed only two orders to instruct: safety measures each visit and to educate patient/ family on oxygen use and safety at each visit. No other orders of instruction was indicated in the plan of care. Review of the skilled nursing visit note dated 9/11/20 included, but was not limited to, the interventions provided: "Assessed pain level using appropriate pain scale ... hospice comfort kit reviewed and is intact with current expiration dates ... instructed patient/ caregiver regarding use of comfort kit ... Instructed patient/ caregiver on safety measures ... Reinforced nurse's instructions regarding safety .... " The narcotic			

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	count in the narrative note indicated "Norco 2, Rest of cpmfort [sic] meds [medications] still at pharmacy. The goals met indicated "Patient/ Family verbalizes proper use of comfort kit" which was inconsistent with the narcotic count in the narrative note. The Interventions not provided indicated "Obtain Lab as ordered ... Not applicable to current visit" which was inconsistent with the goals met of "Patient verbalizes tolerance to lab procedure." The note also indicated a goal met of "Patient/ caregiver verbalizes understanding of proper safety measures related to fall awareness" but the visit note failed to evidence the specific education that was provided. The note failed to evidence an assessment of the right heel. Review of the 9/12/20 IDG note indicated the narcotic count as follows: the morphine was not in the home, Lorazepam 30 tabs, Xanax 33 tabs, and Norco 2 tabs. Review of the skilled nursing visit note dated 9/12/20 indicated the patient's repeat pain assessment "N/A - Patient was at or below their acceptable level for pain during the initial pain assessment" and the visit note failed to evidence a blood sugar assessment. The interventions provided indicated "Hospice comfort kit reviewed and is intact with current expiration dates, instructed patient/ caregiver regarding use of comfort kit. The interventions indicated "Instruct on safety measures ... Reinforced nurse's instructions regarding safety." The note failed to indicate the specific medications and what was taught from the comfort kit. The note also indicated a goal met of "Patient/ caregiver verbalizes understanding of proper safety measures related to fall awareness" but the visit note failed to evidence the specific education that was provided. The assessment note failed to evidence an assessment of the right heel.			

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	Review of the skilled nursing visit note dated 9/13/20 , the interventions provided indicated "Hospice comfort kit reviewed and is intact with current expiration dates, instructed patient/ caregiver regarding use of comfort kit. The interventions indicated. The interventions also stated "... 10. Provide venous [stasis ulcer] wound care per orders" when the patient does not have stasis ulcers but pressure ulcers. Other interventions revealed "Instructed patient/ caregiver on wound care ... Instructed patient/ caregiver in performing wound care including proper disposal of used wound supplies ... Instructed patient/ caregiver in preventative skin care ... Instructed patient/ caregiver regarding proper nutrition including calories/ protein intake necessary to promote wound healing ... Identified sources of pressure ... " when the plan of care failed to be updated to include these instructions/ education. Other interventions include: "Instruct on safety measures ... Reinforced nurse's instructions regarding safety." The note failed to indicate the specific medications and what was taught from the comfort kit. The note also indicated a goal met of "Patient/ caregiver verbalizes understanding of proper safety measures related to fall awareness" but the visit note failed to evidence the specific education that was provided. The assessment note failed to evidence an assessment of the right heel and the visit note failed to evidence a blood sugar assessment. Review of the 9/14/20 IDG note indicated the narcotic count as follows: the morphine was not in the home, Lorazepam 30 tabs, Xanax 30 tabs, Norco 1 tab. Review of the skilled nursing visit note dated 9/14/20 indicated the patient's repeat pain assessment "N/A - Patient was at or below			

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PREMIER HOSPICE & PALLIATIVE CARE - INDIANA LLC	11550 N MERIDIAN STREET, SUITE 375 CARMEL, IN 46032

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	their acceptable level for pain during the initial pain assessment". The interventions provided indicated "Hospice comfort kit reviewed and is intact with current expiration dates, instructed patient/ caregiver regarding use of comfort kit" when the narrative note indicated Norco: 2 tabs and "Comfort meds being PU [picked up] from pharmacy today." Other interventions provided revealed "... 10. Provide venous [stasis ulcer] wound care per orders .... " when the patient does not have stasis ulcers but pressure ulcers. The visit note failed to include any documentation about the use of hydrocodone. The assessment note failed to evidence an assessment of the right heel. Review of a physician order dated 9/16/20, indicated the hospice nurse to monitor pain level using verbal pain scale each visit and to report the changes in pain level to the physician, monitor effectiveness of prn Norco and prn morphine. Review of the skilled nursing visit note dated 9/16/20, indicated the last bowel movement was on 9/9/20 when the 9/14/20 visit note indicated 9/14/20. The Integumentary assessment indicated there were 3 pressure ulcers, but only identified one at stage 3 and 4, and inaccurately indicated zero to stage 2 pressure ulcers. The visit note identified the patient was a diabetic but failed to include an assessment of blood sugars, the patient's repeat pain assessment "N/A - Patient was at or below their acceptable level for pain during the initial pain assessment", the functional assessment indicated the patient was a quadriplegic with the patient is a paraplegic, the wound assessment indicated the left trochanter was a stage 3 but a suspected deep tissue injury with a large amount of purulent draining with a strong odor with 76-100% necrotic slough tissue			

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	and 0-25% of necrotic eschar tissue, the sacral wound was a stage 4 but described as a suspected deep tissue injury with a moderate amount of purulent drainage and a strong odor with 0-25% of necrotic slough and eschar tissue, and the left heel is a stage 2 but described as a suspected deep tissue injury with 75-100% epithelialization tissue, soft black necrotic tissue and 0-25% necrotic slough tissue. The wound identification and assessments failed to be consistent and accurate according to the wound assessment websites. The assessment note failed to evidence an assessment of the right heel. The narrative note indicated the patient was having episodes of a fixed stare without identifying this as a possible seizure incident. The narrative indicated the patient was out of Norco and the patient had pain in the left arm on 9/15/20. The visit note failed to indicate if the physician was notified of the odor and drainage of the wounds and possible seizure. The interventions provided indicated "Hospice comfort kit reviewed and is intact with current expiration dates, instructed patient/ caregiver regarding use of comfort kit. The IDG note dated 9/17/20 indicated the narcotic count was not completed due to multiple family members in the home and the caregiver was uncomfortable getting the medications out. Review of the skilled nursing visit note dated 9/18/20 indicated the patient was confused and lethargic, anxiety does not significantly affect the patient, the patient's repeat pain assessment "N/A - Patient was at or below their acceptable level for pain during the initial pain assessment" but the narrative note indicated the clinician gave the patient lorazepam and hydrocodone due to the patient being confused speaking in nonsensical sentences and wincing. The note indicated the patient was "active" and notified the physician,			

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	discontinued routine medications, and only ordered comfort medications/ scheduled Morphine and Lorazepam. The narcotic count within the narrative note indicated Hydrocodone 25, Roxanol 30 ml, Lorazepam 29. The count failed to include the patient's Xanax. Review of the 9/19/20 IDG note indicated the narcotic count as follows: Morphine is not in the home. Lorazepam 22 tab, Xanax 11 tabs, Norco 45 tabs. Review of the skilled nursing visit note dated 9/19/20, the Integumentary section indicated that the patient had zero pressure ulcers when the patient has wounds to bilateral heels, left trochanter and sacrum, the patient was alert and oriented x3, anxiety does not affect the patient, the patient's worst pain level in the last 24 hours, on a scale of 1-10 (with 10 being the worse pain) was a 6 but currently has no pain, the patient's repeat pain assessment "N/A - Patient was at or below their acceptable level for pain during the initial pain assessment". The IDG narcotic count for the morphine was inconsistent with the narcotic count on 9/18, the inconsistent number of Norco from 25 tabs on 9/18 to current 45 tab, and failed to identify an assessment of the patient's anxiety level due to 7 Lorazepam tabs being used from previous day. The assessment note failed to evidence an assessment of the right heel. Review of the 9/20/20 IDG note indicated the narcotic count as follows: Morphine is not in the home which is inconsistent from 9/18/20. Lorazepam 21 tabs, Xanax 11 tabs, Norco 42 tabs. Review of the skilled nursing visit note dated 9/20/20, indicated the patient did not have anxiety that significantly affected him/ her, the pain assessment continued to indicate the patient has no pain or pain does not interfere with activity or			

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	movement and the repeat pain assessment indicated "N/A - Patient was at or below their acceptable level for pain during the initial pain assessment" but the narrative note indicated the patient reported the prn (as needed) Norco was effective in managing their pain. The visit note failed to include an assessment of the patient anxiety and pain level due to the use of the narcotics. The assessment note failed to evidence an assessment of the right heel. Review of the skilled nursing visit note dated 9/21/20, indicated the patient did not have anxiety that significantly affected him/ her, the pain assessment continued to indicate the patient has no pain or pain does not interfere with activity or movement and the repeat pain assessment indicated "N/A - Patient was at or below their acceptable level for pain during the initial pain assessment." The left trochanter wound assessment indicated the depth description was extensive and the patient had a large amount of purulent drainage with a strong odor, the sacral wound assessment indicated the depth description was extensive with a strong odor, and the left heel continued to be a stage 2 but the depth description was described as necrotic. The narcotic count within the narrative indicated Norco 35 (7 tabs taken within 24 hours), Lorazepam was blank, Roxanol 29 ml, and Xanax 11. The visit note failed to include an assessment of the patient anxiety and pain due to the use of the narcotics. The assessment note failed to evidence an assessment of the right heel. Review of the skilled nursing visit note dated 9/23/20, indicated the patient did not have anxiety that significantly affected him/ her, the pain assessment continued to indicate the patient has no pain or pain does not interfere with activity or			

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	movement and the repeat pain assessment indicated "N/A - Patient was at or below their acceptable level for pain during the initial pain assessment." The left heel continued to be a stage 2 but the depth description was described as necrotic with a measurement of 5 x 6 x 0.1 cm. The wound identification and assessments failed to be consistent and accurate according to the wound assessment websites. The assessment note failed to evidence an assessment of the right heel. The narcotic count within the narrative note indicated Norco 26 (9 tabs taken within 48 hours), Lorazepam 9 (12 tabs taken in 72 hours in conjunction with Xanax), Roxanol (Morphine) 30 ml, and Xanax 7 (4 tabs taken in 72 hours in conjunction with Lorazepam). The caregiver requested refills on the Xanax and Lorazepam. The visit note failed to evidence a comprehensive assessment of the patient's use of pain and anti-anxiety medications. Review of the skilled nursing visit note dated 9/25/20, indicated the patient did not have anxiety that significantly affected him/ her, the pain assessment continued to indicate the patient has no pain or pain does not interfere with activity or movement and the repeat pain assessment indicated "N/A - Patient was at or below their acceptable level for pain during the initial pain assessment." The left heel continued to be a stage 2 but the depth description was described as necrotic without a measurement. The wound identification and assessments failed to be consistent and accurate according to the wound assessment websites. The assessment note failed to evidence an assessment of the right heel. The narcotic count within the narrative note indicated Lorazepam 33 tabs, Xanax 60 tabs, Roxanol 30 ml, and Norco 21 tabs. The visit note failed to evidence a comprehensive assessment of the			

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	patient's use of pain and anti-anxiety medications. Review of the skilled nursing visit note dated 9/28/20, indicated the patient did not have anxiety that significantly affected him/ her, the pain assessment continued to indicate the patient has no pain or pain does not interfere with activity or movement and the repeat pain assessment indicated "N/A - Patient was at or below their acceptable level for pain during the initial pain assessment." The left heel continued to be a stage 2 but the depth description was described as necrotic without a measurement. The wound identification and assessments failed to be consistent and accurate according to the wound assessment websites. The assessment note failed to evidence an assessment of the right heel. The narrative note indicated the patient's muscle spasms were worsening and orders were received to increase Baclofen to four times a day. The narcotic count within the narrative note indicated Lorazepam 21 tabs (12 tabs taken in 72 hours in conjunction with Xanax), Xanax 49 tabs 11 tabs taken in 72 hours in conjunction with Lorazepam), Roxanol 30 ml, and Norco 10 tabs (11 tabs taken in 72 hours). The narrative note indicated education provided was safety. The interventions indicated there was instruction regarding the use of the comfort kit, instruction regarding routine inspection of the skin, instruction regarding proper positioning, regarding appropriate hydration and nutrition, and use of support surfaces. These interventions failed to be consistent with the narrative note. The visit note failed to evidence a comprehensive assessment of the patient's use of pain and anti-anxiety medications. Review of the skilled nursing visit note dated 9/30/20, indicated the patient did not have anxiety			

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	that significantly affected him/ her, the pain assessment continued to indicate the patient has no pain or pain does not interfere with activity or movement and the repeat pain assessment indicated "N/A - Patient was at or below their acceptable level for pain during the initial pain assessment." The left heel wound assessment indicated a measurement of 5.5 x 6.5 x 0.1 cm, continued to be a stage 2 but the depth description was described as necrotic. The wound identification and assessments failed to be consistent and accurate according to the wound assessment websites and the sacral wound measurements of tunneling and undermining failed to be consistent with the 9/28/20 assessment. The assessment note failed to evidence an assessment of the right heel. The narrative note indicated the patient's muscle spasms were worsening and orders were received to increase Baclofen to four times a day. The narcotic count within the narrative note indicated Lorazepam 18 tabs, Xanax 41 tabs 8 tabs taken in 48 hours in conjunction with Lorazepam), Roxanol 30 ml, and Norco 61 tabs. The narrative note indicated education provided was safety. The interventions indicated there was instruction regarding the use of the comfort kit, instruction regarding routine inspection of the skin, instruction regarding proper positioning, regarding appropriate hydration and nutrition, and use of support surfaces. These interventions failed to be consistent with the narrative note. The visit note failed to evidence a comprehensive assessment of the patient's use of pain and anti-anxiety medications. 8. During an interview on 9/30/20 at 4:55 p.m., the Administrator stated that the agency did not provide "comfort kits."			

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	9. The above findings were reviewed with the Regional Director of Compliance, Director of Nursing, Patient Care Manager of the Bloomington Branch, and Administrator on 10/01/2020 at 1:20 p.m., the Director of Nursing stated that the assessment was accurate in indicating there would be no pain or anxiety if medication was working and did not feel that there needed to be any further assessments since the patient was taking medications as prescribed. The Director of Nursing indicated he felt the description and staging of wounds were appropriate.			
L 0544 Bldg. 00	418.56(b) PLAN OF CARE The hospice must ensure that each patient and the primary care giver(s) receive education and training provided by the hospice as appropriate to their responsibilities for the care and services identified in the plan of care. Based on record review and interview, the agency failed to ensure visit notes contained specific details of education to patients and family members along with their response for 2 of 3 records reviewed. (Patient #1, 2) Findings include: 1. Review of an agency policy titled "Patient Education Process Policy No. 2-025.1-3" dated 5/11/20, indicated " ... Procedure ... 6. ... the patient and family/ caregiver will receive verbal, and as appropriate, written instructions on: ... B. The patient's disease process C. The medical regimen D. Medication management and administration ... G. Prescribed treatments ... 7. Documentation of patient and family/ caregiver	L 0544	**L 544** 418.56(b) PLAN OF CARE The hospice must ensure that each patient and the primary care giver(s) receive education and training provided by the hospice as appropriate to their responsibilities for the care and services identified in the plan of care. **How are you going to correct the deficiency? If already corrected, include the following steps and state date of correction.** From 10/14/20-10/9/20, all Nurses were In-serviced on the following *Premier Hospice & Palliative Care CHAP Hospice Policy and Procedure Manual*, 2020 policies:	10/30/2020

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	education will consist of: A. Describing what was taught to the patient ... B. Describing the patient's response to the teaching, including level of understanding and the ability to repeat or demonstrate what was taught. C. Describing any additional learning needs not currently met ... 11. The patient's and family/ caregiver's knowledge, skills, and behaviors will be assessed during hospice visits. Re-education, when appropriate, will be provided .... " 2. Review of an agency policy titled "Pain Management Education Policy No. 2-026.1" dated 5/11/20, indicated " ... 3. Documentation of patient and family/ caregiver instruction and understanding in the clinical record will include: A. Information taught B. Patient and family/ caregiver understanding C. Response to teaching .... " 3. Review of clinical record #1, Election date of 08/06/2020, included a plan of care for the benefit period of 08/06/2020 to 10/04/2020, with orders to instruct medication "indications, uses, side effects of each medication prior to administration .... " The plan of care revealed that the patient was prescribed approximately 23 medications. Review of a skilled nursing visit note dated 08/07, 08/08, 08/09, 08/10, 08/13/20, failed to evidence any instructions or education in regards to the patient medications. Review of a skilled nursing visit note dated 08/17/20, indicated the patient was placed on cardizem 120 mg daily. The visit note failed to evidence any education about the new medication nor any instruction or education of the patient's prescribed medications.		1.PATIENT EDUCATION PROCESS, Policy No. 2-025; 2.PAIN MANAGEMENT EDUCATION, Policy No. 2-026; 3.BASIC HOME SAFETY, Policy No. 2-048. Involved staff acknowledged this in-service re-training in writing: Organization policies set forth the organization shall ensure visit notes contain specific details of education to patients and family members along with their response. Patients and family/caregivers will receive information regarding pain and the management of pain as an integral part of hospice care. The patient and family/caregiver will receive verbal or written instructions, as appropriate, regarding: 1.A. The pain process 2.B. The risk for pain 3.C. The pain assessment process 4.D. The importance of effective pain management 5.E. Methods for pain management, when identified as part of treatment 6.F. Potential limitations of pain management modalities 7.G. Side effects of pain treatment 8.Documentation of patient and family/caregiver instruction and understanding in the clinical record will include: A. Specific information taught; B. Patient and family/caregiver specific	

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	During an interview on 9/30/20 at 4:55 p.m., when asked if patients/ caregivers should have a copy of the medication profile, the Administrator stated "Yes" the medication profile should be printed out and given to the patient/ caregiver. During an interview on 10/01/20 at 9:20 a.m., when asked if the agency provided them with a medication list indicating instruction or provided any verbal education on the prescribed medications, the caregiver indicated they were only provided a small handwritten note which indicated for the morphine, 0.5 ml (milliliters) to be given every hour and Ativan, 1 tab every hour then 2 tabs 0.5 mg (milligram), which was a new dose but there was some confusion on the exact dosage. The caregiver indicated she was not provided any education on the medication and felt that both medications given multiple times in an hour resulted in their loved ones death. The above findings were reviewed with the Regional Director of Compliance, Director of Nursing, Patient Care Manager of the Bloomington Branch, and Administrator on 10/01/2020 at 1:20 p.m., in which no further information or documentation was provided. 4. Review of clinical record #2, Election date of 9/10/20, included a plan of care for the benefit period of 9/10/2020 to 12/8/2020, with only two orders to instruct: safety measures each visit and to educate patient/ family on oxygen use and safety at each visit. No other orders of instruction was indicated in the plan of care.		understanding; C. Response to teaching; D. Additional learning needs. Nurses will document pain and symptom assessments and reassessments as required. When pain is identified, a more comprehensive pain assessment will be completed. Pain assessments will facilitate regular reassessment and follow-up by clinicians. Patients receive information regarding basic home safety in the *Patient Hospice Admission Booklet, page 29,* including: 1. Fire response including Oxygen Safety 2. Electrical safety 3. Environmental and mobility safety 4. Bathroom safety 1.Documentation of patient and family/caregiver instruction in the clinical record will include: 2.A. Specific Information taught 3.B. Adaptations made to the environment 4.C. Patient and family/caregiver understanding 5.D. Return demonstrations in use of equipment, if appropriate 6.E. Response to teaching 7.F. Additional learning needs 1. **How are you going to prevent the deficiency from recurring in the future, even if already corrected?**	

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			1.100% Focused chart audit for 90 days on Admissions, then ongoing, 10% review each quarter to ensure specific patient education and response is charted; 2.100% focused audit prior to each Interdisciplinary Group Meeting/IDG, then ongoing, 10% each quarter to ensure specific patient education and response is charted; 3.Threshold for focused audits is 100% compliance with documentation of patient and caregiver education. If threshold not met, Patient Care Managers will re-educate involved staff, progressively, involving human resources for work plans, if needed. **Who is going to be responsible for prevention above: i.e., director, supervisor, etc.?** Patient Care Managers (PCMs) are responsible for audits and staff correction. PCMs will be overseen by Director(s) of Clinical Services (DCS) who report to the Administrator. The Administrator shall report Focus audit results to the QAPI Committee and then the Governing Body for three consecutive quarters. **By what date are you going to have the deficiency corrected?** 10/30/20. Nurses completed re-education by	

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			10/30/20. By no later than 10/30/20, the organization will have implemented 100% Focus audits on documentation of education at Admission and Prior to each IDG.	
L 0546 Bldg. 00	418.56(c)(1) CONTENT OF PLAN OF CARE [The plan of care must include all services necessary for the palliation and management of the terminal illness and related conditions, including the following:] (1) Interventions to manage pain and symptoms. Based on record review and interview, the Interdisciplinary Group (IDG) failed to ensure the plan of care included interventions for 1 of 1 active record reviewed. (Patient #2) Finding include: Review of an agency's policy titled "Prioritizing Patient Problems/ Needs Policy No. 1-033.1" dated 5/11/20, indicated " ... A written, individualized plan of care will be established within 48 hours of hospice benefit election to assist with identification and prioritization of patient immediate problems/ needs. ..." The clinical record for patient #2, Election date 9/10/20, included history and physical from an entity dated 8/14/20, which stated the patient has a history of C6 spinal cord injury after a motor vehicle accident in 2002 that resulted in the patient becoming a paraplegic, has sacral/ ischial and heel wounds. The patient was admitted prior to this hospitalization for sepsis related to wound infections. The patient underwent debridement	L 0546	**L 546** 18.56(c)(1) CONTENT OF PLAN OF CARE [The plan of care must include all services necessary for the palliation and management of the terminal illness and related conditions, including the following:] (1) Interventions to manage pain and symptoms. **How are you going to correct the deficiency? If already corrected, include the following steps and state date of correction.** From 10/14/20-10/30/20, all Nurses were In-serviced on the following *Premier Hospice & Palliative Care CHAP Hospice Policy and Procedure Manual*, 2020 policies: 1.INITIAL ASSESSMENT, Policy No. 1-013; 2.THE PLAN OF CARE-INDIANA, Policy No. 9-017;	10/30/2020

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	and antibiotic therapy. The patient returned to the hospital due to unresponsiveness and fever. The patient was treated again for recurrent sepsis and ended up having 3 seizures during their hospital stay. The clinical record also contained notes from a skilled nursing facility that the patient was sent to after hospitalization for wound treatment with a wound vac (a type of device that decreases air pressure on the wound to help it heal), IV (intravenous) antibiotics for sepsis, and seizures. A 9/5/20 note indicated the patient's sacral wound increased in size from 7 to 10 cm due to loose stools, causing further infection to the sacral wound. The note also indicated the patient had a diagnosis of an anxiety disorder. On 9/1, the note indicated the patient has a deep tissue injury to the right heel possibly measuring 2.6 x 5 cm, a wound to the right trochanter measuring 2 x 0.8 x 0.1 cm, left heel measuring was described as an unstageable deep tissue injury measuring 2.5 x 6 cm, Stage IV left trochanter measured 3.5 x 3.5 x 0.4 on 8/28/20. During the patient's stay, the patient had critical labs and refused further treatment and hospice was presented. Review of the start of care comprehensive assessment dated 9/10/20, the narrative note stated the patient had been hospitalized x2 for sepsis related to the wounds and during the last hospitalization, the patient had 3 seizures and the patient consumes 3 to 6 beers daily. The note indicated the patient had a Stage 4 sacral ulcer, stage 3 left hip ulcer, stage 2 left heel ulcer and the right heel was unblancheable and boggy. The note went on to state the patient wore waffle boots and the patient was incontinent of bowel and bladder.		1.PRIORITIZING PATIENT PROBLEMS/NEEDS, Policy No. 1-033. Policy sets forth that the Interdisciplinary Group (IDG) shall ensure the plan of care includes interventions for symptom control. This includes pain management, anxiety management, interventions for seizure and muscle relaxant therapy, interventions to prevent skin breakdown/infection, and interventions for education of the patient of risks while taking narcotics.The hospice registered nurse will complete an initial assessment utilizing scales/rating tools to assess for problems and to establish a baseline status of each symptom rated. Items assessed may include, but are not limited to, the following: 1.A. Pain assessment 2.B. Vital signs 3.C. Fatigue, drowsiness 4.D. Nausea, appetite 5.E. Depression, anxiety 6.F. Shortness of breath 7.G. Well-being 8.The admitting registered nurse will determine the patient's and caregiver's primary concern, goals and immediate care needs. Nurses will document teaching and interventions performed during all visits in accordance with the plan of care. A written individualized patient and family/caregiver plan of care will be	

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	151599	A. BUILDING 00 B. WING	10/01/2020

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	Review of the plan of care for the benefit period of 09/10/20 to 12/8/20. The medication list on the plan of care indicated the patient was prescribed and taking alprazolam 0.5 mg every 6 hours as needed for anxiety, Baclofen 20 mg twice a day for muscle relaxant, levetiracetam 500 mg and Vimpat 100 mg twice a day for seizures, and Norco 5 mg-325 mg tablet every 6 hours as needed for pain. The plan of care revealed only two orders to instruct: safety measures each visit and to educate patient/ family on oxygen use and safety at each visit. No other orders of instruction was indicated in the plan of care. The goals included, but limited to, the patient/ caregiver will understand the pain scale. The plan of care failed to interventions for pain management, patient's anxiety, muscle relaxant, seizures, interventions to prevent any further skin breakdown/ infection, and interventions to education the patient of consuming alcohol while taking narcotics. During an interview on 10/1/20 at 9:14 a.m., the patient's caregiver stated the patient had been on Xanax for years for anxiety and the patient had horrible dysreflexia, which caused his legs to spasm, and does have pain and discomfort, and utilizes the Baclofen routinely and Norco as needed. The above findings were reviewed with the Regional Director of Compliance, Director of Nursing, Patient Care Manager of the Bloomington Branch, and Administrator on 10/01/2020 at 1:20 p.m., in which the team had no further information or documentation to provide.		established. The care provided to the patient must be in accordance with the plan of care. The plan of care will include orders for care. The plan of care will be based on the initial, comprehensive and ongoing comprehensive assessments performed by members of the interdisciplinary group and will be reviewed on a regular basis but no less than every fifteen (15) days. This plan will focus on identified problems, goals, and interventions. The patient and family/caregiver will be encouraged to participate in the development of and continued updating of the plan of care and will be advised of any changes to the plan of care. A written, individualized plan of care will be established to assist with identification and prioritization of patient immediate problems/needs. The plan of care should include: A. Patient and family/caregiver needs (prioritized) 9.B. Goals 10.C. Dates problems identified/onset D. Resolution dates **How are you going to prevent the deficiency from recurring in the future, even if already corrected?** 1.100% Focused chart audit for 90 days on Admissions, then ongoing, 10% review each quarter	

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			to ensure appropriate symptom control interventions and response are charted; 2.100% Focused audit prior to each Interdisciplinary Group Meeting/IDG, then ongoing, 10% each quarter to ensure appropriate symptom control interventions and response are charted; 3.Threshold for focused audits is 100% compliance with plan of care that includes interventions for symptom control. If threshold not met, Patient Care Managers will re-educate involved staff, progressively, involving human resources for work plans, if needed. **Who is going to be responsible for prevention above: i.e., director, supervisor, etc.?** Patient Care Managers (PCMs) are responsible for audits and staff correction. PCMs will be overseen by Director(s) of Clinical Services (DCS) who report to the Administrator. The Administrator shall report Focus audit results to the QAPI Committee and then the Governing Body for three consecutive quarters. **By what date are you going to have the deficiency corrected?** 10/30/20. Nurses completed re-education by 10/30/20. By no later than 10/30/20, the organization will have implemented 100% Focus	

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			audits on symptom control interventions at Admission and Prior to each IDG.	
L 0548 Bldg. 00	418.56(c)(3) CONTENT OF PLAN OF CARE [The plan of care must include all services necessary for the palliation and management of the terminal illness and related conditions, including the following:] (3) Measurable outcomes anticipated from implementing and coordinating the plan of care. Based on record review and interview, the Interdisciplinary Group (IDG) failed to ensure the plan of care included measurable goals for 1 of 1 active record reviewed. (Patient #2) Finding include: The clinical record for patient #2, Election date 9/10/20, included history and physicals from an entity dated 8/14/20, which stated the patient had a history of C6 spinal cord injury after a motor vehicle accident in 2002 that resulted in the patient becoming a paraplegic, had sacral/ ischial and heel wounds. The patient was admitted prior to this hospitalization for sepsis related to wound infections. The patient underwent debridement and antibiotic therapy. The patient returned to the hospital due to unresponsiveness and fever. The patient was treated again for recurrent sepsis and ended up having 3 seizures during their hospital stay. The clinical record also contained notes from a skilled nursing facility that the patient was sent to after hospitalization for wound treatment with a	L 0548	**L 548** [The plan of care must include all services necessary for the palliation and management of the terminal illness and related conditions, including the following:] (3) Measurable outcomes anticipated from implementing and coordinating the plan of care.48 418.56(c)(3) CONTENT OF PLAN OF CARE **How are you going to correct the deficiency? If already corrected, include the following steps and state date of correction.** From 10/14/20-10/30/20, all Nurses were In-serviced on the following *Premier Hospice & Palliative Care CHAP Hospice Policy and Procedure Manual*, 2020 policies: 1.INITIAL ASSESSMENT, Policy No. 1-013; 2.THE PLAN OF CARE-INDIANA, Policy No. 9-017;	10/30/2020

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	wound vac (a type of device that decreases air pressure on the wound to help it heal), IV (intravenous) antibiotics for sepsis, and seizures. A 9/5/20 note indicated the patient's sacral wound increased in size from 7 to 10 cm (centimeters) due to loose stools, causing further infection to the sacral wound. The note also indicated the patient had a diagnosis of an anxiety disorder. On 9/1/20, the note indicated the patient had a deep tissue injury to the right heel possibly measuring 2.6 x 5 cm, a wound to the right trochanter measuring 2 x 0.8 x 0.1 cm, left heel measuring was described as an unstageable deep tissue injury measuring 2.5 x 6 cm, Stage IV left trochanter measured 3.5 x 3.5 x 0.4 cm on 8/28/20. During the patient's stay, the patient had critical labs and refused further treatment and hospice was presented. Review of the start of care comprehensive assessment dated 9/10/20, the narrative note stated the patient had been hospitalized x2 for sepsis related to the wounds and during the last hospitalization, the patient had 3 seizures and the patient consumed 3 to 6 beers daily. The note indicated the patient had a Stage 4 sacral ulcer, stage 3 left hip ulcer, stage 2 left heel ulcer, and the right heel was unblancheable and boggy. The note went on to state the patient wore waffle boots and the patient was incontinent of bowel and bladder. The pain assessment failed to evidence an acceptable pain range/ goal established by the patient. Review of the plan of care for the benefit period of 09/10/20 to 12/8/20. The medication list on the plan of care indicated the patient was prescribed and taking alprazolam 0.5 mg (milligrams) every 6 hours as needed for anxiety, Baclofen 20 mg twice a day for muscle relaxant, levetiracetam 500 mg and Vimpat 100 mg twice a day for seizures, and		3.PRIORITIZING PATIENT PROBLEMS/NEEDS, Policy No. 1-033. Policy sets forth that the Interdisciplinary Group (IDG) shall ensure the plan of care includes patient specific, measurable goals and outcomes. This includes measurable goals for pain and anxiety management, seizure control, dysreflexia, prevention of skin breakdown/infection, and education for patient and caregivers on risks, including narcotic interactions. The hospice registered nurse will complete an initial assessment utilizing scales/rating tools to assess for problems and to establish a baseline status of each symptom rated. Items assessed may include, but are not limited to, the following: 1.A. Pain assessment 2.B. Vital signs 3.C. Fatigue, drowsiness 4.D. Nausea, appetite 5.E. Depression, anxiety 6.F. Shortness of breath 7.G. Well-being 8.The admitting registered nurse will determine the patient's and caregiver's primary concern, goals and immediate care needs. Nurses will document teaching and interventions performed during all visits in accordance with the plan of care. A written individualized patient and family/caregiver plan of care will be	

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	Norco 5 mg-325 mg tablet every 6 hours as needed for pain. The plan of care revealed only two orders to instruct: safety measures each visit and to educate patient/ family on oxygen use and safety at each visit. No other orders of instruction were indicated in the plan of care. The plan of care failed to include an acceptable pain range as measurable goal and failed to include measurable goals in regards to the patient's wounds, anxiety, muscle relaxant, seizures, to prevent further skin breakdown/ infection and goals for patient/ caregiver understanding of mixing alcohol with narcotics. During an interview on 10/1/20 at 9:14 a.m., the patient's caregiver stated the patient had been on Xanax for years for anxiety and the patient had horrible dysreflexia, which caused his legs to spasm, and does have pain and discomfort, and utilizes the Baclofen routinely and Norco as needed. The above findings were reviewed with the Regional Director of Compliance, Director of Nursing, Patient Care Manager of the Bloomington Branch, and Administrator on 10/01/2020 at 1:20 p.m., in which no further information or documentation was provided.		established. The care provided to the patient must be in accordance with the plan of care. The plan of care will include orders for care. The plan of care will be based on the initial, comprehensive and ongoing comprehensive assessments performed by members of the interdisciplinary group and will be reviewed on a regular basis but no less than every fifteen (15) days. This plan will focus on identified problems, goals, and interventions. The patient and family/caregiver will be encouraged to participate in the development of and continued updating of the plan of care and will be advised of any changes to the plan of care. A written, individualized plan of care will be established to assist with identification and prioritization of patient immediate problems/needs. The plan of care should include: A. Patient and family/caregiver needs (prioritized) 9.B. Goals 10.C. Dates problems identified/onset D. Resolution dates **How are you going to prevent the deficiency from recurring in the future, even if already corrected?** 1.100% Focused chart audit for 90 days on Admissions, then ongoing, 10% review each quarter	

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			to ensure measurable goals are included in the plan of care; 1.100% Focused audit prior to each Interdisciplinary Group Meeting/IDG, then ongoing, 10% each quarter to ensure appropriate measurable goals are included in the plan of care update; 2.Threshold for focused audits is 100% compliance with plan of care that includes interventions for symptom control. If threshold not met, Patient Care Managers will re-educate involved staff, progressively, involving human resources for work plans, if needed. **Who is going to be responsible for prevention above: i.e., director, supervisor, etc.?** Patient Care Managers (PCMs) are responsible for audits and staff correction. PCMs will be overseen by Director(s) of Clinical Services (DCS) who report to the Administrator. The Administrator shall report Focus audit results to the QAPI Committee and then the Governing Body for three consecutive quarters. **By what date are you going to have the deficiency corrected?** 10/30/20. Nurses completed re-education by 10/30/20. By no later than 10/30/20, the organization will have implemented 100% Focus audits on patient measurable	

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			goals at Admission and Prior to each IDG.	
L 0553 Bldg. 00	418.56(d) REVIEW OF THE PLAN OF CARE A revised plan of care must include information from the patient's updated comprehensive assessment and must note the patient's progress toward outcomes and goals specified in the plan of care. Based on record review and interview, the IDG (Interdisciplinary Group) failed to ensure the revised plan of care included the patient's progress toward outcomes and goals as specific in the plan of care for 2 of 3 records reviewed. (Patient #1, 2) Findings include: 1. Review of an agency policy titled "Interdisciplinary Group Meeting Policy No. 1-036.1) dated 5/11/20, indicated " ... Each patient's plan of care will be updated utilizing the results from the ongoing comprehensive assessment ... Procedure ... 6. An interdisciplinary group meeting plan of care update form will be used for update of the patient and family/ caregiver ... It will note changes, response to treatment and progress toward targeted outcomes, with may include: A. Pharmacotherapeutic effectiveness of symptoms management outcomes. B. An increase or decrease in symptoms or acuity ... 2. Pain management 3. Condition of skin/ presence/ status of pressure ulcers ... H. Plan for changes in treatments or procedures. 2. The clinical record for patient #1, start of care 8/6/20, was reviewed and included a plan of care	L 0553	**L 553** 418.56(d) REVIEW OF THE PLAN OF CARE A revised plan of care must include information from the patient's updated comprehensive assessment and must note the patient's progress toward outcomes and goals specified in the plan of care. **How are you going to correct the deficiency? If already corrected, include the following steps and state date of correction.** From 10/14/20-10/30/20, all Nursing staff were In-serviced on the following *Premier Hospice & Palliative Care CHAP Hospice Policy and Procedure Manual*, 2020 policies and rules: 1.PRIORITIZING PATIENT PROBLEMS/NEEDS, Policy No. 1-033; 2.MONITORING PATIENT'S RESPONSE/REPORTING TO PHYSICIAN, Policy No. 1-010; 3.ONGOING COMPREHENSIVE ASSESSMENT, Policy No. 1-015.	10/30/2020

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	for the benefit period of 8/6/20 to 10/4/20. The plan of care included goals of "Patient, family, caregivers are knowledgeable and involved in hospice plan of care for patient ... pt/cg (patient/ caregiver) will verbalize understanding of indications, uses, and side effects of each medication and administer medications as prescribed as evidenced by no adverse effects from medication error, narcotic counts will be correct each visit through next benefit period. Patient/ Caregiver will understand the numeric pain scale, how to manage pain and report changes to hospice. Pt [Patient] will rate pain at 5/10 or less by the end of each nursing visit by utilizing pain medications as ordered throughout benefit period. Comfort medications will be given as ordered. Patient will have an effective bowel program AEB [as evidenced by] pt having a BM [bowel movement] at least every 3 days throughout benefit period. Pt will be free of s/s [signs and symptoms] constipation. Pt will be free of s/s of N/V [nausea/ vomiting] by the end of the nrsg [nursing] visit through next benefit period. Anxiety/ agitation/ restlessness will be managed with use prn [as needed] lorazepam as ordered through next benefit period. Patient will rate dypsnea at 5/10 or less by the end of each nursing visit through next benefit. Patient will maintain optimal cardiac function and within constraints of disease AEB dypsnea rating of 5/10 or less rest by the end of each nursing visit through next benefit period. Patient's respiratory status will be stabilized to comfort as possible AEB no adventitious lung sounds, discolored sputum r/t [related to] increased productive cough or increased SOA [shortness of air] throughout benefit period. Patient/ caregiver will be able to verbalize measures to promote comfort related to respiratory system in the terminal patient through next benefit period. Pt will wear oxygen as		Involved staff acknowledged this in-service re-training in writing: Organization policies set forth that the IDG (Interdisciplinary Group) shall ensure the revised plan of care includes the patient's progress toward outcomes and goals as specified in the plan of care update. Clinicians will monitor, document, and report the patient's response to care and treatment provided on each hospice visit in IDG coordination. Progress of goals will be measured at regular intervals and updated on the plan of care. Clinicians will establish and maintain ongoing communication with the patient's physician and the hospice Medical Director to ensure responsive medical care for the patient. A revised plan of care must include information from the patient's updated comprehensive assessment and must note the patient's progress toward outcomes and goals as specified in the plan of care. IDG Discussion shall note patient progress toward wound healing/wound goals, increased use of symptom control medications, identify lack of symptom assessment and related goals, patient changes in status, and implement updated goals and interventions for actively dying patients. **How are you going to prevent the deficiency from recurring in**	

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	ordered through next benefit period. Patient will demonstrate oxygen saturation to patient's optimal level through benefit period. Patient will have safety needs met AEB no falls or injury throughout benefit period. Patient/ caregiver understand the risks and benefits of side rail use through next benefit period. Patient needs will be met throughout the next benefit period ... Patient will receive personal care and hygiene, including other activities of daily living to their optimal level AEB remaining odor free, having a neat/ clean appearance through next benefit period. Patient/ Caregiver understand the risk and benefits of side rail use through next benefit period." Review of the agency's document titled 8/19/20 Hospice IDG Comprehensive Assessment and Plan of Care Update for patient #1, included IDG notes from skilled nursing visits. The Plan of Care Update failed to evidence the patient's/ caregiver progress towards all goals listed on the plan of care, as well as the specific medication that was educated as evidenced by the following: The 8/7/20 IDG note indicated the education provided were safety and comfort medication. Narcotic count indicated: Norco 12, Roxanol 30 ml, and Lorazepam 10. No falls. Patient and/ or caregiver understand the appropriate use, use of side rails and returns demonstration, and dexamethasone was called into the patients pharmacy. Review of the skilled nursing visit note indicated the only interventions/ goals achieved was pain management and safety. The 8/8/20 IDG note indicated "N/A" to education provided. Narcotic count indicated: Norco 12, Morphine (Roxanol) 30 ml, and Lorazepam 20. No falls. Patient and/ or caregiver understand the appropriate use of side rails and returns		**the future, even if already corrected?** 1.100% Focused audit prior to each Interdisciplinary Group Meeting/IDG, then ongoing, 10% each quarter to ensure updates and progress toward measurable goals is included in plan of care update; 2.Threshold for focused audits is 100% compliance with plan of care that includes updates and progress toward measurable goals. If threshold not met, Patient Care Managers will re-educate involved staff, progressively, involving human resources for work plans, if needed. **Who is going to be responsible for prevention above: i.e., director, supervisor, etc.?** Patient Care Managers (PCMs) are responsible for audits and staff correction. PCMs will be overseen by Director(s) of Clinical Services (DCS) who report to the Administrator. The Administrator shall report Focus audit results to the QAPI Committee and then the Governing Body for three consecutive quarters. **By what date are you going to have the deficiency corrected?** 10/30/20. Nurses completed re-education by 10/30/20. By no later than 10/30/20, the organization will have implemented 100% Focus	

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	demonstration. Respirations even but slightly labored at rest at times and the patient denied a need for intervention, no edema, and DME (durable medical equipment) concerns. Review of the skilled nursing visit note indicated the only interventions/ goals achieved was pain management and safety. The 8/9/20 IDG note indicated "N/A" to education provided. Narcotic count indicated: Norco 12, Morphine (Roxanol) 29.5 ml, and Lorazepam 20. No falls. Patient and/ or caregiver understand the appropriate use of side rails and returns demonstration. Over the counter eye drops used and spouse instructed on hospice not delivering medications. Review of the skilled nursing visit note indicated the only interventions/ goals achieved was pain management and safety. The 8/10/20 IDG note indicated the education provided were safety and comfort medication. Narcotic count indicated: Norco 12, Roxanol 28 ml, Lorazepam 21. No falls. Patient and/ or caregiver understand the appropriate use of side rails and returns demonstration. Shortness of breath at baseline. Concerns and request for a trapeze for the patient's bed. Review of the skilled nursing visit note indicated the only interventions/ goals achieved was pain management and safety. The 8/13/20 IDG note indicated the education provided were safety and comfort medication. Narcotic count indicated: Norco 12, Roxanol 28 ml, Lorazepam 20. No falls. Patient and/ or caregiver understand the appropriate use of side rails and returns demonstration. Shortness of breath at baseline. Spouse requests a bariatric bed extender and was advised that it was not available. Review of the skilled nursing visit note		audits on progress toward patient measurable goals Prior to each IDG.	

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	indicated the only interventions/ goals achieved was pain management and safety. The 8/17/20 IDG note indicated the education provided was on safety and comfort medication. Narcotic count indicated: Norco 12, Roxanol 28 ml, Lorazepam 21. No falls. and/ or caregiver understand the appropriate use of side rails and returns demonstration. The patient had tachycardia with an irregular heart rate of 140-160, new order for cardizem 120 mg daily was called into the pharmacy. No shortness of breath above baseline. Review of the skilled nursing visit note indicated the only interventions/ goals achieved was pain management and safety. 3. The clinical record for patient #2, start of care 9/10/20, was reviewed and included a plan of care for the benefit period of 9/10/20 to 12/8/20. The medication list indicated the patient was prescribed Xanax 0.5 mg every 6 hours as needed for anxiety, Baclofen 20 mg tables 2 times daily for muscle relaxant, Lorazepam 1 mg tablet every 4 hours as needed for anxiety, agitation, and restlessness, Norco 5 mg - 325 mg tablet 1 every 6 hours as needed for pain, and Morphine concentrate 100 mg/ 5 ml (20 mg/ml) oral solution give 0.25 ml every 4 hours as needed for pain or air hunger. The interventions indicated the hospice nurse to obtain blood sugar readings from the patient/ caregiver at each visit, wound treatment to 3 pressure ulcers (located at the left trochanter, sacral, and left heal), and failed to evidence a goal of what is an acceptable level of pain. Review of the comprehensive assessment dated 9/10/20, failed to include an acceptable pain range. Review of the wound assessment indicated the patient had a stage 3 wound to the left greater			

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	trochanter that measured 10 (L) x 8.5 (W) x 0.5 (D) centimeters (cm), with < 25 % granulation tissue and 51-75% necrotic tissue; the sacral wound was stage 4 wound that measured 18 x 25 x 1.5 cm, depth description indicated a full thickness wound with 25 - 50 % necrosis and 26 - 50% necrotic tissue slough; and a stage 2 wound to the left heel that measured 7.6 x 7.6 x 0.1 cm, depth description indicated a partial thickness wound with 100% epithelialization and 0-25 % necrotic tissue slough and eschar. Review of the skilled nursing visit note dated 9/13/20 and 9/14/20, the interventions provided indicated "Instructed patient/ caregiver on wound care ... Instructed patient/ caregiver in performing wound care including proper disposal of used wound supplies ... Instructed patient/ caregiver in preventative skin care ... Instructed patient/ caregiver regarding proper nutrition including calories/ protein intake necessary to promote wound healing ... Identified sources of pressure ... " The plan of care failed to be updated to include these interventions and the prospective measurable goals for these interventions. Review of the 9/16/20 Hospice IDG Comprehensive Assessment and Plan of Care update, the Medical Director note indicated the patient had an unstageable wound on the right heel and wears waffle boots, which failed to be supported by the comprehensive nursing assessments. The IDG note made by the Patient Care Manger, and not by the patient's case manager, indicated "See Admission Note" versus providing information in regards to the patient wounds and the progress or lack there of with the current wound treatment. The note failed to include if any other interventions were offered to the patient in regards to pressure relieving			

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	mattress, blood sugar readings, and reason for morphine not being in the home and any other education that needs to be provided to the patient and their caregiver. Review of the skilled nursing visit note dated 9/16/20, indicated the last bowel movement was on 9/9/20 when the 9/14/20 visit note indicated 9/14/20. The Integumentary assessment indicated there were 3 pressure ulcers, but only identified one at stage 3 and 4, and inaccurately indicated zero to stage 2 pressure ulcers. The visit note identified the patient is a diabetic but failed to include an assessment of blood sugars, the patient's repeat pain assessment "N/A - Patient was at or below their acceptable level for pain during the initial pain assessment", the functional assessment indicated the patient was a quadriplegic with the patient is a paraplegic, the wound assessment indicated the left trochanter is a stage 3 but a suspected deep tissue injury with a large amount of purulent draining with a strong odor with 76-100% necrotic slough tissue and 025% of necrotic eschar tissue, the sacral wound is a stage 4 but described as a suspected deep tissue injury with a moderate amount of purulent drainage and a strong odor with 0-25% of necrotic slough and eschar tissue, and the left heel is a stage 2 but described as a suspected deep tissue injury with 75-100% epithelialization tissue, soft black necrotic tissue and 0-25% necrotic slough tissue. The wound identification and assessments failed to be consistent and accurate according to the wound assessment websites. The narrative note indicated the patient was having episodes of a fixed stare without identifying this as a possible seizure incident. The narrative indicated the patient was out of Norco and the patient had pain in the left arm on 9/15/20. The visit note failed to indicate if the			

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	physician was notified of the odor and drainage of the wounds and possible seizure. The interventions provided indicated "Hospice comfort kit reviewed and is intact with current expiration dates, instructed patient/ caregiver regarding use of comfort kit. The IDG note dated 9/17/20 indicated the narcotic count was not completed due to multiple family members in the home and the caregiver was uncomfortable getting the medications out. Review of the skilled nursing visit note dated 9/18/20 indicated the patient was confused and lethargic, anxiety does not significantly affect the patient, the patient's repeat pain assessment "N/A - Patient was at or below their acceptable level for pain during the initial pain assessment" but the narrative note indicated the clinician gave the patient lorazepam and hydrocodone due to the patient being confused speaking in nonsensical sentences and wincing. The note indicated the patient was "active" and notified the physician, discontinued routine medications, and only ordered comfort medications/ scheduled Morphine and Lorazepam. The narcotic count within the narrative note indicated Hydrocodone 25, Roxanol 30 ml, Lorazepam 29. The count failed to include the patient's Xanax. Review of the 9/19/20 IDG note indicated the narcotic count as follows: Morphine is not in the home. Lorazepam 22 tab, Xanax 11 tabs, Norco 45 tabs. Review of the skilled nursing visit note dated 9/19/20, the Integumentary section indicated that the patient had zero pressure ulcers, the patient was alert and oriented x3, anxiety does not affect the patient, the patient's worst pain level in the last 24 hours, on a scale of 1-10 (with 10 being the worse pain) was a 6 but currently has no pain, the patient's repeat pain assessment			

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	"N/A - Patient was at or below their acceptable level for pain during the initial pain assessment". The IDG narcotic count for the morphine was inconsistent with the narcotic count on 9/18, the inconsistent number of Norco from 25 tabs on 9/18 to current 45 tab, and failed to identify an assessment of the patient's anxiety level due to 7 Lorazepam tabs being used from previous day. Review of the 9/20/20 IDG note indicated the narcotic count as follows: Morphine is not in the home which is inconsistent from 9/18/20. Lorazepam 21 tabs, Xanax 11 tabs, Norco 42 tabs. Review of the skilled nursing visit note dated 9/20/20, indicated the patient did not have anxiety that significantly affected him/ her, the pain assessment continued to indicate the patient has no pain or pain does not interfere with activity or movement and the repeat pain assessment indicated "N/A - Patient was at or below their acceptable level for pain during the initial pain assessment" but the narrative note indicated the patient reported the prn Norco was effective in managing their pain. The visit note failed to include an assessment of the patient anxiety and pain level due to the use of the narcotics. Review of the skilled nursing visit note dated 9/21/20, indicated the patient did not have anxiety that significantly affected him/ her, the pain assessment continued to indicate the patient has no pain or pain does not interfere with activity or movement and the repeat pain assessment indicated "N/A - Patient was at or below their acceptable level for pain during the initial pain assessment." The left trochanter wound assessment indicated the depth description was extensive and the patient had a large amount of purulent drainage with a strong odor, the sacral wound assessment indicated the depth			

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	description was extensive with a strong odor, and the left heel continued to be a stage 2 but the depth description was described as necrotic. The narcotic count within the narrative indicated Norco 35 (7 tabs taken within 24 hours), Lorazepam was blank, Roxanol 29 ml, and Xanax 11. The visit note failed to include an assessment of the patient anxiety and pain level due to the use of the narcotics. Review of the skilled nursing visit note dated 9/23/20, indicated the patient did not have anxiety that significantly affected him/ her, the pain assessment continued to indicate the patient has no pain or pain does not interfere with activity or movement and the repeat pain assessment indicated "N/A - Patient was at or below their acceptable level for pain during the initial pain assessment." The left trochanter wound assessment indicated the depth description was extensive and the patient had a large amount of purulent drainage with a strong odor, the wound measurement indicated 5 x 5 x 0.5 cm with <2 cm undermining (0.5 cm at 12 - 3 o'clock, 3 - 6 at o'clock, 6-9 at o'clock, and 9-12 at o'clock) and 1 cm of tunneling at 9-12 o'clock. The sacral wound assessment indicated the depth description was extensive and had a strong odor, with < 2 cm undermining (1 cm at 12 - 3 o'clock, 3 - 6 at o'clock, 6-9 at o'clock, and 9-12 at o'clock) and 1 cm of tunneling at 9-12 o'clock. The left heel continued to be a stage 2 but the depth description was described as necrotic with a measurement of 5 x 6 x 0.1 cm. The wound identification and assessments failed to be consistent and accurate according to the wound assessment websites. The narcotic count within the narrative note indicated Norco 26 (9 tabs taken within 48 hours), Lorazepam 9 (12 tabs taken in 72 hours in conjunction with Xanax), Roxanol (Morphine) 30			

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	ml, and Xanax 7 (4 tabs taken in 72 hours in conjunction with Lorazepam). The caregiver requested refills on the Xanax and Lorazepam. The visit note failed to evidence a comprehensive assessment of the patient's use of pain and anti-anxiety medications. Review of the skilled nursing visit note dated 9/25/20, indicated the patient did not have anxiety that significantly affected him/ her, the pain assessment continued to indicate the patient has no pain or pain does not interfere with activity or movement and the repeat pain assessment indicated "N/A - Patient was at or below their acceptable level for pain during the initial pain assessment." The left trochanter wound assessment indicated the depth description was extensive and the patient had a large amount of purulent drainage with moderate odor, <25 % epithelialization, 76-100% Necrotic tissue slough and 0-25% Necrotic tissue eschar. The assessment failed to evidence a wound measurement but included <2 cm undermining (2 cm at 12 - 3 o'clock, 3 - 6 at o'clock, 6-9 at o'clock, and 9-12 at o'clock) and no tunneling. The sacral wound assessment indicated the depth description was extensive with moderate odor, <25% epithelialization 0-25% of necrotic tissue with slough and eschar. The assessment failed to evidence a wound measurement but included < 2 cm undermining (2 cm at 12 - 3 o'clock, 3 - 6 at o'clock, 6-9 at o'clock, and 9-12 at o'clock) and 2 cm of tunneling at 9-12 o'clock. The left heel continued to be a stage 2 but the depth description was described as necrotic without a measurement. The wound identification and assessments failed to be consistent and accurate according to the wound assessment websites. The narcotic count within the narrative note indicated Lorazepam 33 tabs, Xanax 60 tabs,			

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	Roxanol 30 ml, and Norco 21 tabs. The visit note failed to evidence a comprehensive assessment of the patient's use of pain and anti-anxiety medications. Review of the skilled nursing visit note dated 9/28/20, indicated the patient did not have anxiety that significantly affected him/ her, the pain assessment continued to indicate the patient has no pain or pain does not interfere with activity or movement and the repeat pain assessment indicated "N/A - Patient was at or below their acceptable level for pain during the initial pain assessment." The left trochanter wound assessment indicated the depth description was extensive and the patient had a large amount of purulent drainage with strong odor, <25 % epithelialization, 76-100% Necrotic tissue slough and 0-25% Necrotic tissue eschar. The assessment failed to evidence a wound measurement but included <2 cm undermining (2 cm at 12 - 3 o'clock, 3 - 6 at o'clock, 6-9 at o'clock, and 9-12 at o'clock) and no tunneling. The sacral wound assessment indicated the depth description was extensive and with strong odor, <25% epithelialization 0-25% of necrotic tissue with slough and eschar. The assessment failed to evidence a wound measurement but included < 2 cm undermining (2 cm at 12 - 3 o'clock, 3 - 6 at o'clock, 6-9 at o'clock, and 9-12 at o'clock) and 2.5 cm of tunneling at 9-12 o'clock. The left heel continued to be a stage 2 but the depth description was described as necrotic without a measurement. The wound identification and assessments failed to be consistent and accurate according to the wound assessment websites. The narrative note indicated the patient's muscle spasms were worsening and orders were received to increase Baclofen to four times a day. The narcotic count within the narrative note indicated			

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	Lorazepam 21 tabs (12 tabs taken in 72 hours in conjunction with Xanax), Xanax 49 tabs 11 tabs taken in 72 hours in conjunction with Lorazepam), Roxanol 30 ml, and Norco 10 tabs (11 tabs taken in 72 hours). The narrative note indicated education provided was safety. The interventions indicated there was instruction regarding the use of the comfort kit, instruction regarding routine inspection of the skin, instruction regarding proper positioning, regarding appropriate hydration and nutrition, and use of support surfaces. These interventions failed to be consistent with the narrative note. The visit note failed to evidence a comprehensive assessment of the patient's use of pain and anti-anxiety medications. Review of the skilled nursing visit note dated 9/30/20, indicated the patient did not have anxiety that significantly affected him/ her, the pain assessment continued to indicate the patient has no pain or pain does not interfere with activity or movement and the repeat pain assessment indicated "N/A - Patient was at or below their acceptable level for pain during the initial pain assessment." The left trochanter wound assessment indicated a measurement of 4.6 x 4.5 x 1 cm the depth description was extensive and the patient had a large amount of purulent drainage with strong odor, <25 % epithelialization, 75<100% necrotic tissue amount and 0-25% necrotic tissue slough and eschar, with <2 cm undermining (1.5 cm at 12 - 3 o'clock, 3 - 6 at o'clock, 6-9 at o'clock, and 9-12 at o'clock) and no tunneling. The sacral wound assessment indicated a measurement of 10 x 10 x 3 cm, the depth description was extensive and with small purulent drainage and strong odor, <25% epithelialization 0-25% of necrotic tissue with slough and eschar, with < 2 cm, no undermining identified and 5 cm of tunneling at 12			

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	- 3 o'clock. The left heel wound assessment indicated a measurement of 5.5 x 6.5 x 0.1 cm, continued to be a stage 2 but the depth description was described as necrotic. The wound identification and assessments failed to be consistent and accurate according to the wound assessment websites and the sacral wound measurements of tunneling and undermining failed to be consistent with the 9/28/20 assessment. The narrative note indicated the patient's muscle spasms were worsening and orders were received to increase Baclofen to four times a day. The narcotic count within the narrative note indicated Lorazepam 18 tabs, Xanax 41 tabs 8 tabs taken in 48 hours in conjunction with Lorazepam), Roxanol 30 ml, and Norco 61 tabs. The narrative note indicated education provided was safety. The interventions indicated there was instruction regarding the use of the comfort kit, instruction regarding routine inspection of the skin, instruction regarding proper positioning, regarding appropriate hydration and nutrition, and use of support surfaces. These interventions failed to be consistent with the narrative note. The visit note failed to evidence a comprehensive assessment of the patient's use of pain and anti-anxiety medications. Review of the 9/30/20 IDG note revealed that the Medical Director's failed to include any feedback pertaining to the patient's lack of progress toward wound healing, increase use of anti-anxiety medications and pain medications and their lack of assessments and acceptable pain goal. The IDG failed to include information in regards to the patient's "stare" and failed to mention when the patient appeared to be actively dying. During an interview on 10/1/20 at 9:14 a.m., the			

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	patient's caregiver stated the patient had been on Xanax for years for anxiety and the patient had horrible dysreflexia, which caused his legs to spasm, and does have pain and discomfort, and utilizes the Baclofen routinely and Norco as needed. The caregiver also stated that they were never taught on how to provide wound care. The caregiver stated they felt the wounds were getting worse. 4. The above findings were reviewed with the Regional Director of Compliance, Director of Nursing, Patient Care Manager of the Bloomington Branch, and Administrator on 10/01/2020 at 1:20 p.m., the Director of Nursing indicated he felt the description and staging of wounds were appropriate and interventions had been approached to the patient #2, but the declined their efforts. In regards progress towards goals, the Director of Nursing and Patient Care Manager stated they felt the record met the requirement.			
L 0591 Bldg. 00	418.64(b)(1) NURSING SERVICES (1) The hospice must provide nursing care and services by or under the supervision of a registered nurse. Nursing services must ensure that the nursing needs of the patient are met as identified in the patient's initial assessment, comprehensive assessment, and updated assessments. Based on record review and interview, the nurse failed to ensure patients were accurately assessed and documentation was consistent, given the prescribed medications as received in a verbal order during the dying process, failed to indicate the time, amount, and patient response after each dose given, for 2 of 2 records reviewed of recently	L 0591	**L 591** 418.64(b)(1) NURSING SERVICES (1) The hospice must provide nursing care and services by or under the supervision of a registered nurse. Nursing services must ensure that the nursing needs of the patient are met as	10/30/2020

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	deceased patients. (Patient #1, 3) Findings include: 1. Review of an article titled Preventing Delirium at the End of Lie: Lessons From Recent Research at ncbi.nim.nih.gov indicated " ... The medications that most frequently contribute to delirium are benzodiazepines [Lorazepam], opioids [Morphine/Roxanol], and steroids ... Pain and Delirium ... For the patient with pain who is treated at the end of life, pain relief often requires opiates, and pain is difficult to assess when the patient is already confused. Moaning, grimacing, and agitation that may occur in the nightmare of agitated delirium can be misunderstood as a physically painful state. Patients who are in pain but frequently disoriented, with problems in memory and attention, cannot report accurately whether a remedy worked. ... The benzodiazepines and opioids administered in the hope of treating distress can worsen confusion ... The older patient is at greater risk of opiate-induced delirium; the risk of delirium from any cause is also greater if the patient is older. Delirium is more likely to be missed if the patient is lethargic and presents no management problem .... " 2. Review of an agency policy titled "Comfort Kits Policy No. 2-0005.A.1" dated 5/11/20, indicated " ... Education and use of Comfort Kits 1. After delivery, the visiting hospice nurse will educate the patient and family on the use and storage of the comfort kit .... " 3. The clinical record of patient #1 was reviewed on 09/30/20, and contained a plan of care for the benefit period of 08/06/20 to 10/04/20, with medication orders, included but not limited to,		identified in the patient's initial assessment, comprehensive assessment, and updated assessments. **How are you going to correct the deficiency? If already corrected, include the following steps and state date of correction.** From 10/14/20-10/30/20, all Nurses were In-serviced on the following *Premier Hospice & Palliative Care CHAP Hospice Policy and Procedure Manual*, 2020 policies: 1.NURSING CARE, Policy No. 9-019; 2.IDENTIFICATION OF MEDICATION FOR ADMINISTRATION, Policy No. 2-005; 3.POSSESSION OF CERTAIN DRUGS AND OTHER HEALTHCARE ITEMS- INDIANA, Policy No 2-005.B; 4.ADMINISTRATION AND DOCUMENTATION OF MEDICATIONS, Policy No. 2-006; 5.COMFORT KITS, Policy No. 2-005.A. Involved staff acknowledged this in-service re-training in writing: Organization policies set forth that the hospice nurse will ensure patients are accurately assessed and charted assessments, narrative, and intervention documentation is consistent. Nurses may administer prescribed medications as received in a	

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	151599	A. BUILDING 00 B. WING	10/01/2020

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	Lorazepam 1 mg tablet every 4 hours as needed for anxiety/ restlessness/ agitation and Morphine Concentrate 20 mg/ ml, give 0.25 ml every 4 hours as needed for severe pain/ air hunger. Review of a death visit note dated 8/21/20, the narrative note stated "Patient found to be extremely restless. Order received to increase dose and frequency of morphine and lorazepam, required multiple doses of of [sic] Lorazepam and morphine with minimal effect. Call to [name of Medical Director] again and order given for haldol 1mg/hr .... " Review of the clinical record failed to evidence verbal orders that the nurse received from the Medical Director. The note failed to evidence the specific order received as well the amount and time given during each episode. During an interview on 09/30/20 at 9:20 a.m., the spouse indicated they observed between the hour of Employee A's arrival and the patient's death, 0.5 ml of Roxanol (no comfort to the patient), then a whole syringe of Roxanol (no comfort to the patient), another whole syringe of Roxanol then Lorazepam, (no comfort to the patient and family member sent to drug store to pick up Haldol), followed by another whole syringe of Roxanol and Lorazepam. The caregiver indicated she was not provided any education on the medication and felt that both medications given multiple times in an hour resulted in their loved ones death. Employee A was interviewed on 10/01/20 at 9:00 a.m. When queried on the medication given, Employee A stated "multiple multiple" doses of meds were given, had many calls to the doctor and called the Patient Care Manager. 4. The clinical record of patient #3, Election date of 9/9/20, was reviewed and included a plan of		verbal order during the dying process and shall document the time, drug, amount, and patient response after each dose given. The Hospice Nurse shall: A. Manage discomfort and provide symptom relief. 1.B. Incorporate specialized nursing skills related to palliative end-of-life care into all clinical care. 1.C. Provide education on disease process, self-care, end-of-life care. 2.D. Provide emotional support to the patient and family. 3.E. Assess for risks of grief, cultural, spiritual implications exacerbated by the terminal diagnosis. 4.F. Initiate appropriate preventive and rehabilitative nursing procedures. 5.G. Prepare clinical and progress notes that demonstrate progress toward established goals. 6.H. Coordinate all services and prioritization of needs with the interdisciplinary group. 7.I. Use a case management approach and make referrals to other services as needed. 8.J. Provide specialized hospice training to other staff, family/caregivers to ensure adequate care. 9.K. Provide an ongoing evaluation of the patient and family/caregiver response to care.	

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	care dated 9/9/20, with a medication list of, but not limited to, Risperdal 0.25 mg at bedtime, Lorazepam 1 mg tablet every 4 hours as needed for anxiety and restlessness and Morphine (Roxanol) concentrate 100 mg/5 ml (20 mg/ml) oral solution 0.25 ml every 4 hours as needed for pain and shortness of breath. Review of a hospital paperwork dated 7/28/20 revealed the patient had a diagnosis of Dementia with behavioral disturbances and had been taking Dispersedly 0.25 mg daily then on 9/4/20, revealed the patient was in the hospital for a fractured hip which was surgically repaired and was discharged home with hydrocodone 5 mg - 325 mg. Review of a skilled nursing visit note dated 9/10/20, the pain assessment indicated the patient was not in pain and the narrative note indicated the patient stated his/her hip was a little sore., which was inconsistent with the assessment. Interventions provided section indicated the hospice comfort kit was reviewed and was intact with current expiration dates and was instructed on the use of the comfort kit. The narrative section indicated there was no narcotic count because the medications had not been picked up by the pharmacy. The interventions provided was inconsistent with the narrative section. Review of a skilled nursing visit note dated 9/11/20, the interventions provided section indicated the hospice comfort kit was reviewed and was intact with current expiration dates and was instructed on the use of the comfort kit. The narrative section indicated there was no narcotic count because the medications were not at the home and at the pharmacy. The interventions provided was inconsistent with the narrative section.		10.L. Assess the ability of the caregiver to meet the patient's immediate needs. O. Assure communication between the hospice and other health care providers involved in care. Patient and family/caregiver education and training activities will be initiated and continued throughout the course of care. Nursing services must ensure that the nursing needs of the patient are met as identified in the patient's initial assessment, comprehensive assessment, and updated assessments. Orders will be present for nurse medication administration. Orders for the administration of medications must be given by a physician (or other authorized independent practitioner) and include patient name, patient identifier, the name of the medication, dosage, dilution, route, frequency of administration, and rate of infusion. The individual receiving the order must record it, sign it immediately and have the prescribing person sign it in accordance with state and federal regulations. Licensed nursing personnel will administer and document only those medications which have been ordered by the physician, as a part of the plan of care and have been approved for safe administration and monitoring during a hospice visit. Hospice patients not residing in a nursing	

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	Review of a skilled nursing visit note dated 9/14/20 from 10:02 p.m. to 10:34 p.m., the pain assessment indicated the patient was not in pain. The narrative note indicated a phone call was received from the caregiver reporting the patient was restless and had bedsores. A prn (as needed) visit was made and upon arrival, the patient was alert, hallucinating, and reported he/ she was having pain, which was inconsistent with the assessment. Lorazepam and Roxanol was given. The surgical incision was slightly red and warm. The patient's buttocks had reddened areas. No measurements/ assessments were documented. New antibiotic order was received. The note indicated the patient continued to be restless and pace. Physician was contacted and orders were received to increase morphine to 0.5 ml every 4 hours and Lorazepam 2 mg every 4 hours. The patient received the 2 mg of Lorazepam and 1 ml of Morphine. The nurse also documented "prn dose repeared [sic] 2 more times." According to this note, the nurse failed to follow the new verbal orders provided by the physician and administered more Morphine and Lorazepam than what was prescribed. Review of a skilled nursing visit note dated 9/15/20, the mental assessment indicated the patient was "comatose", answered of "no" to a question asking if anxiety significantly affect the patient, and answered the patient's facial cues were "relaxed and calm expression and the "patient was at or below their acceptable level for pain during the initial pain assessment. The narrative note indicated the patient was sleeping in bed but the patient was grimacing upon arrival, which was inconsistent with the assessments. The narrative note indicated that 2 mg of Lorazepam and 0.5 ml of morphine was given. The		home will receive a comfort kit as needed, based on their comprehensive assessment. The comfort kit will contain emergency medication(s) as ordered by the patient's physician or the Hospice Medical Director and will be maintained in the patient's home until orders are received for its use. After delivery: 1. The visiting hospice nurse will re-educate the patient and family on the use and storage of the comfort kit. The hospice nurse will notify the patient's physician or Medical Director when there is a change in the patient's condition that may warrant use of one or more medications in the comfort kit and will obtain specific orders for their use. **How are you going to prevent the deficiency from recurring in the future, even if already corrected?** 1.100% Focused chart audit for 90 days on Admissions, then ongoing, 10% review each quarter to ensure charting consistency between assessment, narrative, and intervention documentation, verbal medication orders are included in the written plan of care, and charting of hospice nurse medication administration includes time, drug, amount, and patient response after each dose given; 2.100% Focused audit prior to	

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	patient became unresponsive to touch and calling. Orders were received to discontinue home medications and to schedule 2 mg of Lorazepam every 4 hours and Roxanol 0.5 ml every 4 hours. The assessment in the visit note was inconsistent with the narrative and the skilled nurse failed to follow physician orders and administered the Lorazepam and Morphine when the patient was not displaying any signs of anxiety, restlessness, nor pain. Review of a skilled nursing visit note dated 9/16/20 at 10:29 a.m., the mental assessment indicated the patient was "comatose", answered of "no" to a question asking if anxiety significantly affect the patient, indicated the patient was restless, answered "no" when asked if patient response "are you uncomfortable because of pain" and patient had no pain or pain does not interfere with activity or movement but did indicate current severity of verbal cues of whining,whimpering, or moaning and the question of severity of facial cues indicate "drawn around mouth and eyes." The narrative note indicated the patient was trying to get up from the bed upon her arrival. The patient was moaning and crying in pain. The note indicated that orders were received to give Lorazepam and Morphine every 15 minutes until the patient was comfortable. The skilled nurse failed to document a consistent assessment and failed to evidence a time, amount of medication administered, and patient response after each dose of Morphine and Lorazepam given. Review of a skilled nursing visit note dated 9/16/20 at 8:49 p.m., the pain assessment indicated the patient facial cues were "relaxed and calm." The narrative note indicated the patient was in bed upon arrival, the patient had a calm facial		each Interdisciplinary Group Meeting/IDG, then ongoing, 10% each quarter to ensure charting consistency between assessment, narrative, and intervention documentation, verbal medication orders are included in the written plan of care update; and to ensure charting of hospice nurse medication administration includes time, drug, amount, and patient response after each dose given; 3. Threshold for focused audits is 100% compliance with documentation of verbal order and medication administration. If threshold not met, Patient Care Managers will re-educate involved staff, progressively, involving human resources for work plans, if needed. **Who is going to be responsible for prevention above: i.e., director, supervisor, etc.?** Patient Care Managers (PCMs) are responsible for audits and staff correction. PCMs will be overseen by Director(s) of Clinical Services (DCS) who report to the Administrator. The Administrator shall report Focus audit results to the QAPI Committee and then the Governing Body for three consecutive quarters. **By what date are you going to have the deficiency corrected?** 10/30/20.	

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	expression, respirations were labored with accessory muscle use noted. The hospice nurse received an order to give "morphine and Lorazepam until every 15 minutes until comfortable. Lorazepam 2 mg and Morphine 1 ml given x2. No edema or mottling noted. Respirations slowed to 8. The narrative note indicated "Action taken or orders obtained [verbal orders must be written]: Morphine 1 ml every 4 hours. A physician order written on 9/16/20 at 8:49 p.m. indicated "Morphine 1 ml q [every] 4 hrs [hours], discontinued Lorazepam Intensol 2 mg/ ml. The narrative note failed to be consistent on what orders were received and written, failed to evidence any documentation of terminal restlessness, failed to evidence the time, amount, and patient response after each dose of Morphine and Lorazepam given, and failed to indicate the number of respirations per minute prior to the administration of Lorazepam and Morphine every 15 minutes. During an interview on 10/01/20 at 9:40 a.m., the spouse stated they felt that the morphine and ativan killed the patient and how guilty they felt. The spouse stated they didn't receive any education on the use or side effects. The spouse stated in the past, when the patient would have anxiety, they always gave extra risperdal which always helped. The spouse indicated the nurse came in one day when the patient was restless, asked the patient if they wanted to be comfortable, and the nurse instructed them to give the Lorazepam and Roxanol to be given routinely. The spouse stated if he/ she and the patient's adult child had known that Roxanol was morphine, they wouldn't have given the patient the medication. 5. During an interview on 9/30/20 at 4:55 p.m.,		Nurses completed re-education by 10/30/20. By no later than 10/30/20, the organization will have implemented 100% Focus audits on documentation of verbal orders and medication administration at Admission and Prior to each IDG.	

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	when asked if nurses have the ability to administer more medications when the patient is restless/ actively dying than what is ordered, the Administrator stated "No, we do not do standing orders" and the agency did not provide or order "comfort kits." 6. The above findings were reviewed with the Regional Director of Compliance, Director of Nursing, Patient Care Manager of the Bloomington Branch, and Administrator on 10/01/2020 at 1:20 p.m., the Director of Nursing stated when patients were pretty restless, morphine and ativan was the standard medications to use.			
L 0690 Bldg. 00	418.106(b) ORDERING OF DRUGS (1) Only a physician as defined by section 1861(r)(1) of the Act, or a nurse practitioner in accordance with the plan of care and State law, may order drugs for the patient. (2) If the drug order is verbal or given by or through electronic transmission- (i) It must be given only to a licensed nurse, nurse practitioner (where appropriate), pharmacist, or physician; and (ii) The individual receiving the order must record and sign it immediately and have the prescribing person sign it in accordance with State and Federal regulations. Based on record review and interview, the agency failed to ensure nursing put verbal orders into writing, signature with date, and sent to the ordering physician for signature for 2 out of 2 closed records reviewed of patients who recently passed. (Patients #1, 3) Findings include:	L 0690	**L 690** 18.106(b) ORDERING OF DRUGS (1) Only a physician as defined by section 1861(r) (1) of the Act, or a nurse practitioner in accordance with the plan of care and State law, may order drugs for the patient. (2) If the drug order is verbal	10/30/2020

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	1. The clinical record of patient #1 was reviewed on 09/30/20, and contained a plan of care for the benefit period of 08/06/20 to 10/04/20, with medication orders, included but not limited to, Lorazepam 1 mg tablet every 4 hours as needed for anxiety/ restlessness/ agitation and Morphine Concentrate 20 mg/ ml, give 0.25 ml every 4 hours as needed for severe pain/ air hunger. Review of a death visit note dated 8/21/20, the narrative note stated "Patient found to be extremely restless. Order received to increase dose and frequency of morphine and lorazepam, required multiple doses of of [sic] Lorazepam and morphine with minimal effect. Call to [name of Medical Director] again and order given for Haldol 1 mg/hr .... " Review of the clinical record failed to evidence verbal orders that the nurse received from the Medical Director. During an interview on 09/30/20 at 9:20 a.m., the spouse indicated they observed between the hour of Employee A's arrival and the patient's death, 0.5 ml of Roxanol (no comfort to the patient), then a whole syringe of Roxanol (no comfort to the patient), another whole syringe of Roxanol then Lorazepam, (no comfort to the patient and family member sent to drug store to pick up Haldol), followed by another whole syringe of Roxanol and Lorazepam. Employee A was interviewed on 10/01/20 at 9:00 a.m. When queried on the medication given and if the verbal order was written, Employee A stated "multiple multiple" doses of meds were given, had many calls to the doctor and called the Patient Care Manager and she didn't write the order since the patient was no longer "in the house."		or given by or through electronic transmission- (i) It must be given only to a licensed nurse, nurse practitioner (where appropriate), pharmacist, or physician; and (ii) The individual receiving the order must record and sign it immediately and have the prescribing person sign it in accordance with State and Federal regulations. **How are you going to correct the deficiency? If already corrected, include the following steps and state date of correction.** From 10/14/20-10/30/20, all Nurses were In-serviced on the following *Premier Hospice & Palliative Care CHAP Hospice Policy and Procedure Manual*, 2020 policies: 1.IDENTIFICATION OF MEDICATION FOR ADMINISTRATION, Policy No. 2-005; 2.POSSESSION OF CERTAIN DRUGS AND OTHER HEALTHCARE ITEMS- INDIANA, Policy No 2-005.B; Involved staff acknowledged this in-service re-training in writing: Organization policies set forth that the Hospice Nurse shall ensure orders will be present for nurse medication administration. Orders for the administration of medications must be given by a	

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	2. The clinical record of patient #3, Election date of 9/9/20, was reviewed and included a plan of care dated 9/9/20, with a medication list of, but not limited to, Lorazepam 1 mg tablet every 4 hours as needed for anxiety and restlessness and Morphine (Roxanol) concentrate 100 mg/5 ml (20 mg/ml) oral solution 0.25 ml every 4 hours as needed for pain and shortness of breath. Review of a skilled nursing visit note dated 9/14/20 indicated Lorazepam and Roxanol was given after arrival for restlessness. The note indicated the patient continued to be restless and pace. Physician was contacted and orders were received to increase morphine to 0.5 ml every 4 hours and Lorazepam 2 mg every 4 hours. The patient received the 2 mg of Lorazepam and 1 ml of Morphine. The nurse also documented "prn dose repeared [sic] 2 more times." Review of the clinical record failed to evidence the written orders to repeat the dosages given x 2. Review of a skilled nursing visit note dated 9/16/20 at 10:29 a.m., indicated that orders were received to give Lorazepam and Morphine every 15 minutes until the patient was comfortable. Review of the clinical record failed to evidence the written orders to give Lorazepam and Morphine every 15 minutes. Review of a skilled nursing visit note dated 9/16/20 at 8:49 p.m., indicated the hospice nurse received an order to give "Morphine and Lorazepam every 15 minutes until comfortable. Lorazepam 2 mg and Morphine 1 ml given x2. The narrative note indicated "Action taken or orders obtained [verbal orders must be written]: Morphine 1 ml every 4 hours. A physician order written on 9/16/20 at 8:49 p.m. indicated "Morphine 1 ml q [every] 4 hrs [hours],		physician (or other authorized independent practitioner) and include patient name, patient identifier, the name of the medication, dosage, dilution, route, frequency of administration, and rate of infusion. The individual receiving the order must record it, sign it immediately and have the prescribing person sign it in accordance with state and federal regulations. **How are you going to prevent the deficiency from recurring in the future, even if already corrected?** 1.100% Focused chart audit for 90 days on Admissions, then ongoing, 10% review each quarter to ensure verbal medication orders are included in the written plan of care; 2.100% Focused audit prior to each Interdisciplinary Group Meeting/IDG, then ongoing, 10% each quarter to ensure verbal medication orders are included in the written plan of care update; 3.Threshold for focused audits is 100% compliance with documentation of verbal order compliance. If threshold not met, Patient Care Managers will re-educate involved staff, progressively, involving human resources for work plans, if needed. **Who is going to be responsible**	

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	discontinued Lorazepam Intensol 2 mg/ ml. The order written failed to be consistent with what was documented within the visit note. (to give Morphine and Lorazepam every 15 minutes until comfortable). 3. During an interview on 9/30/20 at 4:55 p.m., when asked if nurses have the ability to administer more medications when the patient is restless/ actively dying than what is ordered, the Administrator stated "No, we do not do standing orders." 4. The above findings were reviewed with the Regional Director of Compliance, Director of Nursing, Patient Care Manager of the Bloomington Branch, and Administrator on 10/01/2020 at 1:20 p.m., in which no further information or documentation was provided.		**for prevention above: i.e., director, supervisor, etc.?** Patient Care Managers (PCMs) are responsible for audits and staff correction. PCMs will be overseen by Director(s) of Clinical Services (DCS) who report to the Administrator. The Administrator shall report Focus audit results to the QAPI Committee and then the Governing Body for three consecutive quarters. **By what date are you going to have the deficiency corrected?** 10/30/20. Nurses completed re-education by 10/30/20. By no later than 10/30/20, the organization will have implemented 100% Focus audits on documentation of verbal orders at Admission and Prior to each IDG.	
L 0696 Bldg. 00	418.106(e)(2)(i)(B) LABEL DISPOSE STORAGE DRUGS [At the time when controlled drugs are first ordered the hospice must:] (B) Discuss the hospice policies and procedures for managing the safe use and disposal of controlled drugs with the patient or representative and the family in a language and manner that they understand to ensure that these parties are educated regarding the safe use and disposal of controlled drugs; Based on record review and interview, the agency	L 0696	**L 696** 418.106(e)(2)(i)(B) LABEL DISPOSE STORAGE DRUGS	11/12/2020

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	151599	A. BUILDING 00 B. WING	10/01/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
PREMIER HOSPICE & PALLIATIVE CARE - INDIANA LLC	11550 N MERIDIAN STREET, SUITE 375 CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	failed to ensure the Interdisciplinary Group discussed the written policies and procedures for the safe use and disposal of controlled drugs with the patient/ caregiver in a language and manner that they understand to ensure that the parties were educated for 1 of 3 patient records reviewed. (Patient #1) Findings include: Review of an agency's document found within the admission folder titled "Drug Disposal Guidelines" revised 11/17, stated " ... 1. ... The case manager will verbally discuss the policy in a language and manner that they understand to ensure the safe disposal medications ... Patient/ family education will be documented in the clinical record. ... 2. Upon patient death or when a hospice patient otherwise no longer has a need for one or more medications, the hospice nurse or other appropriate hospice staff will assist the patient/ family to dispose of them or will instruct the patient/ family to dispose of them according to policy. The hospice will also provide information on take-back and mail-back programs. 3. Drugs will disposed of on site .... " Review of a revised policy titled "Home Use of Controlled Substances Policy No. 2008.1" dated 5/11/20, stated " ... 2. The Admitting Nurse/ Case Manager will provide a copy of the written policies and procedures on the management of controlled drugs to the patient/ representative and family ... 6. When a hospice patient no longer has a need for a controlled substance, the Case Manager will instruct the patient and family/ caregiver regarding proper disposal." Review of a revised policy titled "Drug Disposal Policy No. 2-008.A.1" dated 5/11/20, stated " ... 1.		[At the time when controlled drugs are first ordered the hospice must:] (B) Discuss the hospice policies and procedures for managing the safe use and disposal of controlled drugs with the patient or representative and the family in a language and manner that they understand to ensure that these parties are educated regarding the safe use and disposal of controlled drugs; **How are you going to correct the deficiency? If already corrected, include the following steps and state date of correction.** This area was not identified as a concern at the survey Exit Conference with the Organization. From 10/10-10/12/20, all nurses were In-serviced on the following *Premier Hospice & Palliative Care CHAP Hospice Policy and Procedure Manual*, 2020 policies: **1.Home Use of Controlled Substances; Policy No. 2-008;** **2.Drug Disposal, Policy No. 2-008.A.** Organization policies set forth that the Interdisciplinary Group shall discuss written policies and procedures for the safe use and disposal of controlled drugs with the patient/caregiver in a language and manner that they understand. The Admitting Nurse will provide a copy of the written policy and	

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	The Admitting Nurse/ Case Manager will provide a copy of the written policies and procedures on the management and disposal of drugs, including controlled drugs to the patient/ representative and family. The Admitting Nurse/ Case Manager will verbally discuss the policy in a language and manner that they understand to ensure the safe use and disposal of medication, including controlled drugs. The Admitting Nurse/ Case manager will document in the clinical record that the patient/ Representative and family have received a copy of the policies and procedures. 2. The Admitting Nurse/ Case Manager will document in a clinical note who is responsible for the disposal of the patient's drugs ... 5. The nurse will document in the medical record: disposal instructions given, the patient/ family's verbal response as to their understanding of the disposal/ process and their responsibility to properly dispose of the unneeded medication(s) ... Disposal of Controlled Substances - Family 1. When a hospice patient no longer has a need for a controlled substance, the Case Manager will instruct the patient and family/ caregiver regarding proper disposal of the drugs ... 2. The Admitting Nurse/ Case Manger will document in the clinical record that the patient and family/ caregiver were given the written policies and procedures for managing controlled drugs and discussed the disposal of medication and took responsibility to do so .... " Review of patient #1's clinical record, revealed a start of care date of 08/06/2020, and a plan of care for the benefit period of 08/06/2020 to 10/04/20, with orders for skilled nursing 3 times a week for 2 weeks then 2 times a week for 7 weeks. Review of admission note dated 8/6/20 and the following skilled nursing visit notes dated 8/7, 8/8,		procedure on the management of controlled drugs to the patient/representative and family. The person responsible for drug disposal will be identified. Per policy, the Admitting Nurse will verbally discuss the policy in a language and manner that they understand to ensure the safe use/disposal of controlled drugs. The responsible individual will acknowledge this education by signing the policy that is provided as part of the Hospice Patient Admission Booklet. A copy of the signed policy will be uploaded to the chart. In clinical notes, Nurses shall document the patient or caregivers understanding of this policy at admission and any time the patient or caregiver needs re-education. When a hospice patient no longer has a need for a controlled substance, the nurse will re-instruct the patient and family/caregiver regarding proper disposal. The nurse will document in the medical record: disposal instructions given, the patient/family's verbal response as to their understanding of the disposal process and their responsibility to properly dispose of the unneeded medication(s). If the patient/family refuses the disposal/destruction of medications, this will be reported to the patient's physician and clinical supervisor and documented in the patient record.	

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	8/9, 8/10, 8/13, 8/17, 8/21/2020, failed to evidence that the safe use and management of controlled substances was discussed and the patient/ family verbal response as to their understanding. During an interview on 09/30/20 at 9:20 a.m., the spouse indicated she thought the hospice was going to take the medications or destroy after the patient died. The spouse indicated a family member, who was a sheriff, took the medications and had them destroyed. The death visit note dated 8/21/2020 failed to evidence this information. Employee A was interviewed on 10/01/20 at 9:00 a.m., and indicated that the patient's medications were not destroyed during the death visit for she was not allowed to go back in and that the DON was made aware. The death visit note dated 8/21/2020 failed to evidence this information. The above findings were reviewed with the Regional Director of Compliance, Director of Nursing, Patient Care Manager of the Bloomington Branch, and Administrator on 10/01/2020 at 1:20 p.m., the Director of Nursing indicated he was aware of the employee not destroying patient #1's medications.		**How are you going to prevent the deficiency from recurring in the future, even if already corrected?** 1.100% focused chart audit for 90 days on home patient Admissions, then ongoing, 10% each quarter to ensure documentation of signed policy and that patients and caregivers understand the drug disposal policy per charted education. Nurses shall securely submit a copy of signed document to the office for chart attachments. 2.100% Focused audit prior to each home patient Interdisciplinary Group Meeting/IDG, then ongoing, 10% each quarter to ensure and that patients and caregivers understand the drug disposal policy per charted re-education and that refusals are reported to the Clinical Supervisor/Designee; 3.Threshold for focused audits is 100% with evidence patient's/representative's understanding of drug disposal. If threshold not met, Patient Care Managers will re-educate involved staff, progressively, involving human resources for work plans, if needed. **Who is going to be responsible for prevention above: i.e., director, supervisor, etc.?** Patient Care Managers (PCMs) are responsible for audits and staff	

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			correction. PCMs will be overseen by Director(s) of Clinical Services (DCS) who report to the Administrator. The Administrator shall report Focus audit results to the QAPI Committee and then the Governing Body for three consecutive quarters. **By what date are you going to have the deficiency corrected?** 11/12/20. Nurses completed re-education by 11/12/20. By no later than 11/12/20, the organization will have implemented 100% Focus audits on drug disposal policy signed and education documentation at Admission and Prior to each IDG.	
L 0697 Bldg. 00	418.106(e)(2)(i)(C) LABEL DISPOSE STORAGE DRUGS [At the time when controlled drugs are first ordered the hospice must:] (C) Document in the patient's clinical record that the written policies and procedures for managing controlled drugs was provided and discussed. Based on record review and interview, the agency failed to ensure the clinician followed agency policy and documented in the patient's clinical record the written policies and procedures for managing controlled drugs was discussed with the patient/ caregiver for 2 of 3 (Patient #1, 2) patient records reviewed, and failed to ensure to document the name of the drug, amount, and method of disposal upon death for 1 of 2 (Patient	L 0697	**L 697** 418.106(e)(2)(i)(C) LABEL DISPOSE STORAGE DRUGS [At the time when controlled drugs are first ordered the hospice must:] (B) Discuss the hospice policies and procedures for managing the safe use and disposal of controlled drugs with the patient or representative and the family in a	11/12/2020

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	#3) closed records reviewed. Findings include: 1. Review of an agency's document found within the admission folder titled "Drug Disposal Guidelines" revised 11/17, stated " ... 1. ... The case manager will verbally discuss the policy in a language and manner that they understand to ensure the safe disposal medications ... Patient/ family education will be documented in the clinical record. ... 2. Upon patient death or when a hospice patient otherwise no longer has a need for one or more medications, the hospice nurse or other appropriate hospice staff will assist the patient/ family to dispose of them or will instruct the patient/ family to dispose of them according to policy. The hospice will also provide information on take-back and mail-back programs. 3. Drugs will be disposed of on site .... " 2. Review of a revised policy titled "Home Use of Controlled Substances Policy No. 2008.1" dated 5/11/20, stated " ... 2. The Admitting Nurse/ Case Manager will provide a copy of the written policies and procedures on the management of controlled drugs to the patient/ representative and family ... 6. When a hospice patient no longer has a need for a controlled substance, the Case Manager will instruct the patient and family/ caregiver regarding proper disposal." 3. Review of a revised policy titled "Drug Disposal Policy No. 2-008.A.1" dated 5/11/20, stated " ... 1. The Admitting Nurse/ Case Manager will provide a copy of the written policies and procedures on the management and disposal of drugs, including controlled drugs to the patient/ representative and family. The Admitting Nurse/ Case Manager will verbally		language and manner that they understand to ensure that these parties are educated regarding the safe use and disposal of controlled drugs; **How are you going to correct the deficiency? If already corrected, include the following steps and state date of correction.** This area was not identified as a concern at the survey Exit Conference with the Organization. From 10/10-10/12/20, all nurses were In-serviced on the following *Premier Hospice & Palliative Care CHAP Hospice Policy and Procedure Manual*, 2020 policies: **1.Home Use of Controlled Substances; Policy No. 2-008;** **2.Drug Disposal, Policy No. 2-008.A.** Organization policies set forth that the Interdisciplinary Group shall discuss written policies and procedures for the safe use and disposal of controlled drugs with the patient/caregiver in a language and manner that they understand. The Admitting Nurse will provide a copy of the written policy and procedure on the management of controlled drugs to the patient/representative and family. The person responsible for drug disposal will be identified. Per policy, the Admitting Nurse will verbally discuss the policy in a language and manner that they	

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	discuss the policy in a language and manner that they understand to ensure the safe use and disposal of medication, including controlled drugs. The Admitting Nurse/ Case manager will document in the clinical record that the patient/ Representative and family have received a copy of the policies and procedures. 2. The Admitting Nurse/ Case Manager will document in a clinical note who is responsible for the disposal of the patient's drugs ... 5. The nurse will document in the medical record: disposal instructions given, the patient/ family's verbal response as to their understanding of the disposal/ process and their responsibility to properly dispose of the unneeded medication(s) ... Disposal of Controlled Substances - Family 1. When a hospice patient no longer has a need for a controlled substance, the Case Manager will instruct the patient and family/ caregiver regarding proper disposal of the drugs ... 2. The Admitting Nurse/ Case Manger will document in the clinical record that the patient and family/ caregiver were given the written policies and procedures for managing controlled drugs and discussed the disposal of medication and took responsibility to do so. 3. The hospice nurse, social worker, or chaplain attending the death of a hospice patient will inform the family/ caregiver of their responsibility to dispose of all the patient's prescribed medications and will document this instruction in a clinical note and include the name of the drug, amount, method of disposal, and who witnessed the disposal .... " 4. Review of patient #1's clinical record revealed a start of care date of 08/06/2020, and a plan of care for the benefit period of 08/06/20 to 10/04/20, with orders for skilled nursing 3 times a week for 2 weeks then 2 times a week for 7 weeks. Review of admission note dated 8/6/20 and the		understand to ensure the safe use/disposal of controlled drugs. The responsible individual will acknowledge this education by signing the policy that is provided as part of the Hospice Patient Admission Booklet. A copy of the signed policy will be uploaded to the chart. In clinical notes, Nurses shall document the patient or caregivers understanding of this policy at admission and any time the patient or caregiver needs re-education. When a hospice patient no longer has a need for a controlled substance, the nurse will re-instruct the patient and family/caregiver as needed regarding proper drug disposal. The nurse will document in the medical record: disposal instructions given, the patient/family's verbal response as to their understanding of the disposal process and their responsibility to properly dispose of the unneeded medication(s). If the family/caregiver requests assistance with the disposal, the hospice nurse will observe and provide verbal assistance as the family/caregiver properly disposes of the prescribed medication(s). The disposal will be documented in a clinical note. Documentation will include the name of the drug, amount, method of disposal, the person disposing of the drug, and the role of the hospice employee in assisting with the disposal. If	

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	following skilled nursing visit notes dated 8/7, 8/8, 8/9, 8/10, 8/13, 8/17, 8/21/2020, failed to evidence that the agency's policy was adhered to by failing to document the responsible person for the disposal, the disposal instructions given, patient/ family verbal response as to their understanding, as well as observing the medications being destroyed upon death on 8/21/2020. During an interview on 09/30/20 at 9:20 a.m., the spouse stated she thought the hospice was going to take the medications or destroy after the patient died. The spouse indicated a family member, who was a sheriff, took the medications and had them destroyed. The death visit note dated 8/21/2020 failed to evidence this information. Employee A was interviewed on 10/01/20 at 9:00 a.m., and stated that the patient's medications were not destroyed during the death visit for she was not allowed to go back in and that the DON was made aware. The death visit note dated 8/21/2020 failed to evidence this information. 5. Review of patient #2's clinical record revealed a start of care date of 09/10/2020, and a plan of care for the benefit period of 9/10/2020 to 12/08/2020, with orders for skilled nursing 3 times a week for 1 week, 4 times a week for 1 week, 3 times a week for 11 weeks, then 1 time a week for 1 week. Review of the start of care visit note dated 9/10/20 and the following skilled nursing visit notes dated 9/11, 9/12, 9/13, 9/14, 9/16, 9/18, 9/19, 9/20, 9/21, 9/23, 9/25, 9/28, and 9/30/20, failed to evidence the agency's policy was adhered to by failing to document the responsible person for the disposal, the disposal instructions given, patient/ family verbal response as to their understanding.		the patient/family refuses the disposal/destruction of medications, this will be reported to the patient's physician and clinical supervisor and documented in the patient record. **How are you going to prevent the deficiency from recurring in the future, even if already corrected?** 1.100% focused chart audit for 90 days on home patient Admissions, then ongoing, 10% each quarter to ensure documentation of signed policy, that patients and caregivers understand the drug disposal policy per charted education, and that disposal charting includes the name of the drug(s), amount(s), method of disposal, the person disposing of the drug, and the role of the hospice employee. Nurses shall securely submit a copy of signed disposal policy document to the office to be viewed in chart attachments. 2.100% Focused audit prior to each home patient Interdisciplinary Group Meeting/IDG, then ongoing, 10% each quarter to ensure and that patients and caregivers understand the drug disposal policy per charted re-education, drug disposal charting includes the name of the drug(s), amount(s), method of disposal, the person disposing of the drug, and the role of the hospice	

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	6. The clinical record of patient #3, Election date of 9/9/2020, included a death visit note on 9/17/20, which indicated "This writer witnessed [name of family member] destroy medications." The clinician failed to document the name of the drug, amount, and method of disposal. 7. During an interview on 9/30/20 at 4:55 p.m., when queried on who was responsible for the destruction of medications after death, especially narcotics, the Administrator stated that it was their policy that the clinician was not allowed to destroy the narcotics but they can witness the destruction by the family, but the family has a right to refuse. If they do refuse, the clinician on site would need to document the refusal and notify the physician. 8. The above findings were reviewed with the Regional Director of Compliance, Director of Nursing, Patient Care Manager of the Bloomington Branch, and Administrator on 10/01/2020 at 1:20 p.m., in which no further information or documentation was provided.		employee, and that refusals to dispose of unneeded narcotics are reported to the Clinical Supervisor/Designee; 3.Threshold for focused audits is 100% with charted drug disposal. If threshold not met, Patient Care Managers will re-educate involved staff, progressively, involving human resources for work plans, if needed. **Who is going to be responsible for prevention above: i.e., director, supervisor, etc.?** Patient Care Managers (PCMs) are responsible for audits and staff correction. PCMs will be overseen by Director(s) of Clinical Services (DCS) who report to the Administrator. The Administrator shall report Focus audit results to the QAPI Committee and then the Governing Body for three consecutive quarters. **By what date are you going to have the deficiency corrected?** 11/12/20. Nurses completed re-education by 11/12/20. By no later than 11/12/20, the organization will have implemented 100% Focus audits on drug disposal at Admission and Prior to each IDG.	
S 0000 Bldg. 00				

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	The visit was for a State Complaint survey of a Deemed Hospice provider. Survey Dates: 09/30 to 10/01/2020 Complaint #: IN00337284: Substantiated. Deficiencies related and unrelated to the complaint were cited. Records Reviewed: 3	S 0000	**S 000** This Plan of Correction constitutes **PREMIER HOSPICE & PALLIATIVE CARE - INDIANA LLC's** written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and/or federal law.	
S 0515 Bldg. 00	418.52(c)(4) RIGHTS OF THE PATIENT [The patient has a right to the following:] (4) Choose his or her attending physician; Based on record review and interview, the agency failed to ensure patients were informed of their right to choose his or her attending physician in 3 of 4 interviews conducted. (Patients #1, 3, 9) Findings include: 1. Review of the agency's document titled "Hospice Election of Benefit Statement" revealed a section titled "Right to choose an attending physician" which indicated "I understand that I have a right to choose my attending physician to oversee my care .... " 2. Review of the admission packet which contained the patient rights, a section on page 14 titled "Decision Making - You have the right to", indicated the patient has the right to choose their attending physician and other health care providers and communicate with these providers.	S 0515	**S 515** 418.52(c)(4) RIGHTS OF THE PATIENT [The patient has a right to the following:] (4) Choose his or her attending physician. **How are you going to correct the deficiency? If already corrected, include the following steps and state date of correction.** From 10/8/20-10/9/20, all Community Liaison staff were In-serviced on the following *Premier Hospice & Palliative Care CHAP Hospice Policy and Procedure Manual*, 2020 policies, and rules: 1.ADMISSION CRITERIA AND PROCESS- INDIANA, Policy No. 1-009; 2.HOSPICE ELECTION	10/30/2020

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	3. Review of the agency's active client roster and discharge report that was provided on 09/30/2020, revealed 25 out of 30 active client roster and 20 out of 27 discharged patients had the hospice medical director as their primary physician. 4. The family member for patient #1 was interviewed on 09/30/20 at 9:20 a.m., and indicated while the patient was at the hospital, a hospice liaison visited and was told that they could not use their own MD and had to use the hospice Medical Director, as well as what they could and could not do, would "get rid" of the patient's medications and provide only comfort medications, no emergency room visits, no reaching to their primary care physician, and they could only reach out to the hospice physician. 5. The family member for patient #3 was interviewed on 10/01/20 at 9:40 a.m., and indicated during their admission, they were not provided with an option to keep their primary care physician but was instructed that the Medical Director would be their primary physician while on service. 6. The family member for patient #9 was interviewed on 09/30/2020 at 4:43 p.m., and indicated during their admission, they were not provided with an option to keep their primary care physician. When asked about the consents that were signed indicating their understanding of patient rights and if these rights were explained in full detail, the family member indicated the person who had them sign the admission documents reviewed "main topics", told them where to sign, gave them "stuff to read" and was told they couldn't see their primary care physician.		STATEMENT, Policy No. 1-031; 3.§418.52 Condition of Participation: Patient's Rights. Involved staff acknowledged this in-service re-training in writing. Organization policies set forth that the patient has the right to be informed of his or her rights, and the hospice shall protect and promote the exercise of these rights. The patient has the right to choose his or her attending physician and to have this person involved in their medical care in all hospice settings as long as the attending physician, in turn, undertakes to provide care for the patient. **How are you going to prevent the deficiency from recurring in the future, even if already corrected?** 1.100% focused chart audit for 90 days on Admissions, then ongoing, 10% review each quarter to ensure patients were informed they have the right to choose their attending physician, as evidenced by patient or representative placing their initials next to the statement "YOU HAVE THE RIGHT TO: choose your attending physician.." education on Page 14 of the *Patient Hospice Admission Booklet*. Nurses shall securely submit a copy of the initialed page to the office for chart attachments. Nurses shall report any Complaints related to Liaison	

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	7. During an interview on 09/30/2020 at 4:55 p.m., and when queried if patients are allowed to choose their own physician for hospice services, the Administrator stated patients could "elect who-ever, 100% their choice." 8. The above findings were reviewed with the Regional Director of Compliance, Director of Nursing, Patient Care Manager of the Bloomington Branch, and Administrator on 10/01/2020 at 1:20 p.m.. in which they responded that the patients/ caregivers signed the consents upon admission, therefore, they knew they had a choice. When asked how certain they were that their clinicians and liaisons were thoroughly reviewing patient rights and consents upon admission when 3 out of 4 people indicated they were told they must use the Medical Director, they had no other response.		misinformation/misunderstanding to the agency Administrator who will interview the beneficiary and/or caregivers; 2.Patient Care Managers/Designee(s) shall phone survey all new Admissions to verify patient/representative understanding of education on Patient's Rights including patient's right to choose their attending physician; 3.Thresholds for focused audits and phone surveys are 100% with evidence patients/representatives were informed and understood their right to choose their attending physician. If threshold not met, Patient Care Managers will re-educate involved staff, progressively, involving human resources for discipline, if needed. **Who is going to be responsible for prevention above: i.e., director, supervisor, etc.?** Patient Care Managers (PCMs) are responsible for audits, surveys and staff correction. PCMs will be overseen by Director(s) of Clinical Services (DCS) who report to the Administrator. The Administrator shall report Focus audit and Patient survey results to the QAPI Committee and then the Governing Body for three consecutive quarters. **By what date are you going to have the deficiency corrected?**	

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			10/30/20. Liaisons completed re-education by 10/9/20. Nurses completed education on their role in compliance by 10/30/20. By no later than 10/30/20, the organization will have implemented 100% Focus audits and Surveys.	
S 0525 Bldg. 00	418.54(c)(1) CONTENT OF COMPREHENSIVE ASSESSMENT The comprehensive assessment must take into consideration the following factors: (1) The nature and condition causing admission (including the presence or lack of objective data and subjective complaints). Based on record review and interview, the agency failed to ensure comprehensive assessments were complete and included assessments of bruising, location of diminished breath sounds, past medical histories/ medication use of anti-seizure, anti-anxiety, muscle relaxant, and pain medications, as well as ensuring wound measurements were accurate for 2 of 3 records reviewed. (Patient #1, 2) Findings include: 1. Review of an agency's policy titled "Comprehensive Assessment Policy No. 1-014.1" dated 5/11/20, indicated " ... 1. During the comprehensive assessment, all baseline data and other relevant information will be documented in the patient's clinical record ... B. ... 2.	S 0525	**S 525** 18.54(c)(1) CONTENT OF COMPREHENSIVE ASSESSMENT The comprehensive assessment must take into consideration the following factors: (1) The nature and condition causing admission (including the presence or lack of objective data and subjective complaints). **How are you going to correct the deficiency? If already corrected, include the following steps and state date of correction.** From 10/14/20-10/30/20, all Registered Nurses were In-serviced on the following	10/30/2020

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	Restlessness, anxiety ... 4. Skin Integrity ... E. Alleviating and exacerbating factors for physical symptoms. F. Current treatment and patient response to that treatment. I. A physical assessment, including ... skin ... N. Patients past and present medical and psychiatric history including any pertinent diagnosis and any co-morbid conditions .... " 2. According to an article titled "Table 2, [National Pressure Ulcer Staging System] at https://www.ncbi.nlm.nik.gov, described a deep tissue injury as a "pressure-related injury to subcutaneous tissues under intact skin.. Initially, these lesions have the appearance of a deep bruise ... purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/ or sheer." A Stage 2 pressure wound is described as a "partial thickness loss or dermis presenting as a shallow open ulcer with a red, pink wound bed without slough. May also present as an intact or open/ruptured serum-filled blister. Presents as a shiny or dry shallow ulcer without slough or bruising." A Stage 3 pressure wound is described as a "full thickness tissue loss. Subcutaneous fat may be visible, but bone, tendon, or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling." A Stage 4 pressure wound is described as a full thickness tissue loss; extensive destruction; with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling. An Unstageable wound is described as a "full thickness tissue loss in which actual depth of the ulcer is completely obscured by slough (yellow, tan, gray, green, or brown) and / or eschar (tan, brown or black) in the		*Premier Hospice & Palliative Care CHAP Hospice Policy and Procedure Manual*, 2020 policies, and wound assessment and care guidelines: 1.COMPREHENSIVE ASSESSMENT, Policy No. 1-014 2.PAIN ASSESSMENT, Policy No. 1-018; 3.WOUND CARE, Policy No. 2-035.A; 4.SKIN AND WOUNDCARE QUICK REFERENCE/GUIDELINE; National Pressure Ulcer Advisory Panel (NPUAP) Staging System. Involved staff acknowledged this in-service re-training in writing. Organization policies set forth that complete comprehensive assessment includes assessments of bruising, location of diminished breath sounds, acceptable pain range, past medication histories/medication use of anti-seizure, anti-anxiety, muscle relaxant, as well as ensuring wound measurements are accurate and wounds are staged according to the NPUAP Staging System. The hospice will conduct and document in writing a patient-specific comprehensive assessment that identifies the patient's need for hospice care and services, and the patient's need for physical, psychosocial, emotional, and spiritual care. This assessment will include all areas of hospice care related to the palliation and management of the	

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	wound bed. Until enough slough and/ or eschar is removed to expose the base of the wound, the true depth and stage cannot be determined .... " 3. Review of clinical record #1, Election date of 08/06/2020, revealed the patient had bruising. The assessment failed to evidence the size, description, and location of the bruises. 4. The clinical record for patient #2, Election date 9/10/20, included history and physical from an entity dated 8/14/20, which stated the patient has a history of C6 spinal cord injury after a motor vehicle accident in 2002 that resulted in the patient becoming a paraplegic, has sacral/ ischial and heel wounds. The patient was admitted prior to this hospitalization for sepsis related to wound infections. The patient underwent debridement and antibiotic therapy. The patient returned to the hospital due to unresponsiveness and fever. The patient was treated again for recurrent sepsis and ended up having 3 seizures during their hospital stay. The clinical record also contained notes from a skilled nursing facility that the patient was sent to after hospitalization for wound treatment with a wound vac (a type of device that decreases air pressure on the wound to help it heal), IV (intravenous) antibiotics for sepsis, and seizures. A 9/5/20 note indicated the patient's sacral wound increased in size from 7 to 10 cm (centimeter) due to loose stools, causing further infection to the sacral wound. The note also indicated the patient had a diagnosis of an anxiety disorder. On 9/1, the note indicated the patient had a deep tissue injury to the right heel possibly measuring 2.6 x 5 cm (centimeters), a wound to the right trochanter measuring 2 x 0.8 x 0.1 cm, left heel measuring was described as an unstageable deep tissue injury		terminal illness and related conditions. During the comprehensive patient assessment, all baseline data and other relevant information will be documented in the patient's clinical record, including at least the following information, as relevant: A. An assessment of pain, including the origin, location, duration, severity, and relief measures. [Nurses will document pain and symptom assessments and reassessments as required. When pain is identified, a more comprehensive pain assessment will be completed. Pain assessments will facilitate regular reassessment and follow-up by clinicians.] 1.B. An assessment of severity of secondary symptoms, such as: 1.1. Dyspnea, nausea, vomiting, constipation, respiratory distress, and nutritional status 2.2. Restlessness, anxiety, emotional distress 3.3. Sleep Disorders 4.4. Skin Integrity 5.5. Confusion 1.C. An assessment of the need for a bowel regimen, esp. when the patient is prescribed opioids. 2.D. Nature and condition causing admission 3.E. Alleviating and	

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	measuring 2.5 x 6 cm, Stage IV left trochanter measured 3.5 x 3.5 x 0.4 cm on 8/28/20. During the patient's stay, the patient had critical labs and refused further treatment and hospice was presented. Review of the plan of care for the benefit period of 09/10/20 to 12/8/20. The medication list on the plan of care indicated the patient was prescribed and taking Alprazolam (Xanax) 0.5 mg (milligrams) every 6 hours as needed for anxiety, Baclofen 20 mg twice a day for muscle relaxant, levetiracetam 500 mg and Vimpat 100 mg twice a day for seizures, and Norco 5 mg-325 mg tablet every 6 hours as needed for pain. Review of the start of care comprehensive assessment dated 9/10/20, failed to include an acceptable pain range. The assessment failed to include any information/ assessment of the patient's need for anti-anxiety medication, muscle relaxant, anti-seizure medication, pain medication, right heel and right trochanter. Review of the wound assessment indicated the patient had a stage 3 wound to the left greater trochanter that measured 10 (L) x 8.5 (W) x 0.5 (D) centimeters (cm); the sacral wound was stage 4 wound that measured 18 x 25 x 1.5 cm; and a stage 2 wound to the left heel that measured 7.6 x 7.6 x 0.1 cm. The narrative note indicated the right heel was unblancheable and boggy. The wound assessment failed to include a full assessment with measurements of the right heel, failed to identify the left heel accurately according to professional wound standards; failed to be consistent with the patient's stay at the facility and failed to be consistent with ongoing assessments as evidenced by the following: Review of the updated comprehensive		exacerbating factors for physical symptoms 1. Effectiveness drug therapy 2. Unwanted side and toxic effects 3. Drug interactions (actual or potential) 4. Duplicate drug therapy F. Current treatment and patient response to that treatment G. An assessment of the patient's response to palliative treatment H. An assessment of the patient's well-being, comfort and dignity throughout the dying process. I. A physical assessment, including blood pressure, temperature, pulse, respiration, skin, and other relevant data related to pertinent physical findings and the patient's terminal illness J. Imminence of death K. Patient's functional status including, but not limited to, the degree of self-care and the amount and level of assistance needed L. Patient's cognitive status including the ability to understand and participate in his or her own care Complication and risk factors that affect care planning M. Complication and risk factors that affect care planning, including drug diversion N. Patient's past and present medical, psychiatric history, pertinent diagnosis, co-morbid conditions O. Name and address of the patient's attending physician	

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	assessment dated 9/14/20, indicated the left trochanter measured 3.5 x 5 x 1 cm, the sacral wound measured 8.5 x 9 x 3 cm, and the left heel measured 4 x 3.5 x 0 cm. Review of the updated comprehensive assessment dated 9/23/20, indicated the left trochanter measured 5 x 5 x 0.5 cm, the sacral wound measured 5 x 9 x 1.5 cm, and the left heel measured 5 x 6 x 0.1 cm. During an interview on 9/30/20 at 5:00 p.m., when asked about the inconsistent measurements of the patient wounds, the Patient Care Manager acknowledged the discrepancy. During an interview on 10/1/20 at 9:14 a.m., the patient's caregiver stated the patient had been on Xanax for years for anxiety and the patient had horrible dysreflexia, which caused his legs to spasm, and did have pain and discomfort, and utilized the Baclofen routinely and Norco as needed. 5. The above findings were reviewed with the Regional Director of Compliance, Director of Nursing, Patient Care Manager of the Bloomington Branch, and Administrator on 10/01/2020 at 1:20 p.m., in which no further information or documentation was provided.		P. Name of hospital, other agencies, persons involved in the past & present care of the patient Q. An evaluation of the home environment and assessment of emergency preparedness R. Presence of any Advance Directives for care and/or discussions with patient and family/caregiver regarding the withholding/withdrawal of resuscitative services or treatment S. Equipment presently in home and potentially needed by patient T. Review of current and related past medications, including prescription and over-the-counter medications, supplements, herbal remedies, alternative treatments, allergy history and other medication information U. Patient and family/caregiver support systems and the care the family/caregiver is available, capable, and willing to provide, including applicable strengths of patient, physical, psychosocial, and/or spiritual resources available V. The patient’s psychosocial status, including emotional barriers to treatment, cognitive limitations, memory and orientation, family relationships, social history, source and adequacy of environmental and other resources, coping mechanisms, and the patient’s and family/caregiver’s reaction to illness. W. An assessment of the patient's	

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			and family/caregiver's spiritual orientation, including, as appropriate, any involvement in a religious group such as a church or synagogue or a support group such as Alcoholics Anonymous and spiritual concerns or needs such as despair, suffering, guilt, etc. X. Involvement of family/caregiver, neighbors, and/or other individuals/organizations, including involvement in any support groups Y. An assessment of the need for volunteer services to offer support or respite to the patient and family/caregiver Z. A bereavement assessment of the needs of the patient's family and other individuals AA. Laboratory results BB. Medical, alcohol, and other drug history CC. TB screening DD. Specific, individualized patient needs/problems pertinent to the hospice care being provided EE. Past medical and surgical care, including dates of onset/exacerbation FF. The patient's and family/caregiver's educational needs, abilities, motivation, and readiness to learn. GG. The need for referrals and further evaluation by appropriate health professionals 1.The assessment should determine: Probable prognosis of six (6) months or less; Patient	

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			problems and needs related to the terminal illness; Patient goals related to the terminal illness. During each wound care visit, nurse to review prior wound assessment, note significant discrepancies from prior to current wound assessment, communicate to manager and to the physician, and resolve discrepancy in the medical record documentation. Wound care will be evaluated and reviewed at least weekly in response to treatment. All wound care will be performed in accordance with physician orders and practice standards. The physician will be updated regarding a patient's wound status on an ongoing basis. The organization will notify the physician immediately if there are signs and symptoms of wound deterioration, including infection, significant bleeding, or enlargement. If there is no improvement in a wound after two weeks of a treatment, the physician will be consulted to determine if a change in wound care is appropriate. **How are you going to prevent the deficiency from recurring in the future, even if already corrected?** 1.100% focused chart audit for 90 days on Admissions, then ongoing, 10% each quarter to ensure nursing comprehensive	

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			assessment; 2.100% focused wound care audit for 90 days on all Wound care patients, then ongoing, 10% each quarter to ensure pressure ulcer assessment according to NPUAC Staging System; 3.Threshold for focused audits is 100% compliance with comprehensive assessment and wound staging. If threshold not met, Patient Care Managers will re-educate involved staff, progressively, involving human resources for work plans, if needed. **Who is going to be responsible for prevention above: i.e., director, supervisor, etc.?** Patient Care Managers (PCMs) are responsible for audits and staff correction. PCMs will be overseen by Director(s) of Clinical Services (DCS) who report to the Administrator. The Administrator shall report Focus audit results to the QAPI Committee and then the Governing Body for three consecutive quarters. **By what date are you going to have the deficiency corrected?** 10/30/20. Nurses completed re-education by 10/30/20. By no later than 10/30/20, the organization will have implemented 100% Focus audits on Comprehensive Assessment at Admission and	

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			ongoing for Wounds.	
S 0533 Bldg. 00	418.54(d) UPDATE OF COMPREHENSIVE ASSESSMENT The update of the comprehensive assessment must be accomplished by the hospice interdisciplinary group (in collaboration with the individual's attending physician, if any) and must consider changes that have taken place since the initial assessment. It must include information on the patient's progress toward desired outcomes, as well as a reassessment of the patient's response to care. The assessment update must be accomplished as frequently as the condition of the patient requires, but no less frequently than every 15 days. Based on record review and interview, the agency failed to ensure the updated comprehensive assessment included accurate and consistent information on the patient's symptoms, progress toward desired outcomes, and patient's response to care for 2 of 3 records reviewed. (Patients #1, 2) Findings include: 1. Review of an agency policy titled "Ongoing Comprehensive Assessment Policy No. 1-015.1" dated 5/11/20, indicated " ... During each home visit, the Case Manager or other discipline will evaluate the patient according to the problems identified during the initial assessment and thereafter the comprehensive assessment .... " 2. Review of an agency policy titled "Patient Education Process Policy No. 2-025.1-3" dated 5/11/20, indicated " ... Procedure ... 6. ... the	S 0533	**S 533** 418.54(d) UPDATE OF COMPREHENSIVE ASSESSMENT The update of the comprehensive assessment must be accomplished by the hospice interdisciplinary group (in collaboration with the individual's attending physician, if any) and must consider changes that have taken place since the initial assessment. It must include information on the patient's progress toward desired outcomes, as well as a reassessment of the patient's response to care. The assessment update must be accomplished as frequently as the condition of the patient requires, but no less frequently than every	10/30/2020

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	patient and family/ caregiver will receive verbal, and as appropriate, written instructions on: ... B. The patient's disease process C. The medical regimen D. Medication management and administration ... G. Prescribed treatments ... 7. Documentation of patient and family/ caregiver education will consist of: A. Describing what was taught to the patient ... B. Describing the patient's response to the teaching, including level of understanding and the ability to repeat or demonstrate what was taught. C. Describing any additional learning needs not currently met ... 11. The patient's and family/caregiver's knowledge, skills, and behaviors will be assessed during hospice visits. Re-education, when appropriate, will be provided .... " 3. Review of an agency policy titled "Pain Management Education Policy No. 2-026.1" dated 5/11/20, indicated " ... 3. Documentation of patient and family/ caregiver instruction and understanding in the clinical record will include: A. Information taught B. Patient and family/ caregiver understanding C. Response to teaching .... " 4. Review of an agency policy titled "Pain assessment Policy No. 1-018.1" dated 5/11/20, indicated " ... Pain assessments will be appropriate to the patient's age and will be documented to facilitate regular reassessment and follow-up by clinicians ... 2. ... the following in-depth pain assessment information will be obtained whenever possible: ... G. Pain management history, to include a medication history, presence of common barriers to reporting pain and using analgesics, past interventions and response ... I. The patient's pain goal, including pain intensity goals related to function, activities, and quality of life ... Pain Management ... 2. Non-pharmacological		15 days. **How are you going to correct the deficiency? If already corrected, include the following steps and state date of correction.** From 10/14/20-10/30/20, all Nursing staff were In-serviced on the following *Premier Hospice & Palliative Care CHAP Hospice Policy and Procedure Manual*, 2020 policies and wound assessment guidelines: 1.ONGOING COMPREHENSIVE ASSESSMENT, Policy No. 1-015; 1.PATIENT EDUCATION PROCESS, Policy No. 2-025; 2.PAIN MANAGEMENT EDUCATION, Policy No. 2-026; 3.PAIN ASSESSMENT, Policy No. 1-018; 4.WOUND CARE, Policy No. 2-035.A; 5.SKIN AND WOUNDCARE QUICK REFERENCE/GUIDELINE; National Pressure Ulcer Advisory Panel (NPUAP) Staging System. Involved staff acknowledged this in-service re-training in writing: Organization policies set forth the organization shall ensure updates to the comprehensive assessment includes accurate and consistent information on the patient's symptoms, progress toward desired outcomes, and patient's response to care. The ongoing comprehensive assessment will be updated as frequently as the	

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	interventions will be considered for the treatment of pain ... 4. Patient and family / caregiver education will focus on the use and side effects of analgesic and/ or adjuvant medications, expected responses to therapy, and the importance of administering medications according to prescribed dosage and frequency." 5. According to an article titled "Table 2, [National Pressure Ulcer Staging System] at https://www.ncbi.nlm.nik.gov, described a deep tissue injury as a "pressure-related injury to subcutaneous tissues under intact skin.. Initially, these lesions have the appearance of a deep bruise ... purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/ or sheer." A Stage 2 pressure wound is described as a "partial thickness loss or dermis presenting as a shallow open ulcer with a red, pink wound bed without slough. May also present as an intact or open/ruptured serum-filled blister. Presents as a shiny or dry shallow ulcer without slough or bruising." A Stage 3 pressure wound is described as a "full thickness tissue loss. Subcutaneous fat may be visible, but bone, tendon, or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling." A Stage 4 pressure wound is described as a full thickness tissue loss; extensive destruction; with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling. An Unstageable wound is described as a "full thickness tissue loss in which actual depth of the ulcer is completely obscured by slough (yellow, tan, gray, green, or brown) and / or eschar (tan, brown or black) in the wound bed. Until enough slough and/ or eschar		condition of the patient warrants. Each visit, the nurse will assess/data collect for: 1.A. Pain, including the origin, location, duration, severity, and relief measures 2.B. Symptoms such as, nausea, vomiting, respiratory distress, patient's response to care 3.C. Factors that alleviate or exacerbate physical symptoms 4.D. Current treatment related to the identified symptoms and the patient's response 5.E. Vital signs appropriate to the patient's condition 6.F. Breath sounds 7.G. Skin integrity 8.H. Bowel sounds, elimination (urinary and bowel) 9.I. Mental status 10.J. Appetite/diet, nutritional status 11.K. Functional status 12.L. Safety/home environment 13.M. Patient and family/caregiver support 14.N. Progress toward hospice goals and patient needs and problems 15.O. Compliance with treatments and medication regimen 16.[Narcotic Counts including Quantity of medication used since last count and Reason is a required ongoing assessment] 17.P. The need for an	

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	is removed to expose the base of the wound, the true depth and stage cannot be determined .... " 6. According to an article titled "Assessment and Documentation of Pressure Ulcers" at https://healthinsight.org/Internal/events/Nursing_Home/Assessment_and_Documentation_Pressure_Ulcers%20_0110719_Color.pdf described epithelialization as a "process by which the wound surface is covered by new epithelium, this begins when the wound has filled with granulation tissue. The tissue is pink, almost white, and only occurs on top of healthy granulation tissue." Slough is described as "the presence of devitalized yellowish tissue is observed and is formed by an accumulation of dead cells. Must not be confused with the presence of pus." Necrotic tissue is described as a "wound containing dead tissue. The wound may appear hard, dry and black. Dead connective tissue may appear gray. The presence of dead tissue in a wound prevents healing." 7. The clinical record for patient #1, start of care 8/6/20, was reviewed and included a plan of care for the benefit period of 8/6/20 to 10/4/20. The plan of care included, but was not limited to, goals of "Patient, family, caregivers are knowledgeable and involved in hospice plan of care for patient ... pt/cg (patient/ caregiver) will verbalize understanding of indications, uses, and side effects of each medication and administer medications as prescribed as evidenced by no adverse effects from medication error, narcotic counts will be correct each visit through next benefit period ... Anxiety/ agitation/ restlessness will be managed with use prn [as needed] lorazepam as ordered through next benefit period ... Patient/ caregiver will be able to verbalize measures to promote comfort related to		alternative setting or level of care 18.Ongoing comprehensive assessments should focus on progress toward goals: 19.A. Patient's response to care 20.B. Changes in patient condition, level of deterioration 21.C. Changes in patient diagnoses/prognosis 22.D. Changes in the patient's care environment or support systems 23.E. Well-being 24.F. Comfort 25.G. Dignity throughout the dying process 26.Based on the assessments, the plan of care—including problems, needs, goals, and outcomes—will be reviewed and updated by the interdisciplinary group members responsible for the case. Change/verbal orders will be entered immediately and forwarded to the physician. Patients and family/caregivers will receive information regarding pain and the management of pain as an integral part of hospice care. The patient and family/caregiver will receive verbal or written instructions, as appropriate, regarding: 1.A. The pain process 2.B. The risk for pain 3.C. The pain assessment process 4.D. The importance of	

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	respiratory system in the terminal patient through next benefit period .... " Review of the 8/7/20 IDG (interdisciplinary group) note indicated the education provided were safety and comfort medication. Narcotic count indicated: Norco 12 tabs (tablets), Roxanol 30 ml (milliliters), and Lorazepam 10 tabs. Patient and/or caregiver understand the appropriate use, use of side rails and returns demonstration, and dexamethasone was called into the patients pharmacy. Review of the skilled nursing visit note dated 8/7/20 indicated the only interventions/ goals achieved was pain management and safety. The updated comprehensive assessment/ skilled nursing visit notes failed to evidence the patient's/ caregiver progress towards the goals related to the specific medication that was educated and patient/ caregiver understanding of each medication and progress towards understanding/ verbalization of measures to promote comfort related to respiratory system. Review of the 8/8/20 IDG note indicated "N/A" to education provided. Narcotic count indicated: Norco 12 tabs, Morphine (Roxanol) 30 ml, and Lorazepam 20 tabs. Patient and/ or caregiver understand the appropriate use of side rails and returns demonstration. Respirations even but slightly labored at rest at times and the patient denied a need for intervention, no edema, and DME (durable medical equipment) concerns. Review of the skilled nursing visit note dated 8/8/20 indicated the only interventions/ goals achieved was pain management and safety. The updated comprehensive assessment/ skilled nursing visit notes failed to evidence the patient's/ caregiver progress towards the goals related to the specific medication that was educated and patient/ caregiver understanding of		effective pain management 5.E. Methods for pain management, when identified as part of treatment 6.F. Potential limitations of pain management modalities 7.G. Side effects of pain treatment 8.Documentation of patient and family/caregiver instruction and understanding in the clinical record will include: A. Specific information taught; B. Patient and family/caregiver specific understanding; C. Response to teaching; D. Additional learning needs. Nurses will document pain and symptom assessments and reassessments as required. When pain is identified, a more comprehensive pain assessment will be completed. Pain assessments facilitate reassessment and follow-up. During wound care visits, nurse to review prior wound assessment, note significant discrepancies from prior to current wound assessment, communicate to manager and to the physician, and resolve discrepancy in the medical record documentation. Wound care will be evaluated and reviewed at least weekly. All wound care will be performed in accordance with physician orders and practice standards. The physician will be updated regarding a patient's wound status on an ongoing basis. The	

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	each medication and progress towards understanding/ verbalization of measures to promote comfort related to respiratory system. The clinical record also failed to evidence the accuracy of the narcotic count/ if Lorazepam was ordered the previous day or if there was a miscount due to previous days count indicated 10 tabs. Review of the 8/9/20 IDG note indicated "N/A" to education provided. Narcotic count indicated: Norco 12 tabs, Morphine (Roxanol) 29.5 ml, and Lorazepam 20 tabs. Patient and/ or caregiver understand the appropriate use of side rails and returns demonstration. Over the counter eye drops used and spouse instructed on hospice not delivering medications. Review of the skilled nursing visit note dated 8/9/20 indicated the only interventions/ goals achieved was pain management and safety. The updated comprehensive assessment/ skilled nursing visit notes failed to evidence the patient's/ caregiver progress towards the goals related to the specific medication that was educated and patient/ caregiver understanding of each medication and progress towards understanding/ verbalization of measures to promote comfort related to respiratory system. The visit note also failed to evidence an assessment of when the patient used the Roxanol and reason for use. Review of the 8/10/20 IDG note indicated the education provided was on safety and comfort medication. Narcotic count indicated: Norco 12 tabs, Roxanol 28 ml, Lorazepam 21 tabs. Patient and/ or caregiver understand the appropriate use of side rails and returns demonstration. Shortness of breath at baseline. Concerns and request for a trapeze for the patient's bed. Review of the skilled nursing visit note indicated the only		organization will notify the physician immediately if there are signs and symptoms of wound deterioration, including infection, significant bleeding, or enlargement. If there is no improvement in a wound after two weeks of a treatment, the physician will be consulted to determine if a change in wound care is appropriate. **How are you going to prevent the deficiency from recurring in the future, even if already corrected?** 1.100% focused chart audit for 90 days on Update of Comprehensive Assessment prior to each Interdisciplinary Group Meeting/IDG, then ongoing, 10% each quarter to ensure update to the comprehensive assessment; 2.100% focused wound care audit for 90 days on all Wound care patients, then ongoing, 10% each quarter to ensure pressure ulcer assessment according to NPUAC Staging System; 3.Threshold for focused audits is 100% compliance with update to comprehensive assessment and wound staging. If threshold not met, Patient Care Managers will re-educate involved staff, progressively, involving human resources for work plans, if needed. **Who is going to be responsible**	

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	interventions/ goals achieved was pain management and safety. The updated comprehensive assessment/ skilled nursing visit notes failed to evidence the patient's/ caregiver progress towards the goals related to the specific medication that was educated and patient/ caregiver understanding of each medication and progress towards understanding/ verbalization of measures to promote comfort related to respiratory system. The visit note also failed to evidence an assessment of when the patient used the Roxanol and the accuracy of the narcotic count since Lorazepam was counted at 20 tabs on 8/9/20. Review of the 8/13/20 IDG note indicated the education provided were safety and comfort medication. Narcotic count indicated: Norco 12 tabs, Roxanol 28 ml, Lorazepam 20 tabs. Patient and/ or caregiver understand the appropriate use of side rails and returns demonstration. Shortness of breath at baseline. Spouse requests a bariatric bed extender and was advised that it was not available. Review of the skilled nursing visit note indicated the only interventions/ goals achieved was pain management and safety. The updated comprehensive assessment/ skilled nursing visit notes failed to evidence the patient's/ caregiver progress towards the goals related to the specific medication that was educated and patient/ caregiver understanding of each medication and progress towards understanding/ verbalization of measures to promote comfort related to respiratory system. The visit note also failed to evidence an assessment of when the patient used the Lorazepam. Review of the 8/17/20 IDG note indicated the education provided were safety and comfort medication. Narcotic count indicated: Norco 12		**for prevention above: i.e., director, supervisor, etc.?** Patient Care Managers (PCMs) are responsible for audits and staff correction. PCMs will be overseen by Director(s) of Clinical Services (DCS) who report to the Administrator. The Administrator shall report Focus audit results to the QAPI Committee and then the Governing Body for three consecutive quarters. **By what date are you going to have the deficiency corrected?** 10/30/20. Nurses completed re-education by 10/30/20. By no later than 10/30/20, the organization will have implemented 100% Focus audits on Update of Comprehensive Assessment prior to each IDG and Wounds ongoing.	

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	tabs, Roxanol 28 ml, Lorazepam 21 tabs. No falls and caregiver understands the appropriate use of side rails and returns demonstration. The patient had tachycardia with an irregular heart rate of 140-160, new order for cardizem 120 mg daily was called into the pharmacy. No shortness of breath above baseline. Review of the skilled nursing visit note indicated the only interventions/ goals achieved was pain management and safety. The updated comprehensive assessment/ skilled nursing visit notes failed to evidence the patient's/ caregiver progress towards the goals related to the specific medication that was educated and patient/ caregiver understanding of each medication and progress towards understanding/ verbalization of measures to promote comfort related to respiratory system. The visit note also failed to evidence an accurate narcotic count since Lorazepam was counted at 20 tabs on 8/13/20. 8. The clinical record for patient #2, start of care 9/10/20, was reviewed and included start of care comprehensive assessment dated 9/10/20, failed to include an acceptable pain range. Review of the wound assessment indicated the patient had a stage 3 wound to the left greater trochanter that measured 10 (L) [length] x 8.5 (W) [width] x 0.5 (D) [depth] centimeters (cm), with < 25 % (less than 25 percent) granulation tissue and 51-75% necrotic tissue; the sacral wound was stage 4 wound that measured 18 x 25 x 1.5 cm, depth description indicated a full thickness wound with 25 - 50 % necrosis and 26 - 50% necrotic tissue slough; and a stage 2 wound to the left heel that measured 7.6 x 7.6 x 0.1 cm, depth description indicated a partial thickness wound with 100% epithelialization and 0-25 % necrotic tissue slough and eschar. The narrative note indicated the patient had a right heel wound that was non-blanchable and boggy			

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	but unopened. Review of the plan of care for the benefit period of 9/10/20 to 12/8/20. The medication list indicated the patient was prescribed Xanax 0.5 mg every 6 hours as needed for anxiety, Baclofen 20 mg tablets 2 times daily for muscle relaxant, Lorazepam 1 mg tablet every 4 hours as needed for anxiety, agitation, and restlessness, Norco 5 mg - 325 mg tablet 1 every 6 hours as needed for pain, and Morphine concentrate 100 mg/ 5 ml (20 mg/ml) oral solution give 0.25 ml every 4 hours as needed for pain or air hunger. The interventions indicated the hospice nurse to obtain blood sugar readings from the patient/ caregiver at each visit, wound treatment to 3 pressure ulcers (located at the left trochanter, sacral, and left heel), hospice nurse to monitor pain level and report changes in pain level to physician, and failed to evidence a goal of what is an acceptable level of pain. The plan of care revealed only two orders to instruct: safety measures each visit and to educate patient/ family on oxygen use and safety at each visit. No other orders of instruction was indicated in the plan of care. Review of the skilled nursing visit note dated 9/11/20 included, but was not limited to, the interventions provided: "Assessed pain level using appropriate pain scale ... hospice comfort kit reviewed and is intact with current expiration dates ... instructed patient/ caregiver regarding use of comfort kit ... Instructed patient/ caregiver on safety measures ... Reinforced nurse's instructions regarding safety .... " The narcotic count in the narrative note indicated "Norco 2, Rest of cpmfort [sic] meds [medications] still at pharmacy. The goals met indicated "Patient/ Family verbalizes proper use of comfort kit" which was inconsistent with the narcotic count in the			

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	narrative note. The Interventions not provided indicated "Obtain Lab as ordered ... Not applicable to current visit" which was inconsistent with the goals met of "Patient verbalizes tolerance to lab procedure." The note also indicated a goal met of "Patient/ caregiver verbalizes understanding of proper safety measures related to fall awareness" but the visit note failed to evidence the specific education that was provided. The note failed to evidence an assessment of the right heel. Review of the 9/12/20 IDG note indicated the narcotic count as follows: the morphine was not in the home, Lorazepam 30 tabs, Xanax 33 tabs, and Norco 2 tabs. Review of the skilled nursing visit note dated 9/12/20 indicated the patient's repeat pain assessment "N/A - Patient was at or below their acceptable level for pain during the initial pain assessment" and the visit note failed to evidence a blood sugar assessment. The interventions provided indicated "Hospice comfort kit reviewed and is intact with current expiration dates, instructed patient/ caregiver regarding use of comfort kit. The interventions indicated "Instruct on safety measures ... Reinforced nurse's instructions regarding safety." The note failed to indicate the specific medications and what was taught from the comfort kit. The note also indicated a goal met of "Patient/ caregiver verbalizes understanding of proper safety measures related to fall awareness" but the visit note failed to evidence the specific education that was provided. The assessment note failed to evidence an assessment of the right heel. Review of the skilled nursing visit note dated 9/13/20 , the interventions provided indicated "Hospice comfort kit reviewed and is intact with current expiration dates, instructed patient/			

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	caregiver regarding use of comfort kit. The interventions indicated. The interventions also stated "... 10. Provide venous [stasis ulcer] wound care per orders" when the patient does not have stasis ulcers but pressure ulcers. Other interventions revealed "Instructed patient/ caregiver on wound care ... Instructed patient/ caregiver in performing wound care including proper disposal of used wound supplies ... Instructed patient/ caregiver in preventative skin care ... Instructed patient/ caregiver regarding proper nutrition including calories/ protein intake necessary to promote wound healing ... Identified sources of pressure ... " when the plan of care failed to be updated to include these instructions/ education. Other interventions include: "Instruct on safety measures ... Reinforced nurse's instructions regarding safety." The note failed to indicate the specific medications and what was taught from the comfort kit. The note also indicated a goal met of "Patient/ caregiver verbalizes understanding of proper safety measures related to fall awareness" but the visit note failed to evidence the specific education that was provided. The assessment note failed to evidence an assessment of the right heel and the visit note failed to evidence a blood sugar assessment. Review of the 9/14/20 IDG note indicated the narcotic count as follows: the morphine was not in the home, Lorazepam 30 tabs, Xanax 30 tabs, Norco 1 tab. Review of the skilled nursing visit note dated 9/14/20 indicated the patient's repeat pain assessment "N/A - Patient was at or below their acceptable level for pain during the initial pain assessment". The interventions provided indicated "Hospice comfort kit reviewed and is intact with current expiration dates, instructed patient/ caregiver regarding use of comfort kit"			

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	when the narrative note indicated Norco: 2 tabs and "Comfort meds being PU [picked up] from pharmacy today." Other interventions provided revealed "... 10. Provide venous [stasis ulcer] wound care per orders .... " when the patient does not have stasis ulcers but pressure ulcers. The visit note failed to include any documentation about the use of hydrocodone. The assessment note failed to evidence an assessment of the right heel. Review of a physician order dated 9/16/20, indicated the hospice nurse to monitor pain level using verbal pain scale each visit and to report the changes in pain level to the physician, monitor effectiveness of prn Norco and prn morphine. Review of the skilled nursing visit note dated 9/16/20, indicated the last bowel movement was on 9/9/20 when the 9/14/20 visit note indicated 9/14/20. The Integumentary assessment indicated there were 3 pressure ulcers, but only identified one at stage 3 and 4, and inaccurately indicated zero to stage 2 pressure ulcers. The visit note identified the patient was a diabetic but failed to include an assessment of blood sugars, the patient's repeat pain assessment "N/A - Patient was at or below their acceptable level for pain during the initial pain assessment", the functional assessment indicated the patient was a quadriplegic with the patient is a paraplegic, the wound assessment indicated the left trochanter was a stage 3 but a suspected deep tissue injury with a large amount of purulent draining with a strong odor with 76-100% necrotic slough tissue and 0-25% of necrotic eschar tissue, the sacral wound was a stage 4 but described as a suspected deep tissue injury with a moderate amount of purulent drainage and a strong odor with 0-25% of necrotic slough and eschar tissue,			

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PREMIER HOSPICE & PALLIATIVE CARE - INDIANA LLC	11550 N MERIDIAN STREET, SUITE 375 CARMEL, IN 46032

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	and the left heel is a stage 2 but described as a suspected deep tissue injury with 75-100% epithelialization tissue, soft black necrotic tissue and 0-25% necrotic slough tissue. The wound identification and assessments failed to be consistent and accurate according to the wound assessment websites. The assessment note failed to evidence an assessment of the right heel. The narrative note indicated the patient was having episodes of a fixed stare without identifying this as a possible seizure incident. The narrative indicated the patient was out of Norco and the patient had pain in the left arm on 9/15/20. The visit note failed to indicate if the physician was notified of the odor and drainage of the wounds and possible seizure. The interventions provided indicated "Hospice comfort kit reviewed and is intact with current expiration dates, instructed patient/ caregiver regarding use of comfort kit. The IDG note dated 9/17/20 indicated the narcotic count was not completed due to multiple family members in the home and the caregiver was uncomfortable getting the medications out. Review of the skilled nursing visit note dated 9/18/20 indicated the patient was confused and lethargic, anxiety does not significantly affect the patient, the patient's repeat pain assessment "N/A - Patient was at or below their acceptable level for pain during the initial pain assessment" but the narrative note indicated the clinician gave the patient lorazepam and hydrocodone due to the patient being confused speaking in nonsensical sentences and wincing. The note indicated the patient was "active" and notified the physician, discontinued routine medications, and only ordered comfort medications/ scheduled Morphine and Lorazepam. The narcotic count within the narrative note indicated Hydrocodone 25, Roxanol 30 ml, Lorazepam 29. The count failed			

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	to include the patient's Xanax. Review of the 9/19/20 IDG note indicated the narcotic count as follows: Morphine is not in the home. Lorazepam 22 tab, Xanax 11 tabs, Norco 45 tabs. Review of the skilled nursing visit note dated 9/19/20, the Integumentary section indicated that the patient had zero pressure ulcers when the patient has wounds to bilateral heels, left trochanter and sacrum, the patient was alert and oriented x3, anxiety does not affect the patient, the patient's worst pain level in the last 24 hours, on a scale of 1-10 (with 10 being the worse pain) was a 6 but currently has no pain, the patient's repeat pain assessment "N/A - Patient was at or below their acceptable level for pain during the initial pain assessment". The IDG narcotic count for the morphine was inconsistent with the narcotic count on 9/18, the inconsistent number of Norco from 25 tabs on 9/18 to current 45 tab, and failed to identify an assessment of the patient's anxiety level due to 7 Lorazepam tabs being used from previous day. The assessment note failed to evidence an assessment of the right heel. Review of the 9/20/20 IDG note indicated the narcotic count as follows: Morphine is not in the home which is inconsistent from 9/18/20. Lorazepam 21 tabs, Xanax 11 tabs, Norco 42 tabs. Review of the skilled nursing visit note dated 9/20/20, indicated the patient did not have anxiety that significantly affected him/ her, the pain assessment continued to indicate the patient has no pain or pain does not interfere with activity or movement and the repeat pain assessment indicated "N/A - Patient was at or below their acceptable level for pain during the initial pain assessment" but the narrative note indicated the patient reported the prn (as needed) Norco was			

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	effective in managing their pain. The visit note failed to include an assessment of the patient anxiety and pain level due to the use of the narcotics. The assessment note failed to evidence an assessment of the right heel. Review of the skilled nursing visit note dated 9/21/20, indicated the patient did not have anxiety that significantly affected him/ her, the pain assessment continued to indicate the patient has no pain or pain does not interfere with activity or movement and the repeat pain assessment indicated "N/A - Patient was at or below their acceptable level for pain during the initial pain assessment." The left trochanter wound assessment indicated the depth description was extensive and the patient had a large amount of purulent drainage with a strong odor, the sacral wound assessment indicated the depth description was extensive with a strong odor, and the left heel continued to be a stage 2 but the depth description was described as necrotic. The narcotic count within the narrative indicated Norco 35 (7 tabs taken within 24 hours), Lorazepam was blank, Roxanol 29 ml, and Xanax 11. The visit note failed to include an assessment of the patient anxiety and pain due to the use of the narcotics. The assessment note failed to evidence an assessment of the right heel. Review of the skilled nursing visit note dated 9/23/20, indicated the patient did not have anxiety that significantly affected him/ her, the pain assessment continued to indicate the patient has no pain or pain does not interfere with activity or movement and the repeat pain assessment indicated "N/A - Patient was at or below their acceptable level for pain during the initial pain assessment." The left heel continued to be a stage 2 but the depth description was described			

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	as necrotic with a measurement of 5 x 6 x 0.1 cm. The wound identification and assessments failed to be consistent and accurate according to the wound assessment websites. The assessment note failed to evidence an assessment of the right heel. The narcotic count within the narrative note indicated Norco 26 (9 tabs taken within 48 hours), Lorazepam 9 (12 tabs taken in 72 hours in conjunction with Xanax), Roxanol (Morphine) 30 ml, and Xanax 7 (4 tabs taken in 72 hours in conjunction with Lorazepam). The caregiver requested refills on the Xanax and Lorazepam. The visit note failed to evidence a comprehensive assessment of the patient's use of pain and anti-anxiety medications. Review of the skilled nursing visit note dated 9/25/20, indicated the patient did not have anxiety that significantly affected him/ her, the pain assessment continued to indicate the patient has no pain or pain does not interfere with activity or movement and the repeat pain assessment indicated "N/A - Patient was at or below their acceptable level for pain during the initial pain assessment." The left heel continued to be a stage 2 but the depth description was described as necrotic without a measurement. The wound identification and assessments failed to be consistent and accurate according to the wound assessment websites. The assessment note failed to evidence an assessment of the right heel. The narcotic count within the narrative note indicated Lorazepam 33 tabs, Xanax 60 tabs, Roxanol 30 ml, and Norco 21 tabs. The visit note failed to evidence a comprehensive assessment of the patient's use of pain and anti-anxiety medications. Review of the skilled nursing visit note dated 9/28/20, indicated the patient did not have anxiety that significantly affected him/ her, the pain			

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	assessment continued to indicate the patient has no pain or pain does not interfere with activity or movement and the repeat pain assessment indicated "N/A - Patient was at or below their acceptable level for pain during the initial pain assessment." The left heel continued to be a stage 2 but the depth description was described as necrotic without a measurement. The wound identification and assessments failed to be consistent and accurate according to the wound assessment websites. The assessment note failed to evidence an assessment of the right heel. The narrative note indicated the patient's muscle spasms were worsening and orders were received to increase Baclofen to four times a day. The narcotic count within the narrative note indicated Lorazepam 21 tabs (12 tabs taken in 72 hours in conjunction with Xanax), Xanax 49 tabs 11 tabs taken in 72 hours in conjunction with Lorazepam), Roxanol 30 ml, and Norco 10 tabs (11 tabs taken in 72 hours). The narrative note indicated education provided was safety. The interventions indicated there was instruction regarding the use of the comfort kit, instruction regarding routine inspection of the skin, instruction regarding proper positioning, regarding appropriate hydration and nutrition, and use of support surfaces. These interventions failed to be consistent with the narrative note. The visit note failed to evidence a comprehensive assessment of the patient's use of pain and anti-anxiety medications. Review of the skilled nursing visit note dated 9/30/20, indicated the patient did not have anxiety that significantly affected him/ her, the pain assessment continued to indicate the patient has no pain or pain does not interfere with activity or movement and the repeat pain assessment indicated "N/A - Patient was at or below their			

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	acceptable level for pain during the initial pain assessment." The left heel wound assessment indicated a measurement of 5.5 x 6.5 x 0.1 cm, continued to be a stage 2 but the depth description was described as necrotic. The wound identification and assessments failed to be consistent and accurate according to the wound assessment websites and the sacral wound measurements of tunneling and undermining failed to be consistent with the 9/28/20 assessment. The assessment note failed to evidence an assessment of the right heel. The narrative note indicated the patient's muscle spasms were worsening and orders were received to increase Baclofen to four times a day. The narcotic count within the narrative note indicated Lorazepam 18 tabs, Xanax 41 tabs 8 tabs taken in 48 hours in conjunction with Lorazepam), Roxanol 30 ml, and Norco 61 tabs. The narrative note indicated education provided was safety. The interventions indicated there was instruction regarding the use of the comfort kit, instruction regarding routine inspection of the skin, instruction regarding proper positioning, regarding appropriate hydration and nutrition, and use of support surfaces. These interventions failed to be consistent with the narrative note. The visit note failed to evidence a comprehensive assessment of the patient's use of pain and anti-anxiety medications. 8. During an interview on 9/30/20 at 4:55 p.m., the Administrator stated that the agency did not provide "comfort kits." 9. The above findings were reviewed with the Regional Director of Compliance, Director of Nursing, Patient Care Manager of the Bloomington Branch, and Administrator on 10/01/2020 at 1:20 p.m., the Director of Nursing			

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	stated that the assessment was accurate in indicating there would be no pain or anxiety if medication was working and did not feel that there needed to be any further assessments since the patient was taking medications as prescribed. The Director of Nursing indicated he felt the description and staging of wounds were appropriate.			
S 0544 Bldg. 00	418.56(b) PLAN OF CARE The hospice must ensure that each patient and the primary care giver(s) receive education and training provided by the hospice as appropriate to their responsibilities for the care and services identified in the plan of care. Based on record review and interview, the agency failed to ensure visit notes contained specific details of education to patients and family members along with their response for 2 of 3 records reviewed. (Patient #1, 2) Findings include: 1. Review of an agency policy titled "Patient Education Process Policy No. 2-025.1-3" dated 5/11/20, indicated " ... Procedure ... 6. ... the patient and family/ caregiver will receive verbal, and as appropriate, written instructions on: ... B. The patient's disease process C. The medical regimen D. Medication management and administration ... G. Prescribed treatments ... 7. Documentation of patient and family/ caregiver education will consist of: A. Describing what was taught to the patient ... B. Describing the patient's response to the teaching, including level of understanding and the ability to repeat or demonstrate what was taught. C. Describing any	S 0544	**S 544** 418.56(b) PLAN OF CARE The hospice must ensure that each patient and the primary care giver(s) receive education and training provided by the hospice as appropriate to their responsibilities for the care and services identified in the plan of care. **How are you going to correct the deficiency? If already corrected, include the following steps and state date of correction.** From 10/14/20-10/9/20, all Nurses were In-serviced on the following *Premier Hospice & Palliative Care CHAP Hospice Policy and Procedure Manual*, 2020 policies: 1.PATIENT EDUCATION PROCESS, Policy No. 2-025; 2.PAIN MANAGEMENT EDUCATION, Policy No. 2-026; 3.BASIC HOME SAFETY,	10/30/2020

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	additional learning needs not currently met ... 11. The patient's and family/ caregiver's knowledge, skills, and behaviors will be assessed during hospice visits. Re-education, when appropriate, will be provided .... " 2. Review of an agency policy titled "Pain Management Education Policy No. 2-026.1" dated 5/11/20, indicated " ... 3. Documentation of patient and family/ caregiver instruction and understanding in the clinical record will include: A. Information taught B. Patient and family/ caregiver understanding C. Response to teaching .... " 3. Review of clinical record #1, Election date of 08/06/2020, included a plan of care for the benefit period of 08/06/2020 to 10/04/2020, with orders to instruct medication "indications, uses, side effects of each medication prior to administration .... " The plan of care revealed that the patient was prescribed approximately 23 medications. Review of a skilled nursing visit note dated 08/07, 08/08, 08/09, 08/10, 08/13/20, failed to evidence any instructions or education in regards to the patient medications. Review of a skilled nursing visit note dated 08/17/20, indicated the patient was placed on cardizem 120 mg daily. The visit note failed to evidence any education about the new medication nor any instruction or education of the patient's prescribed medications. During an interview on 9/30/20 at 4:55 p.m., when asked if patients/ caregivers should have a copy of the medication profile, the Administrator stated "Yes" the medication profile should be printed out and given to the patient/ caregiver.		Policy No. 2-048. Involved staff acknowledged this in-service re-training in writing: Organization policies set forth the organization shall ensure visit notes contain specific details of education to patients and family members along with their response. Patients and family/caregivers will receive information regarding pain and the management of pain as an integral part of hospice care. The patient and family/caregiver will receive verbal or written instructions, as appropriate, regarding: 1.A. The pain process 2.B. The risk for pain 3.C. The pain assessment process 4.D. The importance of effective pain management 5.E. Methods for pain management, when identified as part of treatment 6.F. Potential limitations of pain management modalities 7.G. Side effects of pain treatment 8.Documentation of patient and family/caregiver instruction and understanding in the clinical record will include: A. Specific information taught; B. Patient and family/caregiver specific understanding; C. Response to teaching; D. Additional learning needs. Nurses will document pain and symptom assessments and reassessments as required. When	

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	During an interview on 10/01/20 at 9:20 a.m., when asked if the agency provided them with a medication list indicating instruction or provided any verbal education on the prescribed medications, the caregiver indicated they were only provided a small handwritten note which indicated for the morphine, 0.5 ml (milliliters) to be given every hour and Ativan, 1 tab every hour then 2 tabs 0.5 mg (milligram), which was a new dose but there was some confusion on the exact dosage. The caregiver indicated she was not provided any education on the medication and felt that both medications given multiple times in an hour resulted in their loved ones death. The above findings were reviewed with the Regional Director of Compliance, Director of Nursing, Patient Care Manager of the Bloomington Branch, and Administrator on 10/01/2020 at 1:20 p.m., in which no further information or documentation was provided. 4. Review of clinical record #2, Election date of 9/10/20, included a plan of care for the benefit period of 9/10/2020 to 12/8/2020, with only two orders to instruct: safety measures each visit and to educate patient/ family on oxygen use and safety at each visit. No other orders of instruction was indicated in the plan of care.		pain is identified, a more comprehensive pain assessment will be completed. Pain assessments will facilitate regular reassessment and follow-up by clinicians. Patients receive information regarding basic home safety in the *Patient Hospice Admission Booklet, page 29,* including: 1. Fire response including Oxygen Safety 2. Electrical safety 3. Environmental and mobility safety 4. Bathroom safety 1.Documentation of patient and family/caregiver instruction in the clinical record will include: 2.A. Specific Information taught 3.B. Adaptations made to the environment 4.C. Patient and family/caregiver understanding 5.D. Return demonstrations in use of equipment, if appropriate 6.E. Response to teaching 7.F. Additional learning needs 1. **How are you going to prevent the deficiency from recurring in the future, even if already corrected?** 1.100% Focused chart audit for 90 days on Admissions, then ongoing, 10% review each quarter to ensure specific patient education and response is	

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			charted; 2.100% focused audit prior to each Interdisciplinary Group Meeting/IDG, then ongoing, 10% each quarter to ensure specific patient education and response is charted; 3.Threshold for focused audits is 100% compliance with documentation of patient and caregiver education. If threshold not met, Patient Care Managers will re-educate involved staff, progressively, involving human resources for work plans, if needed. **Who is going to be responsible for prevention above: i.e., director, supervisor, etc.?** Patient Care Managers (PCMs) are responsible for audits and staff correction. PCMs will be overseen by Director(s) of Clinical Services (DCS) who report to the Administrator. The Administrator shall report Focus audit results to the QAPI Committee and then the Governing Body for three consecutive quarters. **By what date are you going to have the deficiency corrected?** 10/30/20. Nurses completed re-education by 10/30/20. By no later than 10/30/20, the organization will have implemented 100% Focus audits on documentation of education at Admission and Prior	

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S 0546 Bldg. 00	418.56(c)(1) CONTENT OF PLAN OF CARE [The plan of care must include all services necessary for the palliation and management of the terminal illness and related conditions, including the following:] (1) Interventions to manage pain and symptoms. Based on record review and interview, the Interdisciplinary Group (IDG) failed to ensure the plan of care included interventions for 1 of 1 active record reviewed. (Patient #2) Finding include: Review of an agency's policy titled "Prioritizing Patient Problems/ Needs Policy No. 1-033.1" dated 5/11/20, indicated " ... A written, individualized plan of care will be established within 48 hours of hospice benefit election to assist with identification and prioritization of patient immediate problems/ needs. ..." The clinical record for patient #2, Election date 9/10/20, included history and physical from an entity dated 8/14/20, which stated the patient has a history of C6 spinal cord injury after a motor vehicle accident in 2002 that resulted in the patient becoming a paraplegic, has sacral/ ischial and heel wounds. The patient was admitted prior to this hospitalization for sepsis related to wound infections. The patient underwent debridement and antibiotic therapy. The patient returned to the hospital due to unresponsiveness and fever. The patient was treated again for recurrent sepsis and ended up having 3 seizures during their hospital stay.	S 0546	**S 546** 18.56(c)(1) CONTENT OF PLAN OF CARE [The plan of care must include all services necessary for the palliation and management of the terminal illness and related conditions, including the following:] (1) Interventions to manage pain and symptoms. **How are you going to correct the deficiency? If already corrected, include the following steps and state date of correction.** From 10/14/20-10/30/20, all Nurses were In-serviced on the following *Premier Hospice & Palliative Care CHAP Hospice Policy and Procedure Manual*, 2020 policies: 1.INITIAL ASSESSMENT, Policy No. 1-013; 2.THE PLAN OF CARE-INDIANA, Policy No. 9-017; 1.PRIORITIZING PATIENT PROBLEMS/NEEDS, Policy No. 1-033. Policy sets forth that the Interdisciplinary Group (IDG) shall	10/30/2020

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	The clinical record also contained notes from a skilled nursing facility that the patient was sent to after hospitalization for wound treatment with a wound vac (a type of device that decreases air pressure on the wound to help it heal), IV (intravenous) antibiotics for sepsis, and seizures. A 9/5/20 note indicated the patient's sacral wound increased in size from 7 to 10 cm due to loose stools, causing further infection to the sacral wound. The note also indicated the patient had a diagnosis of an anxiety disorder. On 9/1, the note indicated the patient has a deep tissue injury to the right heel possibly measuring 2.6 x 5 cm, a wound to the right trochanter measuring 2 x 0.8 x 0.1 cm, left heel measuring was described as an unstageable deep tissue injury measuring 2.5 x 6 cm, Stage IV left trochanter measured 3.5 x 3.5 x 0.4 on 8/28/20. During the patient's stay, the patient had critical labs and refused further treatment and hospice was presented. Review of the start of care comprehensive assessment dated 9/10/20, the narrative note stated the patient had been hospitalized x2 for sepsis related to the wounds and during the last hospitalization, the patient had 3 seizures and the patient consumes 3 to 6 beers daily. The note indicated the patient had a Stage 4 sacral ulcer, stage 3 left hip ulcer, stage 2 left heel ulcer and the right heel was unblancheable and boggy. The note went on to state the patient wore waffle boots and the patient was incontinent of bowel and bladder. Review of the plan of care for the benefit period of 09/10/20 to 12/8/20. The medication list on the plan of care indicated the patient was prescribed and taking alprazolam 0.5 mg every 6 hours as needed for anxiety, Baclofen 20 mg twice a day for		ensure the plan of care includes interventions for symptom control. This includes pain management, anxiety management, interventions for seizure and muscle relaxant therapy, interventions to prevent skin breakdown/infection, and interventions for education of the patient of risks while taking narcotics.The hospice registered nurse will complete an initial assessment utilizing scales/rating tools to assess for problems and to establish a baseline status of each symptom rated. Items assessed may include, but are not limited to, the following: 1.A. Pain assessment 2.B. Vital signs 3.C. Fatigue, drowsiness 4.D. Nausea, appetite 5.E. Depression, anxiety 6.F. Shortness of breath 7.G. Well-being 8.The admitting registered nurse will determine the patient's and caregiver's primary concern, goals and immediate care needs. Nurses will document teaching and interventions performed during all visits in accordance with the plan of care. A written individualized patient and family/caregiver plan of care will be established. The care provided to the patient must be in accordance with the plan of care. The plan of care will include orders for care. The plan of care will be based on	

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	151599	A. BUILDING 00 B. WING	10/01/2020

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	muscle relaxant, levetiracetam 500 mg and Vimpat 100 mg twice a day for seizures, and Norco 5 mg-325 mg tablet every 6 hours as needed for pain. The plan of care revealed only two orders to instruct: safety measures each visit and to educate patient/ family on oxygen use and safety at each visit. No other orders of instruction was indicated in the plan of care. The goals included, but limited to, the patient/ caregiver will understand the pain scale. The plan of care failed to interventions for pain management, patient's anxiety, muscle relaxant, seizures, interventions to prevent any further skin breakdown/ infection, and interventions to education the patient of consuming alcohol while taking narcotics. During an interview on 10/1/20 at 9:14 a.m., the patient's caregiver stated the patient had been on Xanax for years for anxiety and the patient had horrible dysreflexia, which caused his legs to spasm, and does have pain and discomfort, and utilizes the Baclofen routinely and Norco as needed. The above findings were reviewed with the Regional Director of Compliance, Director of Nursing, Patient Care Manager of the Bloomington Branch, and Administrator on 10/01/2020 at 1:20 p.m., in which the team had no further information or documentation to provide.		the initial, comprehensive and ongoing comprehensive assessments performed by members of the interdisciplinary group and will be reviewed on a regular basis but no less than every fifteen (15) days. This plan will focus on identified problems, goals, and interventions. The patient and family/caregiver will be encouraged to participate in the development of and continued updating of the plan of care and will be advised of any changes to the plan of care. A written, individualized plan of care will be established to assist with identification and prioritization of patient immediate problems/needs. The plan of care should include: A. Patient and family/caregiver needs (prioritized) 9.B. Goals 10.C. Dates problems identified/onset D. Resolution dates **How are you going to prevent the deficiency from recurring in the future, even if already corrected?** 1.100% Focused chart audit for 90 days on Admissions, then ongoing, 10% review each quarter to ensure appropriate symptom control interventions and response are charted; 2.100% Focused audit prior to each Interdisciplinary Group	

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			Meeting/IDG, then ongoing, 10% each quarter to ensure appropriate symptom control interventions and response are charted; 3.Threshold for focused audits is 100% compliance with plan of care that includes interventions for symptom control. If threshold not met, Patient Care Managers will re-educate involved staff, progressively, involving human resources for work plans, if needed. **Who is going to be responsible for prevention above: i.e., director, supervisor, etc.?** Patient Care Managers (PCMs) are responsible for audits and staff correction. PCMs will be overseen by Director(s) of Clinical Services (DCS) who report to the Administrator. The Administrator shall report Focus audit results to the QAPI Committee and then the Governing Body for three consecutive quarters. **By what date are you going to have the deficiency corrected?** 10/30/20. Nurses completed re-education by 10/30/20. By no later than 10/30/20, the organization will have implemented 100% Focus audits on symptom control interventions at Admission and Prior to each IDG.	

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S 0548 Bldg. 00	418.56(c)(3) CONTENT OF PLAN OF CARE [The plan of care must include all services necessary for the palliation and management of the terminal illness and related conditions, including the following:] (3) Measurable outcomes anticipated from implementing and coordinating the plan of care. Based on record review and interview, the Interdisciplinary Group (IDG) failed to ensure the plan of care included measurable goals for 1 of 1 active record reviewed. (Patient #2) Finding include: The clinical record for patient #2, Election date 9/10/20, included history and physicals from an entity dated 8/14/20, which stated the patient had a history of C6 spinal cord injury after a motor vehicle accident in 2002 that resulted in the patient becoming a paraplegic, had sacral/ ischial and heel wounds. The patient was admitted prior to this hospitalization for sepsis related to wound infections. The patient underwent debridement and antibiotic therapy. The patient returned to the hospital due to unresponsiveness and fever. The patient was treated again for recurrent sepsis and ended up having 3 seizures during their hospital stay. The clinical record also contained notes from a skilled nursing facility that the patient was sent to after hospitalization for wound treatment with a wound vac (a type of device that decreases air pressure on the wound to help it heal), IV (intravenous) antibiotics for sepsis, and seizures. A 9/5/20 note indicated the patient's sacral wound increased in size from 7 to 10 cm (centimeters) due	S 0548	**S 548** [The plan of care must include all services necessary for the palliation and management of the terminal illness and related conditions, including the following:] (3) Measurable outcomes anticipated from implementing and coordinating the plan of care.48 418.56(c)(3) CONTENT OF PLAN OF CARE **How are you going to correct the deficiency? If already corrected, include the following steps and state date of correction.** From 10/14/20-10/30/20, all Nurses were In-serviced on the following *Premier Hospice & Palliative Care CHAP Hospice Policy and Procedure Manual*, 2020 policies: 1.INITIAL ASSESSMENT, Policy No. 1-013; 2.THE PLAN OF CARE-INDIANA, Policy No. 9-017; 3.PRIORITIZING PATIENT PROBLEMS/NEEDS, Policy No. 1-033. Policy sets forth that the Interdisciplinary Group (IDG) shall	10/30/2020

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	to loose stools, causing further infection to the sacral wound. The note also indicated the patient had a diagnosis of an anxiety disorder. On 9/1/20, the note indicated the patient had a deep tissue injury to the right heel possibly measuring 2.6 x 5 cm, a wound to the right trochanter measuring 2 x 0.8 x 0.1 cm, left heel measuring was described as an unstageable deep tissue injury measuring 2.5 x 6 cm, Stage IV left trochanter measured 3.5 x 3.5 x 0.4 cm on 8/28/20. During the patient's stay, the patient had critical labs and refused further treatment and hospice was presented. Review of the start of care comprehensive assessment dated 9/10/20, the narrative note stated the patient had been hospitalized x2 for sepsis related to the wounds and during the last hospitalization, the patient had 3 seizures and the patient consumed 3 to 6 beers daily. The note indicated the patient had a Stage 4 sacral ulcer, stage 3 left hip ulcer, stage 2 left heel ulcer, and the right heel was unblancheable and boggy. The note went on to state the patient wore waffle boots and the patient was incontinent of bowel and bladder. The pain assessment failed to evidence an acceptable pain range/ goal established by the patient. Review of the plan of care for the benefit period of 09/10/20 to 12/8/20. The medication list on the plan of care indicated the patient was prescribed and taking alprazolam 0.5 mg (milligrams) every 6 hours as needed for anxiety, Baclofen 20 mg twice a day for muscle relaxant, levetiracetam 500 mg and Vimpat 100 mg twice a day for seizures, and Norco 5 mg-325 mg tablet every 6 hours as needed for pain. The plan of care revealed only two orders to instruct: safety measures each visit and to educate patient/ family on oxygen use and safety at each visit. No other orders of instruction		ensure the plan of care includes patient specific, measurable goals and outcomes. This includes measurable goals for pain and anxiety management, seizure control, dysreflexia, prevention of skin breakdown/infection, and education for patient and caregivers on risks, including narcotic interactions. The hospice registered nurse will complete an initial assessment utilizing scales/rating tools to assess for problems and to establish a baseline status of each symptom rated. Items assessed may include, but are not limited to, the following: 1.A. Pain assessment 2.B. Vital signs 3.C. Fatigue, drowsiness 4.D. Nausea, appetite 5.E. Depression, anxiety 6.F. Shortness of breath 7.G. Well-being 8.The admitting registered nurse will determine the patient's and caregiver's primary concern, goals and immediate care needs. Nurses will document teaching and interventions performed during all visits in accordance with the plan of care. A written individualized patient and family/caregiver plan of care will be established. The care provided to the patient must be in accordance with the plan of care. The plan of care will include orders for care. The plan of care will be based on	

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	were indicated in the plan of care. The plan of care failed to include an acceptable pain range as measurable goal and failed to include measurable goals in regards to the patient's wounds, anxiety, muscle relaxant, seizures, to prevent further skin breakdown/ infection and goals for patient/ caregiver understanding of mixing alcohol with narcotics. During an interview on 10/1/20 at 9:14 a.m., the patient's caregiver stated the patient had been on Xanax for years for anxiety and the patient had horrible dysreflexia, which caused his legs to spasm, and does have pain and discomfort, and utilizes the Baclofen routinely and Norco as needed. The above findings were reviewed with the Regional Director of Compliance, Director of Nursing, Patient Care Manager of the Bloomington Branch, and Administrator on 10/01/2020 at 1:20 p.m., in which no further information or documentation was provided.		the initial, comprehensive and ongoing comprehensive assessments performed by members of the interdisciplinary group and will be reviewed on a regular basis but no less than every fifteen (15) days. This plan will focus on identified problems, goals, and interventions. The patient and family/caregiver will be encouraged to participate in the development of and continued updating of the plan of care and will be advised of any changes to the plan of care. A written, individualized plan of care will be established to assist with identification and prioritization of patient immediate problems/needs. The plan of care should include: A. Patient and family/caregiver needs (prioritized) 9.B. Goals 10.C. Dates problems identified/onset D. Resolution dates **How are you going to prevent the deficiency from recurring in the future, even if already corrected?** 1.100% Focused chart audit for 90 days on Admissions, then ongoing, 10% review each quarter to ensure measurable goals are included in the plan of care; 1.100% Focused audit prior to each Interdisciplinary Group Meeting/IDG, then ongoing, 10%	

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			each quarter to ensure appropriate measurable goals are included in the plan of care update; 2.Threshold for focused audits is 100% compliance with plan of care that includes interventions for symptom control. If threshold not met, Patient Care Managers will re-educate involved staff, progressively, involving human resources for work plans, if needed. **Who is going to be responsible for prevention above: i.e., director, supervisor, etc.?** Patient Care Managers (PCMs) are responsible for audits and staff correction. PCMs will be overseen by Director(s) of Clinical Services (DCS) who report to the Administrator. The Administrator shall report Focus audit results to the QAPI Committee and then the Governing Body for three consecutive quarters. **By what date are you going to have the deficiency corrected?** 10/30/20. Nurses completed re-education by 10/30/20. By no later than 10/30/20, the organization will have implemented 100% Focus audits on patient measurable goals at Admission and Prior to each IDG.	

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S 0553 Bldg. 00	418.56(d) REVIEW OF THE PLAN OF CARE A revised plan of care must include information from the patient's updated comprehensive assessment and must note the patient's progress toward outcomes and goals specified in the plan of care. Based on record review and interview, the IDG (Interdisciplinary Group) failed to ensure the revised plan of care included the patient's progress toward outcomes and goals as specific in the plan of care for 2 of 3 records reviewed. (Patient #1, 2) Findings include: 1. Review of an agency policy titled "Interdisciplinary Group Meeting Policy No. 1-036.1) dated 5/11/20, indicated " ... Each patient's plan of care will be updated utilizing the results from the ongoing comprehensive assessment ... Procedure ... 6. An interdisciplinary group meeting plan of care update form will be used for update of the patient and family/ caregiver ... It will note changes, response to treatment and progress toward targeted outcomes, with may include: A. Pharmacotherapeutic effectiveness of symptoms management outcomes. B. An increase or decrease in symptoms or acuity ... 2. Pain management 3. Condition of skin/ presence/ status of pressure ulcers ... H. Plan for changes in treatments or procedures. 2. The clinical record for patient #1, start of care 8/6/20, was reviewed and included a plan of care for the benefit period of 8/6/20 to 10/4/20. The plan of care included goals of "Patient, family, caregivers are knowledgeable and involved in hospice plan of care for patient ... pt/cg (patient/	S 0553	**S 553** 418.56(d) REVIEW OF THE PLAN OF CARE A revised plan of care must include information from the patient's updated comprehensive assessment and must note the patient's progress toward outcomes and goals specified in the plan of care. **How are you going to correct the deficiency? If already corrected, include the following steps and state date of correction.** From 10/14/20-10/30/20, all Nursing staff were In-serviced on the following *Premier Hospice & Palliative Care CHAP Hospice Policy and Procedure Manual*, 2020 policies and rules: 1.PRIORITIZING PATIENT PROBLEMS/NEEDS, Policy No. 1-033; 2.MONITORING PATIENT'S RESPONSE/REPORTING TO PHYSICIAN, Policy No. 1-010; 3.ONGOING COMPREHENSIVE ASSESSMENT, Policy No. 1-015. Involved staff acknowledged this in-service re-training in writing: Organization policies set forth that the IDG (Interdisciplinary Group)	10/30/2020

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	caregiver) will verbalize understanding of indications, uses, and side effects of each medication and administer medications as prescribed as evidenced by no adverse effects from medication error, narcotic counts will be correct each visit through next benefit period. Patient/ Caregiver will understand the numeric pain scale, how to manage pain and report changes to hospice. Pt [Patient] will rate pain at 5/10 or less by the end of each nursing visit by utilizing pain medications as ordered throughout benefit period. Comfort medications will be given as ordered. Patient will have an effective bowel program AEB [as evidenced by] pt having a BM [bowel movement] at least every 3 days throughout benefit period. Pt will be free of s/s [signs and symptoms] constipation. Pt will be free of s/s of N/V [nausea/ vomiting] by the end of the nrsg [nursing] visit through next benefit period. Anxiety/ agitation/ restlessness will be managed with use prn [as needed] lorazepam as ordered through next benefit period. Patient will rate dypsnea at 5/10 or less by the end of each nursing visit through next benefit. Patient will maintain optimal cardiac function and within constraints of disease AEB dypsnea rating of 5/10 or less rest by the end of each nursing visit through next benefit period. Patient's respiratory status will be stabilized to comfort as possible AEB no adventitious lung sounds, discolored sputum r/t [related to] increased productive cough or increased SOA [shortness of air] throughout benefit period. Patient/ caregiver will be able to verbalize measures to promote comfort related to respiratory system in the terminal patient through next benefit period. Pt will wear oxygen as ordered through next benefit period. Patient will demonstrate oxygen saturation to patient's optimal level through benefit period. Patient will have safety needs met AEB no falls or injury		shall ensure the revised plan of care includes the patient's progress toward outcomes and goals as specified in the plan of care update. Clinicians will monitor, document, and report the patient's response to care and treatment provided on each hospice visit in IDG coordination. Progress of goals will be measured at regular intervals and updated on the plan of care. Clinicians will establish and maintain ongoing communication with the patient's physician and the hospice Medical Director to ensure responsive medical care for the patient. A revised plan of care must include information from the patient's updated comprehensive assessment and must note the patient's progress toward outcomes and goals as specified in the plan of care. IDG Discussion shall note patient progress toward wound healing/wound goals, increased use of symptom control medications, identify lack of symptom assessment and related goals, patient changes in status, and implement updated goals and interventions for actively dying patients. **How are you going to prevent the deficiency from recurring in the future, even if already corrected?** 1.100% Focused audit prior to each Interdisciplinary Group	

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	throughout benefit period. Patient/ caregiver understand the risks and benefits of side rail use through next benefit period. Patient needs will be met throughout the next benefit period ... Patient will receive personal care and hygiene, including other activities of daily living to their optimal level AEB remaining odor free, having a neat/ clean appearance through next benefit period. Patient/ Caregiver understand the risk and benefits of side rail use through next benefit period." Review of the agency's document titled 8/19/20 Hospice IDG Comprehensive Assessment and Plan of Care Update for patient #1, included IDG notes from skilled nursing visits. The Plan of Care Update failed to evidence the patient's/ caregiver progress towards all goals listed on the plan of care, as well as the specific medication that was educated as evidenced by the following: The 8/7/20 IDG note indicated the education provided were safety and comfort medication. Narcotic count indicated: Norco 12, Roxanol 30 ml, and Lorazepam 10. No falls. Patient and/ or caregiver understand the appropriate use, use of side rails and returns demonstration, and dexamethasone was called into the patients pharmacy. Review of the skilled nursing visit note indicated the only interventions/ goals achieved was pain management and safety. The 8/8/20 IDG note indicated "N/A" to education provided. Narcotic count indicated: Norco 12, Morphine (Roxanol) 30 ml, and Lorazepam 20. No falls. Patient and/ or caregiver understand the appropriate use of side rails and returns demonstration. Respirations even but slightly labored at rest at times and the patient denied a need for intervention, no edema, and DME (durable medical equipment) concerns. Review of		Meeting/IDG, then ongoing, 10% each quarter to ensure updates and progress toward measurable goals is included in plan of care update; 2.Threshold for focused audits is 100% compliance with plan of care that includes updates and progress toward measurable goals. If threshold not met, Patient Care Managers will re-educate involved staff, progressively, involving human resources for work plans, if needed. **Who is going to be responsible for prevention above: i.e., director, supervisor, etc.?** Patient Care Managers (PCMs) are responsible for audits and staff correction. PCMs will be overseen by Director(s) of Clinical Services (DCS) who report to the Administrator. The Administrator shall report Focus audit results to the QAPI Committee and then the Governing Body for three consecutive quarters. **By what date are you going to have the deficiency corrected?** 10/30/20. Nurses completed re-education by 10/30/20. By no later than 10/30/20, the organization will have implemented 100% Focus audits on progress toward patient measurable goals Prior to each IDG.	

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	the skilled nursing visit note indicated the only interventions/ goals achieved was pain management and safety. The 8/9/20 IDG note indicated "N/A" to education provided. Narcotic count indicated: Norco 12, Morphine (Roxanol) 29.5 ml, and Lorazepam 20. No falls. Patient and/ or caregiver understand the appropriate use of side rails and returns demonstration. Over the counter eye drops used and spouse instructed on hospice not delivering medications. Review of the skilled nursing visit note indicated the only interventions/ goals achieved was pain management and safety. The 8/10/20 IDG note indicated the education provided were safety and comfort medication. Narcotic count indicated: Norco 12, Roxanol 28 ml, Lorazepam 21. No falls. Patient and/ or caregiver understand the appropriate use of side rails and returns demonstration. Shortness of breath at baseline. Concerns and request for a trapeze for the patient's bed. Review of the skilled nursing visit note indicated the only interventions/ goals achieved was pain management and safety. The 8/13/20 IDG note indicated the education provided were safety and comfort medication. Narcotic count indicated: Norco 12, Roxanol 28 ml, Lorazepam 20. No falls. Patient and/ or caregiver understand the appropriate use of side rails and returns demonstration. Shortness of breath at baseline. Spouse requests a bariatric bed extender and was advised that it was not available. Review of the skilled nursing visit note indicated the only interventions/ goals achieved was pain management and safety. The 8/17/20 IDG note indicated the education			

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PREMIER HOSPICE & PALLIATIVE CARE - INDIANA LLC	11550 N MERIDIAN STREET, SUITE 375 CARMEL, IN 46032

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	provided was on safety and comfort medication. Narcotic count indicated: Norco 12, Roxanol 28 ml, Lorazepam 21. No falls. and/ or caregiver understand the appropriate use of side rails and returns demonstration. The patient had tachycardia with an irregular heart rate of 140-160, new order for cardizem 120 mg daily was called into the pharmacy. No shortness of breath above baseline. Review of the skilled nursing visit note indicated the only interventions/ goals achieved was pain management and safety. 3. The clinical record for patient #2, start of care 9/10/20, was reviewed and included a plan of care for the benefit period of 9/10/20 to 12/8/20. The medication list indicated the patient was prescribed Xanax 0.5 mg every 6 hours as needed for anxiety, Baclofen 20 mg tables 2 times daily for muscle relaxant, Lorazepam 1 mg tablet every 4 hours as needed for anxiety, agitation, and restlessness, Norco 5 mg - 325 mg tablet 1 every 6 hours as needed for pain, and Morphine concentrate 100 mg/ 5 ml (20 mg/ml) oral solution give 0.25 ml every 4 hours as needed for pain or air hunger. The interventions indicated the hospice nurse to obtain blood sugar readings from the patient/ caregiver at each visit, wound treatment to 3 pressure ulcers (located at the left trochanter, sacral, and left heal), and failed to evidence a goal of what is an acceptable level of pain. Review of the comprehensive assessment dated 9/10/20, failed to include an acceptable pain range. Review of the wound assessment indicated the patient had a stage 3 wound to the left greater trochanter that measured 10 (L) x 8.5 (W) x 0.5 (D) centimeters (cm), with < 25 % granulation tissue and 51-75% necrotic tissue; the sacral wound was stage 4 wound that measured 18 x 25 x 1.5 cm,			

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	depth description indicated a full thickness wound with 25 - 50 % necrosis and 26 - 50% necrotic tissue slough; and a stage 2 wound to the left heel that measured 7.6 x 7.6 x 0.1 cm, depth description indicated a partial thickness wound with 100% epithelialization and 0-25 % necrotic tissue slough and eschar. Review of the skilled nursing visit note dated 9/13/20 and 9/14/20, the interventions provided indicated "Instructed patient/ caregiver on wound care ... Instructed patient/ caregiver in performing wound care including proper disposal of used wound supplies ... Instructed patient/ caregiver in preventative skin care ... Instructed patient/ caregiver regarding proper nutrition including calories/ protein intake necessary to promote wound healing ... Identified sources of pressure ... " The plan of care failed to be updated to include these interventions and the prospective measurable goals for these interventions. Review of the 9/16/20 Hospice IDG Comprehensive Assessment and Plan of Care update, the Medical Director note indicated the patient had an unstageable wound on the right heel and wears waffle boots, which failed to be supported by the comprehensive nursing assessments. The IDG note made by the Patient Care Manger, and not by the patient's case manager, indicated "See Admission Note" versus providing information in regards to the patient wounds and the progress or lack there of with the current wound treatment. The note failed to include if any other interventions were offered to the patient in regards to pressure relieving mattress, blood sugar readings, and reason for morphine not being in the home and any other education that needs to be provided to the patient and their caregiver.			

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	Review of the skilled nursing visit note dated 9/16/20, indicated the last bowel movement was on 9/9/20 when the 9/14/20 visit note indicated 9/14/20. The Integumentary assessment indicated there were 3 pressure ulcers, but only identified one at stage 3 and 4, and inaccurately indicated zero to stage 2 pressure ulcers. The visit note identified the patient is a diabetic but failed to include an assessment of blood sugars, the patient's repeat pain assessment "N/A - Patient was at or below their acceptable level for pain during the initial pain assessment", the functional assessment indicated the patient was a quadriplegic with the patient is a paraplegic, the wound assessment indicated the left trochanter is a stage 3 but a suspected deep tissue injury with a large amount of purulent draining with a strong odor with 76-100% necrotic slough tissue and 025% of necrotic eschar tissue, the sacral wound is a stage 4 but described as a suspected deep tissue injury with a moderate amount of purulent drainage and a strong odor with 0-25% of necrotic slough and eschar tissue, and the left heel is a stage 2 but described as a suspected deep tissue injury with 75-100% epithelialization tissue, soft black necrotic tissue and 0-25% necrotic slough tissue. The wound identification and assessments failed to be consistent and accurate according to the wound assessment websites. The narrative note indicated the patient was having episodes of a fixed stare without identifying this as a possible seizure incident. The narrative indicated the patient was out of Norco and the patient had pain in the left arm on 9/15/20. The visit note failed to indicate if the physician was notified of the odor and drainage of the wounds and possible seizure. The interventions provided indicated "Hospice comfort kit reviewed and is intact with current			

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	expiration dates, instructed patient/ caregiver regarding use of comfort kit. The IDG note dated 9/17/20 indicated the narcotic count was not completed due to multiple family members in the home and the caregiver was uncomfortable getting the medications out. Review of the skilled nursing visit note dated 9/18/20 indicated the patient was confused and lethargic, anxiety does not significantly affect the patient, the patient's repeat pain assessment "N/A - Patient was at or below their acceptable level for pain during the initial pain assessment" but the narrative note indicated the clinician gave the patient lorazepam and hydrocodone due to the patient being confused speaking in nonsensical sentences and wincing. The note indicated the patient was "active" and notified the physician, discontinued routine medications, and only ordered comfort medications/ scheduled Morphine and Lorazepam. The narcotic count within the narrative note indicated Hydrocodone 25, Roxanol 30 ml, Lorazepam 29. The count failed to include the patient's Xanax. Review of the 9/19/20 IDG note indicated the narcotic count as follows: Morphine is not in the home. Lorazepam 22 tab, Xanax 11 tabs, Norco 45 tabs. Review of the skilled nursing visit note dated 9/19/20, the Integumentary section indicated that the patient had zero pressure ulcers, the patient was alert and oriented x3, anxiety does not affect the patient, the patient's worst pain level in the last 24 hours, on a scale of 1-10 (with 10 being the worse pain) was a 6 but currently has no pain, the patient's repeat pain assessment "N/A - Patient was at or below their acceptable level for pain during the initial pain assessment". The IDG narcotic count for the morphine was inconsistent with the narcotic count on 9/18, the			

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	inconsistent number of Norco from 25 tabs on 9/18 to current 45 tab, and failed to identify an assessment of the patient's anxiety level due to 7 Lorazepam tabs being used from previous day. Review of the 9/20/20 IDG note indicated the narcotic count as follows: Morphine is not in the home which is inconsistent from 9/18/20. Lorazepam 21 tabs, Xanax 11 tabs, Norco 42 tabs. Review of the skilled nursing visit note dated 9/20/20, indicated the patient did not have anxiety that significantly affected him/ her, the pain assessment continued to indicate the patient has no pain or pain does not interfere with activity or movement and the repeat pain assessment indicated "N/A - Patient was at or below their acceptable level for pain during the initial pain assessment" but the narrative note indicated the patient reported the prn Norco was effective in managing their pain. The visit note failed to include an assessment of the patient anxiety and pain level due to the use of the narcotics. Review of the skilled nursing visit note dated 9/21/20, indicated the patient did not have anxiety that significantly affected him/ her, the pain assessment continued to indicate the patient has no pain or pain does not interfere with activity or movement and the repeat pain assessment indicated "N/A - Patient was at or below their acceptable level for pain during the initial pain assessment." The left trochanter wound assessment indicated the depth description was extensive and the patient had a large amount of purulent drainage with a strong odor, the sacral wound assessment indicated the depth description was extensive with a strong odor, and the left heel continued to be a stage 2 but the depth description was described as necrotic. The narcotic count within the narrative indicated			

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	Norco 35 (7 tabs taken within 24 hours), Lorazepam was blank, Roxanol 29 ml, and Xanax 11. The visit note failed to include an assessment of the patient anxiety and pain level due to the use of the narcotics. Review of the skilled nursing visit note dated 9/23/20, indicated the patient did not have anxiety that significantly affected him/ her, the pain assessment continued to indicate the patient has no pain or pain does not interfere with activity or movement and the repeat pain assessment indicated "N/A - Patient was at or below their acceptable level for pain during the initial pain assessment." The left trochanter wound assessment indicated the depth description was extensive and the patient had a large amount of purulent drainage with a strong odor, the wound measurement indicated 5 x 5 x 0.5 cm with <2 cm undermining (0.5 cm at 12 - 3 o'clock, 3 - 6 at o'clock, 6-9 at o'clock, and 9-12 at o'clock) and 1 cm of tunneling at 9-12 o'clock. The sacral wound assessment indicated the depth description was extensive and had a strong odor, with < 2 cm undermining (1 cm at 12 - 3 o'clock, 3 - 6 at o'clock, 6-9 at o'clock, and 9-12 at o'clock) and 1 cm of tunneling at 9-12 o'clock. The left heel continued to be a stage 2 but the depth description was described as necrotic with a measurement of 5 x 6 x 0.1 cm. The wound identification and assessments failed to be consistent and accurate according to the wound assessment websites. The narcotic count within the narrative note indicated Norco 26 (9 tabs taken within 48 hours), Lorazepam 9 (12 tabs taken in 72 hours in conjunction with Xanax), Roxanol (Morphine) 30 ml, and Xanax 7 (4 tabs taken in 72 hours in conjunction with Lorazepam). The caregiver requested refills on the Xanax and Lorazepam. The visit note failed to evidence a comprehensive			

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	assessment of the patient's use of pain and anti-anxiety medications. Review of the skilled nursing visit note dated 9/25/20, indicated the patient did not have anxiety that significantly affected him/ her, the pain assessment continued to indicate the patient has no pain or pain does not interfere with activity or movement and the repeat pain assessment indicated "N/A - Patient was at or below their acceptable level for pain during the initial pain assessment." The left trochanter wound assessment indicated the depth description was extensive and the patient had a large amount of purulent drainage with moderate odor, <25 % epithelialization, 76-100% Necrotic tissue slough and 0-25% Necrotic tissue eschar. The assessment failed to evidence a wound measurement but included <2 cm undermining (2 cm at 12 - 3 o'clock, 3 - 6 at o'clock, 6-9 at o'clock, and 9-12 at o'clock) and no tunneling. The sacral wound assessment indicated the depth description was extensive with moderate odor, <25% epithelialization 0-25% of necrotic tissue with slough and eschar. The assessment failed to evidence a wound measurement but included < 2 cm undermining (2 cm at 12 - 3 o'clock, 3 - 6 at o'clock, 6-9 at o'clock, and 9-12 at o'clock) and 2 cm of tunneling at 9-12 o'clock. The left heel continued to be a stage 2 but the depth description was described as necrotic without a measurement. The wound identification and assessments failed to be consistent and accurate according to the wound assessment websites. The narcotic count within the narrative note indicated Lorazepam 33 tabs, Xanax 60 tabs, Roxanol 30 ml, and Norco 21 tabs. The visit note failed to evidence a comprehensive assessment of the patient's use of pain and anti-anxiety medications.			

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	Review of the skilled nursing visit note dated 9/28/20, indicated the patient did not have anxiety that significantly affected him/ her, the pain assessment continued to indicate the patient has no pain or pain does not interfere with activity or movement and the repeat pain assessment indicated "N/A - Patient was at or below their acceptable level for pain during the initial pain assessment." The left trochanter wound assessment indicated the depth description was extensive and the patient had a large amount of purulent drainage with strong odor, <25 % epithelialization, 76-100% Necrotic tissue slough and 0-25% Necrotic tissue eschar. The assessment failed to evidence a wound measurement but included <2 cm undermining (2 cm at 12 - 3 o'clock, 3 - 6 at o'clock, 6-9 at o'clock, and 9-12 at o'clock) and no tunneling. The sacral wound assessment indicated the depth description was extensive and with strong odor, <25% epithelialization 0-25% of necrotic tissue with slough and eschar. The assessment failed to evidence a wound measurement but included < 2 cm undermining (2 cm at 12 - 3 o'clock, 3 - 6 at o'clock, 6-9 at o'clock, and 9-12 at o'clock) and 2.5 cm of tunneling at 9-12 o'clock. The left heel continued to be a stage 2 but the depth description was described as necrotic without a measurement. The wound identification and assessments failed to be consistent and accurate according to the wound assessment websites. The narrative note indicated the patient's muscle spasms were worsening and orders were received to increase Baclofen to four times a day. The narcotic count within the narrative note indicated Lorazepam 21 tabs (12 tabs taken in 72 hours in conjunction with Xanax), Xanax 49 tabs 11 tabs taken in 72 hours in conjunction with Lorazepam), Roxanol 30 ml, and Norco 10 tabs (11 tabs taken in			

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	72 hours). The narrative note indicated education provided was safety. The interventions indicated there was instruction regarding the use of the comfort kit, instruction regarding routine inspection of the skin, instruction regarding proper positioning, regarding appropriate hydration and nutrition, and use of support surfaces. These interventions failed to be consistent with the narrative note. The visit note failed to evidence a comprehensive assessment of the patient's use of pain and anti-anxiety medications. Review of the skilled nursing visit note dated 9/30/20, indicated the patient did not have anxiety that significantly affected him/ her, the pain assessment continued to indicate the patient has no pain or pain does not interfere with activity or movement and the repeat pain assessment indicated "N/A - Patient was at or below their acceptable level for pain during the initial pain assessment." The left trochanter wound assessment indicated a measurement of 4.6 x 4.5 x 1 cm the depth description was extensive and the patient had a large amount of purulent drainage with strong odor, <25 % epithelialization, 75<100% necrotic tissue amount and 0-25% necrotic tissue slough and eschar, with <2 cm undermining (1.5 cm at 12 - 3 o'clock, 3 - 6 at o'clock, 6-9 at o'clock, and 9-12 at o'clock) and no tunneling. The sacral wound assessment indicated a measurement of 10 x 10 x 3 cm, the depth description was extensive and with small purulent drainage and strong odor, <25% epithelialization 0-25% of necrotic tissue with slough and eschar, with < 2 cm, no undermining identified and 5 cm of tunneling at 12 - 3 o'clock. The left heel wound assessment indicated a measurement of 5.5 x 6.5 x 0.1 cm, continued to be a stage 2 but the depth description was described as necrotic. The			

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	wound identification and assessments failed to be consistent and accurate according to the wound assessment websites and the sacral wound measurements of tunneling and undermining failed to be consistent with the 9/28/20 assessment. The narrative note indicated the patient's muscle spasms were worsening and orders were received to increase Baclofen to four times a day. The narcotic count within the narrative note indicated Lorazepam 18 tabs, Xanax 41 tabs 8 tabs taken in 48 hours in conjunction with Lorazepam), Roxanol 30 ml, and Norco 61 tabs. The narrative note indicated education provided was safety. The interventions indicated there was instruction regarding the use of the comfort kit, instruction regarding routine inspection of the skin, instruction regarding proper positioning, regarding appropriate hydration and nutrition, and use of support surfaces. These interventions failed to be consistent with the narrative note. The visit note failed to evidence a comprehensive assessment of the patient's use of pain and anti-anxiety medications. Review of the 9/30/20 IDG note revealed that the Medical Director's failed to include any feedback pertaining to the patient's lack of progress toward wound healing, increase use of anti-anxiety medications and pain medications and their lack of assessments and acceptable pain goal. The IDG failed to include information in regards to the patient's "stare" and failed to mention when the patient appeared to be actively dying. During an interview on 10/1/20 at 9:14 a.m., the patient's caregiver stated the patient had been on Xanax for years for anxiety and the patient had horrible dysreflexia, which caused his legs to spasm, and does have pain and discomfort, and			

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	utilizes the Baclofen routinely and Norco as needed. The caregiver also stated that they were never taught on how to provide wound care. The caregiver stated they felt the wounds were getting worse. 4. The above findings were reviewed with the Regional Director of Compliance, Director of Nursing, Patient Care Manager of the Bloomington Branch, and Administrator on 10/01/2020 at 1:20 p.m., the Director of Nursing indicated he felt the description and staging of wounds were appropriate and interventions had been approached to the patient #2, but the declined their efforts. In regards progress towards goals, the Director of Nursing and Patient Care Manager stated they felt the record met the requirement.			
S 0591 Bldg. 00	418.64(b)(1) NURSING SERVICES (1) The hospice must provide nursing care and services by or under the supervision of a registered nurse. Nursing services must ensure that the nursing needs of the patient are met as identified in the patient's initial assessment, comprehensive assessment, and updated assessments. Based on record review and interview, the nurse failed to ensure patients were accurately assessed and documentation was consistent, given the prescribed medications as received in a verbal order during the dying process, failed to indicate the time, amount, and patient response after each dose given, for 2 of 2 records reviewed of recently deceased patients. (Patient #1, 3) Findings include:	S 0591	**S 591** 418.64(b)(1) NURSING SERVICES (1) The hospice must provide nursing care and services by or under the supervision of a registered nurse. Nursing services must ensure that the nursing needs of the patient are met as identified in the patient's initial assessment, comprehensive assessment, and updated assessments.	10/30/2020

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	1. Review of an article titled Preventing Delirium at the End of Lie: Lessons From Recent Research at ncbi.nim.nih.gov indicated " ... The medications that most frequently contribute to delirium are benzodiazepines [Lorazepam], opioids [Morphine/Roxanol], and steroids ... Pain and Delirium ... For the patient with pain who is treated at the end of life, pain relief often requires opiates, and pain is difficult to assess when the patient is already confused. Moaning, grimacing, and agitation that may occur in the nightmare of agitated delirium can be misunderstood as a physically painful state. Patients who are in pain but frequently disoriented, with problems in memory and attention, cannot report accurately whether a remedy worked. ... The benzodiazepines and opioids administered in the hope of treating distress can worsen confusion ... The older patient is at greater risk of opiate-induced delirium; the risk of delirium from any cause is also greater if the patient is older. Delirium is more likely to be missed if the patient is lethargic and presents no management problem .... " 2. Review of an agency policy titled "Comfort Kits Policy No. 2-0005.A.1" dated 5/11/20, indicated " ... Education and use of Comfort Kits 1. After delivery, the visiting hospice nurse will educate the patient and family on the use and storage of the comfort kit .... " 3. The clinical record of patient #1 was reviewed on 09/30/20, and contained a plan of care for the benefit period of 08/06/20 to 10/04/20, with medication orders, included but not limited to, Lorazepam 1 mg tablet every 4 hours as needed for anxiety/ restlessness/ agitation and Morphine Concentrate 20 mg/ ml, give 0.25 ml every 4 hours as needed for severe pain/ air hunger.		**How are you going to correct the deficiency? If already corrected, include the following steps and state date of correction.** From 10/14/20-10/30/20, all Nurses were In-serviced on the following *Premier Hospice & Palliative Care CHAP Hospice Policy and Procedure Manual*, 2020 policies: 1.NURSING CARE, Policy No. 9-019; 2.IDENTIFICATION OF MEDICATION FOR ADMINISTRATION, Policy No. 2-005; 3.POSSESSION OF CERTAIN DRUGS AND OTHER HEALTHCARE ITEMS- INDIANA, Policy No 2-005.B; 4.ADMINISTRATION AND DOCUMENTATION OF MEDICATIONS, Policy No. 2-006; 5.COMFORT KITS, Policy No. 2-005.A. Involved staff acknowledged this in-service re-training in writing: Organization policies set forth that the hospice nurse will ensure patients are accurately assessed and charted assessments, narrative, and intervention documentation is consistent. Nurses may administer prescribed medications as received in a verbal order during the dying process and shall document the time, drug, amount, and patient response after each dose given.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	151599	A. BUILDING 00 B. WING	10/01/2020

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	Review of a death visit note dated 8/21/20, the narrative note stated "Patient found to be extremely restless. Order received to increase dose and frequency of morphine and lorazepam, required multiple doses of of [sic] Lorazepam and morphine with minimal effect. Call to [name of Medical Director] again and order given for haldol 1mg/hr .... " Review of the clinical record failed to evidence verbal orders that the nurse received from the Medical Director. The note failed to evidence the specific order received as well the amount and time given during each episode. During an interview on 09/30/20 at 9:20 a.m., the spouse indicated they observed between the hour of Employee A's arrival and the patient's death, 0.5 ml of Roxanol (no comfort to the patient), then a whole syringe of Roxanol (no comfort to the patient), another whole syringe of Roxanol then Lorazepam, (no comfort to the patient and family member sent to drug store to pick up Haldol), followed by another whole syringe of Roxanol and Lorazepam. The caregiver indicated she was not provided any education on the medication and felt that both medications given multiple times in an hour resulted in their loved ones death. Employee A was interviewed on 10/01/20 at 9:00 a.m. When queried on the medication given, Employee A stated "multiple multiple" doses of meds were given, had many calls to the doctor and called the Patient Care Manager. 4. The clinical record of patient #3, Election date of 9/9/20, was reviewed and included a plan of care dated 9/9/20, with a medication list of, but not limited to, Risperdal 0.25 mg at bedtime, Lorazepam 1 mg tablet every 4 hours as needed for anxiety and restlessness and Morphine		The Hospice Nurse shall: A. Manage discomfort and provide symptom relief. 1.B. Incorporate specialized nursing skills related to palliative end-of-life care into all clinical care. 1.C. Provide education on disease process, self-care, end-of-life care. 2.D. Provide emotional support to the patient and family. 3.E. Assess for risks of grief, cultural, spiritual implications exacerbated by the terminal diagnosis. 4.F. Initiate appropriate preventive and rehabilitative nursing procedures. 5.G. Prepare clinical and progress notes that demonstrate progress toward established goals. 6.H. Coordinate all services and prioritization of needs with the interdisciplinary group. 7.I. Use a case management approach and make referrals to other services as needed. 8.J. Provide specialized hospice training to other staff, family/caregivers to ensure adequate care. 9.K. Provide an ongoing evaluation of the patient and family/caregiver response to care. 10.L. Assess the ability of the caregiver to meet the patient's immediate needs. O. Assure communication	

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	(Roxanol) concentrate 100 mg/5 ml (20 mg/ml) oral solution 0.25 ml every 4 hours as needed for pain and shortness of breath. Review of a hospital paperwork dated 7/28/20 revealed the patient had a diagnosis of Dementia with behavioral disturbances and had been taking Dispersedly 0.25 mg daily then on 9/4/20, revealed the patient was in the hospital for a fractured hip which was surgically repaired and was discharged home with hydrocodone 5 mg - 325 mg. Review of a skilled nursing visit note dated 9/10/20, the pain assessment indicated the patient was not in pain and the narrative note indicated the patient stated his/her hip was a little sore., which was inconsistent with the assessment. Interventions provided section indicated the hospice comfort kit was reviewed and was intact with current expiration dates and was instructed on the use of the comfort kit. The narrative section indicated there was no narcotic count because the medications had not been picked up by the pharmacy. The interventions provided was inconsistent with the narrative section. Review of a skilled nursing visit note dated 9/11/20, the interventions provided section indicated the hospice comfort kit was reviewed and was intact with current expiration dates and was instructed on the use of the comfort kit. The narrative section indicated there was no narcotic count because the medications were not at the home and at the pharmacy. The interventions provided was inconsistent with the narrative section. Review of a skilled nursing visit note dated 9/14/20 from 10:02 p.m. to 10:34 p.m., the pain assessment indicated the patient was not in pain.		between the hospice and other health care providers involved in care. Patient and family/caregiver education and training activities will be initiated and continued throughout the course of care. Nursing services must ensure that the nursing needs of the patient are met as identified in the patient's initial assessment, comprehensive assessment, and updated assessments. Orders will be present for nurse medication administration. Orders for the administration of medications must be given by a physician (or other authorized independent practitioner) and include patient name, patient identifier, the name of the medication, dosage, dilution, route, frequency of administration, and rate of infusion. The individual receiving the order must record it, sign it immediately and have the prescribing person sign it in accordance with state and federal regulations. Licensed nursing personnel will administer and document only those medications which have been ordered by the physician, as a part of the plan of care and have been approved for safe administration and monitoring during a hospice visit. Hospice patients not residing in a nursing home will receive a comfort kit as needed, based on their comprehensive assessment. The comfort kit will contain emergency	

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	The narrative note indicated a phone call was received from the caregiver reporting the patient was restless and had bedsores. A prn (as needed) visit was made and upon arrival, the patient was alert, hallucinating, and reported he/ she was having pain, which was inconsistent with the assessment. Lorazepam and Roxanol was given. The surgical incision was slightly red and warm. The patient's buttocks had reddened areas. No measurements/ assessments were documented. New antibiotic order was received. The note indicated the patient continued to be restless and pace. Physician was contacted and orders were received to increase morphine to 0.5 ml every 4 hours and Lorazepam 2 mg every 4 hours. The patient received the 2 mg of Lorazepam and 1 ml of Morphine. The nurse also documented "prn dose repeared [sic] 2 more times." According to this note, the nurse failed to follow the new verbal orders provided by the physician and administered more Morphine and Lorazepam than what was prescribed. Review of a skilled nursing visit note dated 9/15/20, the mental assessment indicated the patient was "comatose", answered of "no" to a question asking if anxiety significantly affect the patient, and answered the patient's facial cues were "relaxed and calm expression and the "patient was at or below their acceptable level for pain during the initial pain assessment. The narrative note indicated the patient was sleeping in bed but the patient was grimacing upon arrival, which was inconsistent with the assessments. The narrative note indicated that 2 mg of Lorazepam and 0.5 ml of morphine was given. The patient became unresponsive to touch and calling. Orders were received to discontinue home medications and to schedule 2 mg of Lorazepam every 4 hours and Roxanol 0.5 ml every 4 hours.		medication(s) as ordered by the patient's physician or the Hospice Medical Director and will be maintained in the patient's home until orders are received for its use. After delivery: 1. The visiting hospice nurse will re-educate the patient and family on the use and storage of the comfort kit. The hospice nurse will notify the patient's physician or Medical Director when there is a change in the patient's condition that may warrant use of one or more medications in the comfort kit and will obtain specific orders for their use. **How are you going to prevent the deficiency from recurring in the future, even if already corrected?** 1.100% Focused chart audit for 90 days on Admissions, then ongoing, 10% review each quarter to ensure charting consistency between assessment, narrative, and intervention documentation, verbal medication orders are included in the written plan of care, and charting of hospice nurse medication administration includes time, drug, amount, and patient response after each dose given; 2.100% Focused audit prior to each Interdisciplinary Group Meeting/IDG, then ongoing, 10% each quarter to ensure charting consistency between	

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	The assessment in the visit note was inconsistent with the narrative and the skilled nurse failed to follow physician orders and administered the Lorazepam and Morphine when the patient was not displaying any signs of anxiety, restlessness, nor pain. Review of a skilled nursing visit note dated 9/16/20 at 10:29 a.m., the mental assessment indicated the patient was "comatose", answered of "no" to a question asking if anxiety significantly affect the patient, indicated the patient was restless, answered "no" when asked if patient response "are you uncomfortable because of pain" and patient had no pain or pain does not interfere with activity or movement but did indicate current severity of verbal cues of whining,whimpering, or moaning and the question of severity of facial cues indicate "drawn around mouth and eyes." The narrative note indicated the patient was trying to get up from the bed upon her arrival. The patient was moaning and crying in pain. The note indicated that orders were received to give Lorazepam and Morphine every 15 minutes until the patient was comfortable. The skilled nurse failed to document a consistent assessment and failed to evidence a time, amount of medication administered, and patient response after each dose of Morphine and Lorazepam given. Review of a skilled nursing visit note dated 9/16/20 at 8:49 p.m., the pain assessment indicated the patient facial cues were "relaxed and calm." The narrative note indicated the patient was in bed upon arrival, the patient had a calm facial expression, respirations were labored with accessory muscle use noted. The hospice nurse received an order to give "morphine and Lorazepam until every 15 minutes until		assessment, narrative, and intervention documentation, verbal medication orders are included in the written plan of care update; and to ensure charting of hospice nurse medication administration includes time, drug, amount, and patient response after each dose given; 3. Threshold for focused audits is 100% compliance with documentation of verbal order and medication administration. If threshold not met, Patient Care Managers will re-educate involved staff, progressively, involving human resources for work plans, if needed. **Who is going to be responsible for prevention above: i.e., director, supervisor, etc.?** Patient Care Managers (PCMs) are responsible for audits and staff correction. PCMs will be overseen by Director(s) of Clinical Services (DCS) who report to the Administrator. The Administrator shall report Focus audit results to the QAPI Committee and then the Governing Body for three consecutive quarters. **By what date are you going to have the deficiency corrected?** 10/30/20. Nurses completed re-education by 10/30/20. By no later than 10/30/20, the organization will have implemented 100% Focus	

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	comfortable. Lorazepam 2 mg and Morphine 1 ml given x2. No edema or mottling noted. Respirations slowed to 8. The narrative note indicated "Action taken or orders obtained [verbal orders must be written]: Morphine 1 ml every 4 hours. A physician order written on 9/16/20 at 8:49 p.m. indicated "Morphine 1 ml q [every] 4 hrs [hours], discontinued Lorazepam Intensol 2 mg/ ml. The narrative note failed to be consistent on what orders were received and written, failed to evidence any documentation of terminal restlessness, failed to evidence the time, amount, and patient response after each dose of Morphine and Lorazepam given, and failed to indicate the number of respirations per minute prior to the administration of Lorazepam and Morphine every 15 minutes. During an interview on 10/01/20 at 9:40 a.m., the spouse stated they felt that the morphine and ativan killed the patient and how guilty they felt. The spouse stated they didn't receive any education on the use or side effects. The spouse stated in the past, when the patient would have anxiety, they always gave extra risperdal which always helped. The spouse indicated the nurse came in one day when the patient was restless, asked the patient if they wanted to be comfortable, and the nurse instructed them to give the Lorazepam and Roxanol to be given routinely. The spouse stated if he/ she and the patient's adult child had known that Roxanol was morphine, they wouldn't have given the patient the medication. 5. During an interview on 9/30/20 at 4:55 p.m., when asked if nurses have the ability to administer more medications when the patient is restless/ actively dying than what is ordered, the Administrator stated "No, we do not do standing		audits on documentation of verbal orders and medication administration at Admission and Prior to each IDG.	

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	orders" and the agency did not provide or order "comfort kits." 6. The above findings were reviewed with the Regional Director of Compliance, Director of Nursing, Patient Care Manager of the Bloomington Branch, and Administrator on 10/01/2020 at 1:20 p.m., the Director of Nursing stated when patients were pretty restless, morphine and ativan was the standard medications to use.			
S 0690 Bldg. 00	418.106(b) ORDERING OF DRUGS (1) Only a physician as defined by section 1861(r)(1) of the Act, or a nurse practitioner in accordance with the plan of care and State law, may order drugs for the patient. (2) If the drug order is verbal or given by or through electronic transmission- (i) It must be given only to a licensed nurse, nurse practitioner (where appropriate), pharmacist, or physician; and (ii) The individual receiving the order must record and sign it immediately and have the prescribing person sign it in accordance with State and Federal regulations. Based on record review and interview, the agency failed to ensure nursing put verbal orders into writing, signature with date, and sent to the ordering physician for signature for 2 out of 2 closed records reviewed of patients who recently passed. (Patients #1, 3) Findings include: 1. The clinical record of patient #1 was reviewed on 09/30/20, and contained a plan of care for the benefit period of 08/06/20 to 10/04/20, with	S 0690	**S 690** 18.106(b) ORDERING OF DRUGS (1) Only a physician as defined by section 1861(r) (1) of the Act, or a nurse practitioner in accordance with the plan of care and State law, may order drugs for the patient. (2) If the drug order is verbal or given by or through electronic transmission- (i) It must be given only to a licensed nurse, nurse	10/30/2020

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	medication orders, included but not limited to, Lorazepam 1 mg tablet every 4 hours as needed for anxiety/ restlessness/ agitation and Morphine Concentrate 20 mg/ ml, give 0.25 ml every 4 hours as needed for severe pain/ air hunger. Review of a death visit note dated 8/21/20, the narrative note stated "Patient found to be extremely restless. Order received to increase dose and frequency of morphine and lorazepam, required multiple doses of of [sic] Lorazepam and morphine with minimal effect. Call to [name of Medical Director] again and order given for Haldol 1 mg/hr .... " Review of the clinical record failed to evidence verbal orders that the nurse received from the Medical Director. During an interview on 09/30/20 at 9:20 a.m., the spouse indicated they observed between the hour of Employee A's arrival and the patient's death, 0.5 ml of Roxanol (no comfort to the patient), then a whole syringe of Roxanol (no comfort to the patient), another whole syringe of Roxanol then Lorazepam, (no comfort to the patient and family member sent to drug store to pick up Haldol), followed by another whole syringe of Roxanol and Lorazepam. Employee A was interviewed on 10/01/20 at 9:00 a.m. When queried on the medication given and if the verbal order was written, Employee A stated "multiple multiple" doses of meds were given, had many calls to the doctor and called the Patient Care Manager and she didn't write the order since the patient was no longer "in the house." 2. The clinical record of patient #3, Election date of 9/9/20, was reviewed and included a plan of care dated 9/9/20, with a medication list of, but not limited to, Lorazepam 1 mg tablet every 4 hours as		practitioner (where appropriate), pharmacist, or physician; and (ii) The individual receiving the order must record and sign it immediately and have the prescribing person sign it in accordance with State and Federal regulations. **How are you going to correct the deficiency? If already corrected, include the following steps and state date of correction.** From 10/14/20-10/30/20, all Nurses were In-serviced on the following *Premier Hospice & Palliative Care CHAP Hospice Policy and Procedure Manual*, 2020 policies: 1.IDENTIFICATION OF MEDICATION FOR ADMINISTRATION, Policy No. 2-005; 2.POSSESSION OF CERTAIN DRUGS AND OTHER HEALTHCARE ITEMS- INDIANA, Policy No 2-005.B; Involved staff acknowledged this in-service re-training in writing: Organization policies set forth that the Hospice Nurse shall ensure orders will be present for nurse medication administration. Orders for the administration of medications must be given by a physician (or other authorized independent practitioner) and include patient name, patient identifier, the name of the	

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	needed for anxiety and restlessness and Morphine (Roxanol) concentrate 100 mg/5 ml (20 mg/ml) oral solution 0.25 ml every 4 hours as needed for pain and shortness of breath. Review of a skilled nursing visit note dated 9/14/20 indicated Lorazepam and Roxanol was given after arrival for restlessness. The note indicated the patient continued to be restless and pace. Physician was contacted and orders were received to increase morphine to 0.5 ml every 4 hours and Lorazepam 2 mg every 4 hours. The patient received the 2 mg of Lorazepam and 1 ml of Morphine. The nurse also documented "prn dose repeared [sic] 2 more times." Review of the clinical record failed to evidence the written orders to repeat the dosages given x 2. Review of a skilled nursing visit note dated 9/16/20 at 10:29 a.m., indicated that orders were received to give Lorazepam and Morphine every 15 minutes until the patient was comfortable. Review of the clinical record failed to evidence the written orders to give Lorazepam and Morphine every 15 minutes. Review of a skilled nursing visit note dated 9/16/20 at 8:49 p.m., indicated the hospice nurse received an order to give "Morphine and Lorazepam every 15 minutes until comfortable. Lorazepam 2 mg and Morphine 1 ml given x2. The narrative note indicated "Action taken or orders obtained [verbal orders must be written]: Morphine 1 ml every 4 hours. A physician order written on 9/16/20 at 8:49 p.m. indicated "Morphine 1 ml q [every] 4 hrs [hours], discontinued Lorazepam Intensol 2 mg/ ml. The order written failed to be consistent with what was documented within the visit note. (to give Morphine and Lorazepam every 15 minutes until		medication, dosage, dilution, route, frequency of administration, and rate of infusion. The individual receiving the order must record it, sign it immediately and have the prescribing person sign it in accordance with state and federal regulations. **How are you going to prevent the deficiency from recurring in the future, even if already corrected?** 1.100% Focused chart audit for 90 days on Admissions, then ongoing, 10% review each quarter to ensure verbal medication orders are included in the written plan of care; 2.100% Focused audit prior to each Interdisciplinary Group Meeting/IDG, then ongoing, 10% each quarter to ensure verbal medication orders are included in the written plan of care update; 3.Threshold for focused audits is 100% compliance with documentation of verbal order compliance. If threshold not met, Patient Care Managers will re-educate involved staff, progressively, involving human resources for work plans, if needed. **Who is going to be responsible for prevention above: i.e., director, supervisor, etc.?** Patient Care Managers (PCMs) are responsible for audits and staff	

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	comfortable). 3. During an interview on 9/30/20 at 4:55 p.m., when asked if nurses have the ability to administer more medications when the patient is restless/ actively dying than what is ordered, the Administrator stated "No, we do not do standing orders." 4. The above findings were reviewed with the Regional Director of Compliance, Director of Nursing, Patient Care Manager of the Bloomington Branch, and Administrator on 10/01/2020 at 1:20 p.m., in which no further information or documentation was provided.		correction. PCMs will be overseen by Director(s) of Clinical Services (DCS) who report to the Administrator. The Administrator shall report Focus audit results to the QAPI Committee and then the Governing Body for three consecutive quarters. **By what date are you going to have the deficiency corrected?** 10/30/20. Nurses completed re-education by 10/30/20. By no later than 10/30/20, the organization will have implemented 100% Focus audits on documentation of verbal orders at Admission and Prior to each IDG.	
S 0696 Bldg. 00	418.106(e)(2)(i)(B) LABEL DISPOSE STORAGE DRUGS [At the time when controlled drugs are first ordered the hospice must:] (B) Discuss the hospice policies and procedures for managing the safe use and disposal of controlled drugs with the patient or representative and the family in a language and manner that they understand to ensure that these parties are educated regarding the safe use and disposal of controlled drugs; Based on record review and interview, the agency failed to ensure the Interdisciplinary Group discussed the written policies and procedures for the safe use and disposal of controlled drugs with the patient/ caregiver in a language and manner	S 0696	**S 696** 418.106(e)(2)(i)(B) LABEL DISPOSE STORAGE DRUGS [At the time when controlled drugs are first ordered the hospice must:] (B) Discuss the hospice policies	11/12/2020

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	151599	A. BUILDING 00 B. WING	10/01/2020

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PREMIER HOSPICE & PALLIATIVE CARE - INDIANA LLC	11550 N MERIDIAN STREET, SUITE 375 CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	that they understand to ensure that the parties were educated for 1 of 3 patient records reviewed. (Patient #1) Findings include: Review of an agency's document found within the admission folder titled "Drug Disposal Guidelines" revised 11/17, stated " ... 1. ... The case manager will verbally discuss the policy in a language and manner that they understand to ensure the safe disposal medications ... Patient/ family education will be documented in the clinical record. ... 2. Upon patient death or when a hospice patient otherwise no longer has a need for one or more medications, the hospice nurse or other appropriate hospice staff will assist the patient/ family to dispose of them or will instruct the patient/ family to dispose of them according to policy. The hospice will also provide information on take-back and mail-back programs. 3. Drugs will disposed of on site .... " Review of a revised policy titled "Home Use of Controlled Substances Policy No. 2008.1" dated 5/11/20, stated " ... 2. The Admitting Nurse/ Case Manager will provide a copy of the written policies and procedures on the management of controlled drugs to the patient/ representative and family ... 6. When a hospice patient no longer has a need for a controlled substance, the Case Manager will instruct the patient and family/ caregiver regarding proper disposal." Review of a revised policy titled "Drug Disposal Policy No. 2-008.A.1" dated 5/11/20, stated " ... 1. The Admitting Nurse/ Case Manager will provide a copy of the written policies and procedures on the management and disposal of drugs, including controlled drugs to the patient/ representative and		and procedures for managing the safe use and disposal of controlled drugs with the patient or representative and the family in a language and manner that they understand to ensure that these parties are educated regarding the safe use and disposal of controlled drugs; **How are you going to correct the deficiency? If already corrected, include the following steps and state date of correction.** This area was not identified as a concern at the survey Exit Conference with the Organization. From 10/10-10/12/20, all nurses were In-serviced on the following *Premier Hospice & Palliative Care CHAP Hospice Policy and Procedure Manual*, 2020 policies: **1.Home Use of Controlled Substances; Policy No. 2-008;** **2.Drug Disposal, Policy No. 2-008.A.** Organization policies set forth that the Interdisciplinary Group shall discuss written policies and procedures for the safe use and disposal of controlled drugs with the patient/caregiver in a language and manner that they understand. The Admitting Nurse will provide a copy of the written policy and procedure on the management of controlled drugs to the patient/representative and family. The person responsible for drug	

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	family. The Admitting Nurse/ Case Manager will verbally discuss the policy in a language and manner that they understand to ensure the safe use and disposal of medication, including controlled drugs. The Admitting Nurse/ Case manager will document in the clinical record that the patient/ Representative and family have received a copy of the policies and procedures. 2. The Admitting Nurse/ Case Manager will document in a clinical note who is responsible for the disposal of the patient's drugs ... 5. The nurse will document in the medical record: disposal instructions given, the patient/ family's verbal response as to their understanding of the disposal/ process and their responsibility to properly dispose of the unneeded medication(s) ... Disposal of Controlled Substances - Family 1. When a hospice patient no longer has a need for a controlled substance, the Case Manager will instruct the patient and family/ caregiver regarding proper disposal of the drugs ... 2. The Admitting Nurse/ Case Manger will document in the clinical record that the patient and family/ caregiver were given the written policies and procedures for managing controlled drugs and discussed the disposal of medication and took responsibility to do so .... " Review of patient #1's clinical record, revealed a start of care date of 08/06/2020, and a plan of care for the benefit period of 08/06/2020 to 10/04/20, with orders for skilled nursing 3 times a week for 2 weeks then 2 times a week for 7 weeks. Review of admission note dated 8/6/20 and the following skilled nursing visit notes dated 8/7, 8/8, 8/9, 8/10, 8/13, 8/17, 8/21/2020, failed to evidence that the safe use and management of controlled substances was discussed and the patient/ family verbal response as to their understanding.		disposal will be identified. Per policy, the Admitting Nurse will verbally discuss the policy in a language and manner that they understand to ensure the safe use/disposal of controlled drugs. The responsible individual will acknowledge this education by signing the policy that is provided as part of the Hospice Patient Admission Booklet. A copy of the signed policy will be uploaded to the chart. In clinical notes, Nurses shall document the patient or caregivers understanding of this policy at admission and any time the patient or caregiver needs re-education. When a hospice patient no longer has a need for a controlled substance, the nurse will re-instruct the patient and family/caregiver regarding proper disposal. The nurse will document in the medical record: disposal instructions given, the patient/family's verbal response as to their understanding of the disposal process and their responsibility to properly dispose of the unneeded medication(s). If the patient/family refuses the disposal/destruction of medications, this will be reported to the patient's physician and clinical supervisor and documented in the patient record. **How are you going to prevent the deficiency from recurring in the future, even if already corrected?**	

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	During an interview on 09/30/20 at 9:20 a.m., the spouse indicated she thought the hospice was going to take the medications or destroy after the patient died. The spouse indicated a family member, who was a sheriff, took the medications and had them destroyed. The death visit note dated 8/21/2020 failed to evidence this information. Employee A was interviewed on 10/01/20 at 9:00 a.m., and indicated that the patient's medications were not destroyed during the death visit for she was not allowed to go back in and that the DON was made aware. The death visit note dated 8/21/2020 failed to evidence this information. The above findings were reviewed with the Regional Director of Compliance, Director of Nursing, Patient Care Manager of the Bloomington Branch, and Administrator on 10/01/2020 at 1:20 p.m., the Director of Nursing indicated he was aware of the employee not destroying patient #1's medications.		1.100% focused chart audit for 90 days on home patient Admissions, then ongoing, 10% each quarter to ensure documentation of signed policy and that patients and caregivers understand the drug disposal policy per charted education. Nurses shall securely submit a copy of signed document to the office for chart attachments. 2.100% Focused audit prior to each home patient Interdisciplinary Group Meeting/IDG, then ongoing, 10% each quarter to ensure and that patients and caregivers understand the drug disposal policy per charted re-education and that refusals are reported to the Clinical Supervisor/Designee; 3.Threshold for focused audits is 100% with evidence patient's/representative's understanding of drug disposal. If threshold not met, Patient Care Managers will re-educate involved staff, progressively, involving human resources for work plans, if needed. **Who is going to be responsible for prevention above: i.e., director, supervisor, etc.?** Patient Care Managers (PCMs) are responsible for audits and staff correction. PCMs will be overseen by Director(s) of Clinical Services (DCS) who report to the Administrator. The Administrator	

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			shall report Focus audit results to the QAPI Committee and then the Governing Body for three consecutive quarters. **By what date are you going to have the deficiency corrected?** 11/12/20. Nurses completed re-education by 11/12/20. By no later than 11/12/20, the organization will have implemented 100% Focus audits on drug disposal policy signed and education documentation at Admission and Prior to each IDG.	
S 0697 Bldg. 00	418.106(e)(2)(i)(C) LABEL DISPOSE STORAGE DRUGS [Based on record review and interview, the agency failed to ensure the clinician followed agency policy and documented in the patient's clinical record the written policies and procedures for managing controlled drugs was discussed with the patient/ caregiver for 2 of 3 (Patient #1, 2) patient records reviewed, and failed to ensure to document the name of the drug, amount, and method of disposal upon death for 1 of 2 (Patient #3) closed records reviewed. Findings include: 1. Review of an agency's document found within the admission folder titled "Drug Disposal Guidelines" revised 11/17, stated " ... 1. ... The case manager will verbally discuss the policy in a language and manner that they understand to	S 0697	**S 697** 418.106(e)(2)(i)(C) LABEL DISPOSE STORAGE DRUGS [At the time when controlled drugs are first ordered the hospice must:] (B) Discuss the hospice policies and procedures for managing the safe use and disposal of controlled drugs with the patient or representative and the family in a language and manner that they understand to ensure that these parties are educated regarding the safe use and disposal of controlled drugs; **How are you going to correct the deficiency? If already corrected, include the**	11/12/2020

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	ensure the safe disposal medications ... Patient/ family education will be documented in the clinical record. ... 2. Upon patient death or when a hospice patient otherwise no longer has a need for one or more medications, the hospice nurse or other appropriate hospice staff will assist the patient/ family to dispose of them or will instruct the patient/ family to dispose of them according to policy. The hospice will also provide information on take-back and mail-back programs. 3. Drugs will be disposed of on site .... " 2. Review of a revised policy titled "Home Use of Controlled Substances Policy No. 2008.1" dated 5/11/20, stated " ... 2. The Admitting Nurse/ Case Manager will provide a copy of the written policies and procedures on the management of controlled drugs to the patient/ representative and family ... 6. When a hospice patient no longer has a need for a controlled substance, the Case Manager will instruct the patient and family/ caregiver regarding proper disposal." 3. Review of a revised policy titled "Drug Disposal Policy No. 2-008.A.1" dated 5/11/20, stated " ... 1. The Admitting Nurse/ Case Manager will provide a copy of the written policies and procedures on the management and disposal of drugs, including controlled drugs to the patient/ representative and family. The Admitting Nurse/ Case Manager will verbally discuss the policy in a language and manner that they understand to ensure the safe use and disposal of medication, including controlled drugs. The Admitting Nurse/ Case manager will document in the clinical record that the patient/ Representative and family have received a copy of the policies and procedures. 2. The Admitting Nurse/ Case Manager will document in a clinical note who is responsible for the disposal of the		**following steps and state date of correction.** This area was not identified as a concern at the survey Exit Conference with the Organization. From 10/10-10/12/20, all nurses were In-serviced on the following *Premier Hospice & Palliative Care CHAP Hospice Policy and Procedure Manual*, 2020 policies: **1.Home Use of Controlled Substances; Policy No. 2-008;** **2.Drug Disposal, Policy No. 2-008.A.** Organization policies set forth that the Interdisciplinary Group shall discuss written policies and procedures for the safe use and disposal of controlled drugs with the patient/caregiver in a language and manner that they understand. The Admitting Nurse will provide a copy of the written policy and procedure on the management of controlled drugs to the patient/representative and family. The person responsible for drug disposal will be identified. Per policy, the Admitting Nurse will verbally discuss the policy in a language and manner that they understand to ensure the safe use/disposal of controlled drugs. The responsible individual will acknowledge this education by signing the policy that is provided as part of the Hospice Patient Admission Booklet. A copy of the signed policy will be uploaded to the chart. In clinical notes, Nurses	

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	patient's drugs ... 5. The nurse will document in the medical record: disposal instructions given, the patient/ family's verbal response as to their understanding of the disposal/ process and their responsibility to properly dispose of the unneeded medication(s) ... Disposal of Controlled Substances - Family 1. When a hospice patient no longer has a need for a controlled substance, the Case Manager will instruct the patient and family/ caregiver regarding proper disposal of the drugs ... 2. The Admitting Nurse/ Case Manger will document in the clinical record that the patient and family/ caregiver were given the written policies and procedures for managing controlled drugs and discussed the disposal of medication and took responsibility to do so. 3. The hospice nurse, social worker, or chaplain attending the death of a hospice patient will inform the family/ caregiver of their responsibility to dispose of all the patient's prescribed medications and will document this instruction in a clinical note and include the name of the drug, amount, method of disposal, and who witnessed the disposal .... " 4. Review of patient #1's clinical record revealed a start of care date of 08/06/2020, and a plan of care for the benefit period of 08/06/20 to 10/04/20, with orders for skilled nursing 3 times a week for 2 weeks then 2 times a week for 7 weeks. Review of admission note dated 8/6/20 and the following skilled nursing visit notes dated 8/7, 8/8, 8/9, 8/10, 8/13, 8/17, 8/21/2020, failed to evidence that the agency's policy was adhered to by failing to document the responsible person for the disposal, the disposal instructions given, patient/ family verbal response as to their understanding, as well as observing the medications being destroyed upon death on 8/21/2020.		shall document the patient or caregivers understanding of this policy at admission and any time the patient or caregiver needs re-education. When a hospice patient no longer has a need for a controlled substance, the nurse will re-instruct the patient and family/caregiver as needed regarding proper drug disposal. The nurse will document in the medical record: disposal instructions given, the patient/family's verbal response as to their understanding of the disposal process and their responsibility to properly dispose of the unneeded medication(s). If the family/caregiver requests assistance with the disposal, the hospice nurse will observe and provide verbal assistance as the family/caregiver properly disposes of the prescribed medication(s). The disposal will be documented in a clinical note. Documentation will include the name of the drug, amount, method of disposal, the person disposing of the drug, and the role of the hospice employee in assisting with the disposal. If the patient/family refuses the disposal/destruction of medications, this will be reported to the patient's physician and clinical supervisor and documented in the patient record. **How are you going to prevent the deficiency from recurring in the future, even if already**	

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	During an interview on 09/30/20 at 9:20 a.m., the spouse stated she thought the hospice was going to take the medications or destroy after the patient died. The spouse indicated a family member, who was a sheriff, took the medications and had them destroyed. The death visit note dated 8/21/2020 failed to evidence this information. Employee A was interviewed on 10/01/20 at 9:00 a.m., and stated that the patient's medications were not destroyed during the death visit for she was not allowed to go back in and that the DON was made aware. The death visit note dated 8/21/2020 failed to evidence this information. 5. Review of patient #2's clinical record revealed a start of care date of 09/10/2020, and a plan of care for the benefit period of 9/10/2020 to 12/08/2020, with orders for skilled nursing 3 times a week for 1 week, 4 times a week for 1 week, 3 times a week for 11 weeks, then 1 time a week for 1 week. Review of the start of care visit note dated 9/10/20 and the following skilled nursing visit notes dated 9/11, 9/12, 9/13, 9/14, 9/16, 9/18, 9/19, 9/20, 9/21, 9/23, 9/25, 9/28, and 9/30/20, failed to evidence the agency's policy was adhered to by failing to document the responsible person for the disposal, the disposal instructions given, patient/ family verbal response as to their understanding. 6. The clinical record of patient #3, Election date of 9/9/2020, included a death visit note on 9/17/20, which indicated "This writer witnessed [name of family member] destroy medications." The clinician failed to document the name of the drug, amount, and method of disposal. 7. During an interview on 9/30/20 at 4:55 p.m., when queried on who was responsible for the		**corrected?** 1.100% focused chart audit for 90 days on home patient Admissions, then ongoing, 10% each quarter to ensure documentation of signed policy, that patients and caregivers understand the drug disposal policy per charted education, and that disposal charting includes the name of the drug(s), amount(s), method of disposal, the person disposing of the drug, and the role of the hospice employee. Nurses shall securely submit a copy of signed disposal policy document to the office to be viewed in chart attachments. 2.100% Focused audit prior to each home patient Interdisciplinary Group Meeting/IDG, then ongoing, 10% each quarter to ensure and that patients and caregivers understand the drug disposal policy per charted re-education, drug disposal charting includes the name of the drug(s), amount(s), method of disposal, the person disposing of the drug, and the role of the hospice employee, and that refusals to dispose of unneeded narcotics are reported to the Clinical Supervisor/Designee; 3.Threshold for focused audits is 100% with charted drug disposal. If threshold not met, Patient Care Managers will re-educate involved staff, progressively, involving	

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	destruction of medications after death, especially narcotics, the Administrator stated that it was their policy that the clinician was not allowed to destroy the narcotics but they can witness the destruction by the family, but the family has a right to refuse. If they do refuse, the clinician on site would need to document the refusal and notify the physician. 8. The above findings were reviewed with the Regional Director of Compliance, Director of Nursing, Patient Care Manager of the Bloomington Branch, and Administrator on 10/01/2020 at 1:20 p.m., in which no further information or documentation was provided.		human resources for work plans, if needed. **Who is going to be responsible for prevention above: i.e., director, supervisor, etc.?** Patient Care Managers (PCMs) are responsible for audits and staff correction. PCMs will be overseen by Director(s) of Clinical Services (DCS) who report to the Administrator. The Administrator shall report Focus audit results to the QAPI Committee and then the Governing Body for three consecutive quarters. **By what date are you going to have the deficiency corrected?** 11/12/20. Nurses completed re-education by 11/12/20. By no later than 11/12/20, the organization will have implemented 100% Focus audits on drug disposal at Admission and Prior to each IDG.	