Based on clinical record review, document review, policy review, and interview, it was determined the hospice failed to ensure patients received the most current revision of Indiana State Department of Health Advance (see L 503); failed to ensure the patient received effective symptom control from the hospice for conditions related to the terminal illness (see L 512); and failed to ensure the confidentiality of patient records and information for 4 of 4 clinical records and records of patients from another hospice were not shared (see L 516).

The cumulative effect of these systemic problems resulted in the hospice's inability to be in compliance with IC 16-25-3 and the Conditions of Participation 42 CFR 418.52 Patients' Rights.

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<th>ID</th>
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<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>ID</th>
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<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
<th>(X5) COMPLETION DATE</th>
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<tr>
<td>L 000</td>
<td>Bldg. 00</td>
<td>L 000</td>
<td>Based on clinical record review, document review, policy review, and interview, it was determined the hospice failed to ensure patients received the most current revision of Indiana State Department of Health Advance (see L 503); failed to ensure the patient received effective symptom control from the hospice for conditions related to the terminal illness (see L 512); and failed to ensure the confidentiality of patient records and information for 4 of 4 clinical records and records of patients from another hospice were not shared (see L 516).</td>
<td>L 500</td>
<td>1 How will this be corrected? The Advanced Directive, right to decide, form has been updated and corrected to the current July 2013 edition and is will be correct in all current patient family orientation for hospice care booklets. The patients will receive effective pain management and symptom control for conditions related to terminal illnesses. The patients will have a confidential clinical record and release of patient information and clinical records will only be done in accordance with 45 CFR parts 160 and 164. 2 How will we prevent it from recurring? An inservice will be given to all Skilled field staff about the July 2013 Advanced directives update and all patient admission booklets have been updated. An inservice will be given to all skilled staff on patient rights for effective pain management and symptom control. The lease with the drop</td>
<td>04/21/2015</td>
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.
Rights.

L 503
Bldg. 00

418.52(a)(2)

NOTICE OF RIGHTS AND RESPONSIBILITIES

(2) The hospice must comply with the requirements of subpart I of part 489 of this chapter regarding advance directives. The hospice must inform and distribute written information to the patient concerning its policies on advance directives, including a description of applicable State law.

Based on admission packet review and interview, the hospice failed to ensure patients received the most current revision of Indiana State Department of Health Advance Directives for 1 of 1 admission packet reviewed.

Findings include

1. The hospice admission packet contained the Indiana State Department of Health Advance Directives Your Right to Decide, revised May 2004. The packet failed to contain the most recent off space used in Crown Point has been terminated and any Hospice materials have been removed from that location. An inservice will be done with all skilled staff regarding the policy on privacy and confidentiality of information. 3. Who is responsible to ensure the deficiency has been corrected and compliance is maintained? The Executive Director will be responsible. 4. By what date will the deficiency be corrected? 04/21/2015
2. During interview on 2/23/15 at 3:30 PM, employee A indicated they were not aware of a revision to the Advance Directives and this was the admission packet given to patients.

3. The hospice's undated admission packet titled "Patient & Family Orientation for Hospice Care," states, "XI. Patient Bill of Rights and Responsibilities ... The hospice agency must inform the patient, in advance of care, its policies on advance directives, including a description of applicable state law. The hospice agency may furnish advance directives information to a patient at the time of the first home visit, as long as the information is furnished before care is provided."

4. The hospice's undated policy titled "Advance Directives," # HSP2-6A, states, "The Agency shall update and disseminate amended information regarding advance directives as soon as possible, but no later than 90 days from the effective date of the changes to state law, to patients/families/caregivers and the community it serves."

5. During interview on 2/26/15 at 3:45 PM, employees A and H indicated there has been a correction and compliance is maintained.

The Executive Director will be responsible for:

- By what date will the deficiency be corrected?
- 04/21/2015

"deficiency has been corrected and compliance is maintained?"

"The Executive Director will be responsible 4. By what date will the deficiency be corrected? 04/21/2015"
<table>
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<tr>
<th>L 512</th>
<th>418.52(c)(1)</th>
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<tr>
<td>Bldg. 00</td>
<td>RIGHTS OF THE PATIENT</td>
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<tr>
<td>Based on clinical record review, document review, and interview, the hospice failed to ensure the patient received effective symptom control from the hospice for conditions related to the terminal illness in 1 of 3 discharged records reviewed. (#8)</td>
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<tr>
<td>Findings include:</td>
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<tr>
<td>1. Clinical record #8, start of care 1/9/15, evidenced a document electronically signed by non-employee #18 dated 1/9/15</td>
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<tr>
<th>L 512</th>
<th>1 How will this be corrected?</th>
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<tr>
<td>The patients will receive effective pain management and symptom control for conditions related to terminal illnesses 2 How will we prevent it from recurring? An inservice will be given to all skilled staff on patient rights for effective pain management. The Director of Patient Care Services/designee will review all RN case managers documentation to ensure all patients receive effective symptom control 3. Who is responsible to ensure the deficiency has been corrected</td>
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<td>04/21/2015</td>
<td>04/21/2015</td>
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titled "(SOC) [start of care] SN [skilled nursing] Clinical Note" ... Pain 6 upon nurses arrival. Caregiver encouraged to give Q 4 hr [hour] dose of morphine and ativan SL [sublingual] to comfort patient."

A. The record contained a document dated 1/9/15 titled "ADMISSION SUMMARY" stating, "Summation of Care: SN: 'Assess and instruct on needed care, wound care, assess pain/control, assess nutritional status' MSW: 'Assess for increased caregiver support' Clergy: 'Assess for other spiritual support' ... Documents Sent: (check off) or NA [not applicable] if not applicable Medicine/Tx [treatment] sheets [checked] Plan of Care [checked] ... Signature of Nurse Completing worksheet: [non-employee #18] ... ."

B. The record contained a skilled nursing visit note dated 1/15/15 with an electronic signature of employee D (registered nurse). This was the next nursing visit for this patient.

C. The record contained a skilled nursing visit note dated 1/15/15 with an electronic signature of employee D stating, "SN Clinical Note Date 1/15/2015 In 12:35 PM Out 01:00 PM.

and compliance is maintained? The Executive Director will be responsible. By what date will the deficiency be corrected? 04/21/2015
D. The record contained a skilled nursing visit note dated 1/15/15 with an electronic signature of employee L stating, "SN Clinical Note Date 1/15/2015 In 01:03 PM Out 02:03 PM.

2. On 2/25/15 at 11 AM, employee A indicated hospice services were initiated on 1/9/15 by non-employee #18 and the plan of care should have been initiated on 1/9/15. The director of clinical services indicated he/she reviewed the plan of care on 1/15/15 and that is why it did not get initiated until 1/15/15. The employee indicated non-employee #18 failed to communicate the plan of care to all other disciplines involved in the patient's care.

3. The hospice admission packet contained a document titled "PATIENT & FAMILY ORIENTATION FOR HOSPICE CARE" stating, "Patient Bill of Rights and Responsibilities ... The patient has the right to: ... Receive effective pain management and symptom control for conditions related to terminal illness(es). ... ."

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**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**IDENTIFICATION NUMBER:** 151598

**DATE SURVEY COMPLETED:** 02/26/2015

**NAME OF PROVIDER OR SUPPLIER:** NIGHTINGALE HOSPICE

**STREET ADDRESS, CITY, STATE, Zip CODE:** 6347 CONSTITUTION DRIVE, FORT WAYNE, IN 46804

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<td>L 516</td>
<td>D. The record contained a skilled nursing visit note dated 1/15/15 with an electronic signature of employee L stating, &quot;SN Clinical Note Date 1/15/2015 In 01:03 PM Out 02:03 PM.</td>
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(5) Have a confidential clinical record. Access to or release of patient information and clinical records is permitted in accordance with 45 CFR parts 160 and 164.

Based on observation at office located at Crown Point Indiana, clinical record review, document review, policy review, and interview, the hospice failed to ensure the confidentiality of patient records and information for 4 of 4 clinical records and records from another hospice were not shared creating the potential to affect all the hospice's patients. (#s 1, 2, 3, and 4)

Finding

1. Confidential medical information found in an unlocked office at the Crown Point office location at second observation (#3) were confidential medical documents for patient #1 and other patients. The office was located at 9150 E 109th Avenue Suite #3A, Crown Point.

2. This was the first observation. The agency address was located inside a brick 3 story professional office building at 9150 E 109th Avenue Suite # 3 A, Crown Point. On arrival at the agency address on 2/23/15 at 8:30 AM, entering the front door, there was a large sign with the names and floors of the business entities located in the building at 9150 E 109th
Avenue, Crown Point. The hospice name was not observed on this signage. Surveyor took the elevator, located next to the sign, to the 3rd floor. To the left of the elevator was a corridor, and immediately to the right of the corridor was a glass door with the name of another agency and daily hours of operation listed as 8:30 AM - 4:30 PM Monday-Friday and a phone number 219-310-8537. Inside the glass door was a hallway with two suites. No one answered when the surveyor knocked on the door.

3. This was the second observation. On 2/23/15 at 9:06 AM, the surveyor visited the office at 9150 E 10th Avenue, Crown Point, on the 3rd floor for a second time. The front door to these suites was unlocked. The suite mentioned in the complaint was to the far right of the entry way. The surveyor knocked on the door. There was no answer. The surveyor opened the door and asked if anyone was inside. No one answered. Inside this office were a conference room, three individual offices, a kitchen area with a copy machine, and a storage room. One office had a fax machine and large L shaped desk and file cabinet. Inside the file cabinet were two large lists of patients. One list was dated 2003 (Document A) and one was dated...
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12/3/14 (Document B)  Inside the desk drawer were resumes of applicants for nursing and marketing positions and other documents C - F and H and J.

Another office contained a large box with marketing material and a letter from Non-employee #1 of the Ft. Wayne office (Document #I). The storage room was filled with medical supplies including syringes and blood specimen tubes. There was also a box with blank chart documents with the name of the Ft. Wayne hospice or the Ft. Wayne hospice phone number on the documents including document #G.

4. An agency document titled "Information sheet" with the name of patient #1 scratched out but still legible included the patient's address, date of birth, diagnosis of liver cancer, Medicare number (scratched out but still legible), and other information about this patient. This document was found in the office desk drawer of the unlocked office. This is document #C listed above.

5. On 2/23/15 at 11:45 AM, Employee A, registered nurse (RN), from the Ft. Wayne office via telephone call, indicated the Crown Point office should have been locked up to protect what had been left behind in the unattended office when the contents of the office were
moved back to Ft. Wayne. She indicated the office had been used by Nightingale Hospice.

6. The agency document titled "Patient and Family Orientation for Hospice care" with no date included a section titled "Patient Bill of Rights and responsibilities." This document stated, "The patient has the right to ... expect confidentiality of all records, communications, and personal information related to the patient's care, in accordance with HIPAA regulations, Federal and state laws ... the patient has the right to ... confidentiality of written, verbal and electronic information about the patient's health, social and financial circumstances."

7. The agency policy titled "Record retention and security" with a copyright date of 2007 - 2010 stated, "Purpose: to safeguard the integrity of hard copy [paper] and computerized patient records and date through administrative and technical controls. Policy ... the agency has developed and implemented systems and processes to protect the integrity of hard copy and computerized patient records and data. The administrator has been charged with the responsibility for oversight of the above systems and processes. All agency personnel,
Governing body and professional advisory committee members are expected to adhere to the agency's privacy policy ... hard copies of patient records and data are stored in a secure area under lock and key ... fireproof, lockable filing cabinet after normal business hours. If the room(s) in which the records are stored unattended during regular business hours, the doors to these rooms must be locked. After regular business hours, all patient records and data is returned to the appropriate storage areas and those storage areas are locked."

8. The agency policy titled "Privacy and confidentiality of information" with a copyright date of 2007 - 2010 stated, "Confidentiality of date and information within the agency applies across all systems and automated, paper and verbal communications, as well as to clinical service, financial and business records, and employee - specific information ... all patient personal and health information and billing data is considered confidential and will be disclosed at the direction of Administration only when appropriately authorized to so by the patient or his / her legal representative."

9. During interview on 2/23/15 at 11:47 AM, employee A (director of clinical services/alternate administrator)
indicated the switchboard/call center operators (located at another hospice entity) have access to all of the hospice's census, they only get face sheet with address, phone number, and the nurse assigned to the patients.

A. On 2/23/15 at 11:48 AM, employee A showed the screen shot of information accessible to the switchboard/call center operators for patient phone calls that come in, including after hours calls routed through India. The screen shot evidenced the switchboard/call center is able to see: Name/Address, Medical record number, date of birth, Insurance provider, phone number, and primary nurse.

B. During interview on 2/23/15 at 12:04 PM, employee B (administrator), indicated the call center is located at the central office in another hospice entity. Employee B indicated that office directs phone calls to the Fort Wayne employees when needed. Employee B indicated the call center has access to patients' address, power of attorney, physician and employee assigned to the patient but not clinical information. Employee B indicated they would have to go through Health Insurance Portability and Accountability Act (HIPAA) stuff first to provide any clinical information if
requested by a patient or caregiver, but they prefer these requests all be routed through the patients’ nurses. Employee B indicated after hours calls have to go through the same access.

C. During interview on 2/24/15 at 11:45 AM, employee A indicated patient #8 was admitted on 1/9/15 by employee D, as that RN was filling in for employee A, but they took the information to another hospice office. Employee A indicated due to Fort Wayne having only 1 active patient, the Interdisciplinary Group (IDG) meetings are combined with the other hospice office and the medical directors there (non-employees #3 and 22) conduct the meetings and discuss patients for both locations, and some are done via phone. Employee A indicated the medical director for Fort Wayne was present via phone on 1/19/15 IDG.

D. Two IDG notes with patient #8 listed, and dated 1/19/15 at 5:00 PM, failed to evidence Fort Wayne's medical director (employee C) was present either in person or via phone, and non-employee #22 is listed at the top of the Attendance sign in sheet.

E. During interview on 2/24/15 at 12:45 PM, employee A indicated Fort Wayne contracts all employees, including
home care aides, nurses, social workers, chaplains, and other services, not just the medical directors.

F. The IDG sheet dated 2/16/15 at 5:00 PM, evidenced discussion of patient #8 and evidenced non-employee # 22 listed as the medical director. The sign in sheet dated 2/16/15 failed to evidence a signature for employee C. The Patients for discussion list evidence patients #8 and 11, in addition to 22 non-patients of this hospice.

G. The IDG sheet dated 12/31/14 at 9:30 AM, evidenced patients #9 and 10 were discussed, in addition to 5 non-patients of this hospice, and evidenced the medical director in attendance was non-employee #3.

H. The IDG sheet dated 12/22/14 at 5:00 PM, evidenced patients #9 and 10 were discussed, in addition to 21 non-patients of this hospice, and evidenced the medical director in attendance was non-employee #22.

I. The IDG sheet dated 12/17/14 at 9:00 AM, evidenced patients #9 and 10 were discussed, in addition to 9 non-patients of this hospice, and evidenced the medical director in attendance was non-employee #3.
J. The IDG sheet dated 12/3/14 at 3:30 PM, evidenced patients # 9 and 10 were discussed, in addition to 10 non-patients of this hospice, and evidenced the medical director in attendance was non-employee # 22.

K. The IDG sheet dated 11/24/14 at 5:00 PM, evidenced patients # 9 and 10 were discussed, in addition to 19 non-patients of this hospice, and evidenced the medical director in attendance was non-employee # 22.

L. The IDG sheet dated 11/10/14 at 5:00 PM, evidenced patient # 10 was discussed, in addition to 23 non-patients of this hospice, and evidenced the medical director in attendance was non-employee # 22.

M. The IDG sheet dated 10/27/14 at 5:00 PM, evidenced patient # 10 was discussed, in addition to 18 non-patients of this hospice, and evidenced the medical director in attendance was non-employee # 22.

N. The IDG sheet dated 10/14/14, evidenced patient # 10 was discussed, in addition to 18 non-patients of this hospice, and evidenced the medical director in attendance was non-employee
O. The IDG sheet dated 10/8/14 evidenced patient # 10 was discussed, in addition to 29 non-patients of this hospice, and evidenced the medical director in attendance was non-employee # 3.

10. During interview on 2/25/15 at 10:10 AM, employee A indicated the IDG meetings are conducted via phone and office with non-employee #3 and employee C. Employee A indicated the sign in sheet for 1/19/15 is on employee C's desk waiting for signature and the last they checked on this was last week. Employee A indicated employee C is not timely with returning the signed IDG attendance sheets but they do call in via phone. Employee A indicated they call in to another hospice entity location for IDG discussions, and non-employee #22 is the back up for the patients here, and non-employees #3 and #22 are present to cover when employee C does not call in.

11. The document titled "Employment Agreement for Medical Director Services," dated 8/1/14 for non-employee #3 failed to evidence the contract is for Nightingale Hospice Care of Northern Indiana, Inc D/B/A (doing business as) Nightingale Hospice.
12. The hospice's undated admission packet titled "Patient & Family Orientation for Hospice Care," states, "XI. Patient Bill of Rights and Responsibilities ... The patient has a right to the following; ... Expect confidentiality of all records, communications and personal information related to the patient's care, in accordance with HIPAA regulations, Federal and State Laws or third party contractors, and to obtain a paper copy of the agency's "Notice of Privacy Practice."

13. During interview on 2/26/15 at 3:45 PM, employees A and H indicated there was no further information to submit for review.

| L 520 | 12. The hospice's undated admission packet titled "Patient & Family Orientation for Hospice Care," states, "XI. Patient Bill of Rights and Responsibilities ... The patient has a right to the following; ... Expect confidentiality of all records, communications and personal information related to the patient's care, in accordance with HIPAA regulations, Federal and State Laws or third party contractors, and to obtain a paper copy of the agency's "Notice of Privacy Practice." | Based on clinical record review, document review, policy review, and | L 520 | 1 How will the deficiency be corrected? All comprehensive | 04/21/2015 |
interview, it was determined the hospice failed to ensure all members of the hospice interdisciplinary group (IDG), in consultation with the individual's attending physician, completed the comprehensive assessment no later than 5 calendar days after the election of hospice care in 2 of 4 clinical records reviewed (see L 523); and failed to ensure the update of the comprehensive assessment was accomplished by the hospice interdisciplinary group and included information on the patient's progress toward desired outcomes as well as reassessment of the patient's response to care in 4 of 4 clinical records reviewed (see L 533).

The cumulative effect of these systemic problems resulted in the hospice's inability to be in compliance with IC 16-25-3 and the Conditions of Participation 42 CFR 418.54 Initial and Comprehensive Assessment of Patient.

assessments will be completed no later than 5 calendar days after the election of hospice care. All current patient records will be reviewed to ensure all members of the hospice interdisciplinary group in consultation with the individual's attending physician is completed within 5 days of start of care The RN, in consultation telephonically/electronically with the other members of the IDT, consider the information gathered from the initial assessment as they develop the plan of care and the group determines who should visit the patient/family during the first 5 days of hospice care in accordance with patient/family needs and desires. If the patient does not have an Attending physician or if the attending physician is unavailable or unresponsive, the hospice physician assumes this role and one or more members consults telephonically/electronically with the physician in completing the comprehensive assessment. The agency will ensure the update of the comprehensive assessment is accomplished by all members of the hospice IDT every 15 days and will include information on the patient's progress toward desired outcomes as well as reassessment of the patient's response to care. IDT meetings will be conducted at least every 15 days with attendance sign in sheets completed and minutes forwarded to the patients.
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<td>L 523</td>
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<td>418.54(b) Timeframe for completion of assessment</td>
<td>The hospice interdisciplinary group, in consultation with the individual's attending physician (if any), must complete the comprehensive assessment no later than 5 calendar days after the election of hospice care in accordance with §418.24. Based on clinical record review, policy review, and interview, the hospice failed to ensure all members of the hospice interdisciplinary group (IDG), in consultation with the individual's attending physician, completed the comprehensive assessment no later than 5 calendar days after the election of hospice care.</td>
<td>04/21/2015</td>
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1 How will the deficiency be corrected? All comprehensive assessments will be completed no later than 5 calendar days after the election of hospice care. All current patient records will be reviewed to ensure all members of the hospice interdisciplinary group in
Findings include:

1. The policy with a revision date as 9/1/09 titled "Plan of Care" states, "PURPOSE To establish a process for the development of a plan of care for each patient PROCEDURE 1 ... 5. Each core discipline will complete their assessment within 5 days and update the POC based on their assessment and needs of the patient and/or family."

2. Clinical record #8, start of care 1/9/15, contained a document titled "Explanation & Election of Hospice Benefits" stating, "Patient Name: [patient #8] Hospice Election Effective Date: 1/9/15. ... ." The record failed to evidenced all members of the IDG completed the comprehensive assessment no later than 5 calendar days after the election effective and start of care date 1/9/15.

On 2/25/15 at 11 AM, employee A (director of clinical services / alternate administrator) indicated the start of care comprehensive assessment was performed on 1/9/15 by non-employee #18 and there were no visits conducted by any discipline until 6 days later on consultation with the individual's attending physician is completed within 5 days of start of care The RN, in consultation telephonically/electronically with the other members of the IDT, consider the information gathered from the initial assessment as they develop the plan of care and the group determines who should visit the patient/family during the first 5 days of hospice care in accordance with patient/family needs and desires. If the patient does not have an Attending physician or if the attending physician is unavailable or unresponsive, the hospice physician assumes this role and one or more members consult telephonically/electronically with the physician in completing the comprehensive assessment

2 How will the deficiency be prevented from reoccurring?

An in-service will be done will all skilled staff regarding the plan of care policy and comprehensive assessment and it's completion timeliness Audits by the Director of Patient Care Services/designee will be done on all new start of care plans and comprehensive assessments to ensure timely completion Any identified noncompliance will result in the implementation of establish progressive disciplinary action

3 Who is responsible?
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**IDENTIFICATION NUMBER:** 151598

**MULTIPLE CONSTRUCTION**

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**DATE SURVEY COMPLETED:** 02/26/2015

**NAME OF PROVIDER OR SUPPLIER:** NIGHTINGALE HOSPICE

**STREET ADDRESS, CITY, STATE, ZIP CODE:**

6347 CONSTITUTION DRIVE
FORT WAYNE, IN 46804

**SUMMARY STATEMENT OF DEFICIENCIES**

1/15/15. Employee A indicated non-employee #18 failed to communicate the plan of care to all other disciplines involved in the patient's care.

3. Clinical record #11, election and start of care date 2/9/15, failed to evidence all members of the IDG completed the comprehensive assessment no later than 5 calendar days after the election of hospice.

    On 2/25/15 at 4 PM, employee A indicated the IDG did not meet until 2/16/15 to review the patient's plan of care.

**PREFIX**

**TAG**

**L 533**

**418.54(d)**

**UPDATE OF COMPREHENSIVE ASSESSMENT**

**PROVIDER'S PLAN OF CORRECTION**

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**The Executive Director**

4 By what date will the deficiency be corrected?

04/21/2015
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 clinical record review, document review, interview, and policy review, the hospice failed to ensure the update of the comprehensive assessment was accomplished by all members of the hospice interdisciplinary group (IDT) every 15 days and included information on the patient's progress toward desired outcomes as well as reassessment of the patient's response to care in 4 of 4 clinical records reviewed, creating the potential to affect all the hospice's patients. (#8, #9, #10, and #11)

Findings include:
1. A document dated 10/8/14 at 9 AM titled "INTERDISCIPLINARY TEAM MEETING AGENDA" states, "Recertification Due Next IDT [interdisciplinary team] Meeting:

<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
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</thead>
<tbody>
<tr>
<td>L 533</td>
<td></td>
<td></td>
<td>1 How will the deficiency be corrected? The agency will ensure the update of the comprehensive assessment is accomplished by all members of the hospice IDT every 15 days and will include information on the patient's progress toward desired outcomes as well as reassessment of the patient's response to care. IDT meetings will be conducted at least every 15 days with attendance sign in sheets completed and the minutes forwarded to the patients attending physician</td>
</tr>
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<td></td>
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<td>2 How will the deficiency be prevented from reoccurring? An inservice will be held with all core IDT members An audit will be done on all IDT meeting minutes by the Director of Patient Care Services/designee to ensure the update of the comprehensive assessment by all members of the IDT is completed and forwarded to the patients attending physician</td>
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<td></td>
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<td>3 Who is</td>
</tr>
</tbody>
</table>

04/21/2015
### Summary of Deficiencies

**NAME OF PROVIDER OR SUPPLIER**

**NIGHTINGALE HOSPICE**

**STREET ADDRESS, CITY, STATE, ZIP CODE**

6347 CONSTITUTION DRIVE
FORT WAYNE, IN 46804

### Statement of Deficiencies and Plan of Correction

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

<table>
<thead>
<tr>
<th>ID</th>
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<tr>
<td>151598</td>
<td>PROVIDER/Supplier/CLIA IDENTIFICATION NUMBER:</td>
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**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**A. BUILDING**

**B. WING**

**DATE SURVEY COMPLETED**

02/26/2015

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<tbody>
<tr>
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<td>MULTIPLE CONSTRUCTION</td>
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</tr>
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</table>

### Examples of Deficiencies

1. *Wednesday, October 22, 2014*

   **Patient Name:** [patient #10]  
   **RN (Registered Nurse):** [employee A-registered nurse]  
   **Recertification Date:** 10/29/2014  
   **DX:** CHF [congestive heart failure]  
   
   The document failed to evidence all members were present during the meeting and failed to evidence documentation of the patient's progress and response to care. **WHY IS THIS QUOTE? RELEVANT. Failed to evidence documentation of the patient's progress and response to care.**

   The IDT sign in sheet dated 10/8/14 failed to evidence the Medical Director and chaplain were present.

2. A document dated 10/14/14 titled "INTERDISCIPLINARY TEAM MEETING AGENDA" states, "Patients for: IDT Discussion/Bi-Weekly Review: ... Patient Name: [patient #10]  

   **RN:** [employee A]  
   **SOC [start of care]:** 9/23/14  
   **DX: CHF ..."** The document failed to evidence all members were present during the meeting and failed to evidence documentation of the patient's progress and response to care.

   The IDT sign in sheet dated 10/14/14 failed to evidence the Medical Director 4 By what date will the deficiency be corrected? 04/21/2015

---

**Event ID:** D56O11  
**Facility ID:** 007361  
**If continuation sheet:** Page 23 of 193
Director was present.

3. A document dated 10/27/14 at 5 PM titled "INTERDISCIPLINARY TEAM MEETING AGENDA" states, "Recertification Due For Today's IDT Meeting: Patient Name: [patient #10] RN: [employee A] Recert Date: 10/29/2014 DX: CHF ... ". The document failed to evidence all members were present during the meeting and failed to evidence documentation of the patient's progress and response to care.

The IDT sign in sheet dated 10/27/14 failed to evidence the Medical Director was present.

4. A document dated 11/10/14 at 5 PM titled "INTERDISCIPLINARY TEAM MEETING AGENDA" states, "Patients for: IDT Discussion/Bi-Weekly Review: ... Patient Name: [patient #10] RN: [employee A] SOC Date 9/23/14 Recert Date: 10/29/2014 DX: CHF ... ". The document failed to evidence all members were present during the meeting and failed to evidence documentation of the patient's progress and response to care.

The IDT sign in sheet dated 11/10/14 failed to evidence the Medical Director was present.
5. A document dated 11/24/14 at 5 PM titled "INTERDISCIPLINARY TEAM MEETING AGENDA" states, "Admissions: Patient Name: [patient #9] RN: [employee A] Date: 11/21/2014 DX: Dementia ... Patient Name: [patient #10] RN: [employee A] SOC Date 9/23/14 Recert Date 10/29/14 DX: CHF ... ". The document failed to evidence all members were present during the meeting and failed to evidence documentation of the patients' progress and response to care.

   The IDT sign in sheet dated 11/24/14 failed to evidence the Medical Director was present.

6. A document dated 12/3/14 at 3:30 PM titled "INTERDISCIPLINARY TEAM MEETING AGENDA" states, "Patients for: IDT Discussion/Bi-Weekly Review: ... Patient Name: [patient #9] Patient Name: [patient #10] ... ". The document failed to evidence all members were present during the meeting and failed to evidence documentation of the patient's progress and response to care.

   The IDT sign in sheet dated 12/3/14 failed to evidence the Medical Director, SW, and chaplain were present.
7. A document dated 12/17/14 at 9 AM titled "INTERDISCIPLINARY TEAM MEETING AGENDA" states, "Patients for: IDT Discussion/Bi-Weekly Review: ... Patient Name: [patient #10] RN: [employee A] SOC Date 9/23/14 Recert Date: 1/26/2015 DX: CHF ... Patient Name: [patient #9] RN: [employee A] SOC Date 10/30/14 Recert Date: 12/27/14 DX: Dementia. ..." The document failed to evidence all members were present during the meeting and failed to evidence documentation of the patient's progress and response to care.

The IDT sign in sheet dated 12/17/14 failed to evidence the Medical Director and chaplain were present.

8. A document dated 12/22/14 at 5 PM titled "ANNOUNCEMENTS / UPDATES" states, "Patients for: IDT Discussion/Bi-Weekly Review: ... Patient Name: [patient #10] DX: ES [end stage Cardiac ... Patient Name: [patient #9] DX: Dementia... " The document failed to evidence all members were present during the meeting and failed to evidence documentation of the patient's progress.
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<th>ID</th>
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<th>TAG</th>
<th>(X5) COMPLETION DATE</th>
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<tr>
<td>STATEMENT OF DEFICIENCIES</td>
<td>(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:</td>
<td>X2) MULTIPLE CONSTRUCTION</td>
<td>A. BUILDING</td>
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<td>B. WING</td>
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<td>02/26/2015</td>
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<td>DATE SURVEY COMPLETED</td>
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<tr>
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<td>STREET ADDRESS, CITY, STATE, ZIP CODE</td>
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<td></td>
<td>NIGHTINGALE HOSPICE</td>
<td>6347 CONSTITUTION DRIVE</td>
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**SUMMARY STATEMENT OF DEFICIENCIES**

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<td>and response to care.</td>
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<tr>
<td>The IDT sign in sheet dated 12/22/14 failed to evidence the Medical Director and chaplain were present.</td>
</tr>
<tr>
<td>9. A document dated 12/31/14 at 9:30 AM titled &quot;ANNOUNCEMENTS/UPDATES&quot; states, &quot;Discharges/Bereavement Patient Name: [patient #10] RN: [employee A] Date: 12/23/14 Comments: RHC [Respirations have Ceased] ... Patients for: IDT Discussion/Bi-Weekly Review: ... Patient Name: [patient #9] RN: [employee A] SOC Date: 10/30/14 Recert Date: 12/27/14 DX: Dementia ....&quot; The document failed to evidence all members were present during the meeting and failed to evidence documentation of the patient's progress and response to care.</td>
</tr>
<tr>
<td>The IDT sign in sheet dated 12/31/14 at 9:30 AM, failed to evidence Medical Director, SW (social worker), and chaplain were present.</td>
</tr>
<tr>
<td>10. A document dated 1/19/15 at 5 PM titled &quot;ANNOUNCEMENTS/UPDATES&quot; states, &quot;Admissions: Patient Name:</td>
</tr>
</tbody>
</table>
### Statement of Deficiencies and Plan of Correction

**Identification Number:** MULTIPLE CONSTRUCTION

**Date Survey Completed:** 02/26/2015

#### Name of Provider or Supplier

**Name:** NIGHTINGALE HOSPICE

**Address:** 6347 Constitution Drive
FORT WAYNE, IN 46804

<table>
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<tr>
<th>ID</th>
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<th>Summary Statement of Deficiencies</th>
<th>Provider's Plan of Correction</th>
<th>(X5) Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>[patient #8] RN: [blank] Date: 1/9/2015 Comments: [blank] ... &quot; The document failed to evidence all members were present during the meeting and failed to evidence documentation of the patient's progress and response to care. The IDT sheet dated 1/19/15 at 5:00 PM, evidenced patient #8's name and had employee C listed as the medical director. The sign in sheet dated 1/19/15 was signed by employee A, Registered Nurse (RN), but failed to evidence the presence of Medical Director (employee C), Social Worker, and Chaplain, employees C, H, and I. 11. A document dated 2/16/15 at 5 PM titled &quot;ANNOUNCEMENTS / UPDATES&quot; states, &quot;Patients for: IDT Discussion/Bi-Weekly Review: ... Patient Name: [patient #8] RN: [blank] SOC Date: 1/9/2015 Recert Date: [blank] DX: Lung Cancer ... Patient Name: [patient #11] ... &quot; The document failed to evidence all members were present during the meeting and failed to evidence documentation of the patient's progress and response to care. The sign in sheet dated 2/16/15 failed to evidence a signature for</td>
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employee C, the Medical Director.

12. During interview on 2/25/15 at 10:10 AM, employee A indicated the IDG meetings are conducted via phone and office with non-employee #3 and employee C. Employee A indicated they call in to the another Nightingale hospice location for IDT discussions, and non-employee #22 is the back up for the patients here, and non-employees #3 and #22 are present to cover when employee C does not call in.

13. During interview on 2/25/15 at 10:20 AM, employee A indicated the last time employee C was available for an IDT meeting was maybe sometime last year, and the administrator said they could use an alternate if needed.

14. The hospice's undated policy titled "Interdisciplinary Group," # HSP2-15B, states, "The IDG provides for ensures the ongoing sharing of information between all disciplines providing care and services in all setting, whether the care and services are provided directly or under arrangement."

15. The hospice's policy titled "Interdisciplinary Group," revised
9/30/08, states, "1. The role of the IDG will include, but not limited to, the following: participation in the establishment of the Plan of Care, Provision or supervision of hospice care and services, Periodic review and updating the Plan of Care for each patient receiving hospice care, Designation of a registered nurse to coordinate the implementation of the Plan of Care for each patient, Identification of potential problems and recommend resolutions for solving the problem."

16. The hospice's undated policy titled "Medical Director and Physician Services," #HSP2-11B.01, HSP4-11A, states, "The Medical director will assume overall responsibility for the medical component of the Hospice's patient care program, ... The Medical Director and any physician employees of Hospice may also serve as the physician representatives of the Interdisciplinary Group (IDG) and/or as an attending physician. Responsibilities of the Medical Director and physician employees of the Hospice include, but are not limited to: ... b) Participation in the development, revision, and approval of
the interdisciplinary group plan of care,
... d) Communication with hospice
interdisciplinary group members, ... f)
attends interdisciplinary group meetings.
... In the absence of the Medical
Director, a qualified physician will be
available to serve as his/her designee."
17. During interview on 2/26/15 at 3:45
PM, employees A and H indicated there
was no further information to submit for
review.
Based on clinical record review, document and policy review, and interview, it was determined the hospice failed to ensure failed to ensure the Interdisciplinary Team (IDT) members provided the care and services ordered in a timely manner for 1 of 4 patients (see L539); failed to ensure all members of the IDT were present for all IDT meetings (see L 541), creating the potential to affect all the hospice's patients; failed to ensure the registered nurse that is a member of the IDT provided coordination of care and ensured continuous assessments of the patient's and family's needs and implementation of the IDT plan of care in 2 of 4 clinical records reviewed creating the potential to affect all patients of the hospice (See L 540); failed to ensure all hospice care and services furnished to patients and their families followed an individualized written plan of care established by the hospice interdisciplinary group with the attending physician (if any), the patient or representative, and the primary caregiver in accordance with the patient's needs in 2 of 4 clinical records reviewed creating the potential to affect all patient's of the hospice (See L 543); and failed to ensure the IDT members reviewed, revised, and

| Bldg. 00 | L 536 | 1 How will the deficiency be corrected? The Hospice agency will ensure IDT team members provide the care and services ordered in a timely manner and ensure all IDT members are present for all IDT meetings and sign in sheets will be recorded. The Hospice will designate an interdisciplinary team for all patients. The Registered Nurse will prepare a written plan of care for each patient and provide coordination of care to ensure continuous assessment of each patient and family's needs and implementation of the interdisciplinary plan of care. The interdisciplinary group will include but limit to a doctor of medicine or osteopathy who is an employee or under contract with the Hospice, a Registered Nurse, a Social worker and either a pastoral care or other counselor. The Plan of care shall be written and established by the hospice interdisciplinary group in collaboration with the attending Physician. The plan of care will be reviewed, revised and documented as frequently as the patient's condition requires but no less than every 15 calendar days. The Plan of care will be electronically signed and updated at every IDT meeting for all patients and a copy will be sent to the attending Physician. A system will be in place to communicate.

| 04/21/2015 |
### Summary of Deficiencies and Plan of Correction

#### Identification Number:
- **MULTIPLE CONSTRUCTION**
  - **Building**: 00
  - **Wing**: __________

#### Name of Provider or Supplier
- **NIGHTINGALE HOSPICE**
  - Address: 6347 CONSTITUTION DRIVE
  - City, State, Zip Code: FORT WAYNE, IN 46804

#### Statement of Deficiencies
- **Event ID**: D56O11
- **Facility ID**: 007361
- **Date Survey Completed**: 02/26/2015
- **Prefix**: 151598

**Summary Statement of Deficiencies**

- Documented the plan of care at least every 15 days (See L 552).

The cumulative effect of these systemic problems resulted in the hospice's inability to be in compliance with IC 16-25-3 and the Conditions of Participation 42 CFR 418.56

Interdisciplinary group, care planning, and coordination of services.

#### Plan of Correction

- **Prefix**: __________
- **Tag**: __________

- **Prefix**: __________
- **Tag**: __________

- **Prefix**: __________
- **Tag**: __________

**Provider's Plan of Correction**

- **Completion Date**: __________

The plan of care is being documented at least every 15 days (See L 552).

The cumulative effect of these systemic problems resulted in the hospice's inability to be in compliance with IC 16-25-3 and the Conditions of Participation 42 CFR 418.56

Interdisciplinary group, care planning, and coordination of services.

and integrate in accordance with our policy and procedure to ensure that the IDT group maintains responsibility for directing coordinating and supervising the care and services provided. All communication will be documented and recorded in the patients clinical record. A medical Director will be contracted or an employee of the Hospice agency at all times. This Hospice Agency will ensure a QAPI performance improvement project is in place and will have documentation of outcomes and ongoing plans. These will be discussed at minimum on a quarterly basis with the QAPI team. The QAPI quarterly meeting will be forwarded and reviewed by the Governing Body.

2. **How will the deficiency be prevented from recurring?**

An inservice will be held with all IDT members to re instruct on their role and responsibility as part of the IDT including the Registered Nurse's role to provide coordination of care and ensure continuous assessment of patient/family needs and implement the plan of care. An inservice will also be held with all RN case managers regarding the timely development of the patient plan of care in collaboration with the attending physician. All current patient clinical records will be
### Statement of Deficiencies and Plan of Correction

#### Identification Number:
- PROVIDER/Supplier/CLIA: 151598
- A. Building
- B. Wing

#### Date Survey Completed:
- 02/26/2015

#### Name of Provider or Supplier:
- NIGHTINGALE HOSPICE

#### Street Address, City, State, Zip Code:
- 6347 CONSTITUTION DRIVE
- FORT WAYNE, IN 46804

#### Summary Statement of Deficiencies

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<tr>
<td>L 537</td>
<td>418.56</td>
<td>IDG, CARE PLANNING, COORDINATION OF SERVICES</td>
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The hospice must designate an interdisciplinary group or groups as specified in paragraph (a) of this section which, in review to ensure the plan of care is accurate, followed and updated according to patient needs. 25% of all current patient charts will be audited quarterly to ensure ongoing compliance. An inservice will be given to all IDT members regarding the required frequency for the IDT to meet to review and update the patients plan of care. Ongoing compliance will be monitored quarterly in the agencies QAPI program. An inservice will be given to all skilled staff regarding the agency policy on interdisciplinary communication. An inservice will be done with all RN case managers and IDT members on the admission plan of care protocol and communication expectations. All new Start of care patients records will be reviewed for the next 90 days to ensure compliance. A QAPI meeting will be held by 04/21/15 to include the agencies outcomes and ongoing plans. An inservice will be given to the governing body and advisory committee regarding responsibility of ongoing QAPI program. 3. Who will be responsible? The Executive Director. 4. By what date? 04/21/2015.
consultation with the patient’s attending physician, must prepare a written plan of care for each patient.

Based on document review, policy review, and interview, the hospice failed to ensure the interdisciplinary group (IDG) meetings involved all members of the IDG for 1 of 1 agency.

Findings include

1. Clinical record # 10, start of care date 9/23/14, listed employee C, the medical director, as the patient’s primary physician. IDT Attendance Sign In sheets failed to evidence all required IDT members were in attendance at IDT meetings.

   A. The IDT sheet dated 2/16/15 at 5:00 PM, evidenced patient #8 was listed and evidenced non-employee # 22 was listed as the medical director. The sign in sheet dated 2/16/15 failed to evidence a signature for employee C, the Medical Director.

   B. The IDT sheet dated 1/19/15 at 5:00 PM, evidenced patient #8 was listed and had employee C listed as the medical director. The sign in sheet dated 1/19/15 was signed by employee A, Registered Nurse (RN), but failed to evidence signatures for Medical Director, Social Worker (SW), and Chaplain, employees

   1 How will the deficiency be corrected? The Hospice agency will ensure IDT team members provide the care and services ordered in a timely manner and ensure all IDT members are present for all IDT meetings and sign in sheets will be recorded. The Hospice will designate an interdisciplinary team for all patients in consultation with the patients physician. The Registered Nurse will prepare a written plan of care for each patient in consultation with the IDT members and provide coordination of care to ensure continuous assessment of each patient and family’s needs and implementation of the interdisciplinary plan of care in collaboration with the attending physician. The interdisciplinary group will include but limit to a doctor of medicine or osteopathy who is an employee or under contract with the Hospice, a Registered Nurse, a Social worker and either a pastoral or other counselor. The plan of care will be reviewed, revised and documented as frequently as the patient’s condition requires but no less than every 15 calendar days. The Plan of care will be electronically signed and updated at every IDT meeting for all patients and a copy will be sent to the attending Physician. 2 How
### STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

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### C, L, H, and I.

C. The IDT sign in sheet dated 12/31/14 at 9:30 AM, failed to evidence Medical Director, SW, and chaplain were present.

D. The IDT sign in sheet dated 12/22/14 failed to evidence the Medical Director and chaplain were present.

E. The IDT sign in sheet dated 12/17/14 failed to evidence the Medical Director and chaplain were present.

F. The IDT sign in sheet dated 12/3/14 failed to evidence the Medical Director, SW, and chaplain were present.

G. The IDT sign in sheet dated 11/24/14 failed to evidence the Medical Director was present.

H. The IDT sign in sheet dated 11/10/14 failed to evidence the Medical Director was present.

J. The IDT sign in sheet dated 10/27/14 failed to evidence the Medical Director was present.

K. The IDT sign in sheet dated 10/14/14 failed to evidence the Medical Director was present.

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will the deficiency be prevented from recurring? An in-service will be held with all IDT members to which will include a RN case manager, Medical Director, a pastoral counselor and a MSW to re instruct on their role and responsibility as part of the IDT including the Registered Nurse’s role to provide coordination of care and ensure continuous assessment of patient/family needs and implement the plan of care. 100% of all patient records will be audited for 90 days or until 100% compliance is achieved. Who will be responsible? The Executive Director 4 By what date will the deficiency be corrected? 04/21/2015
L. The IDT sign in sheet dated 10/8/14 failed to evidence the Medical Director and chaplain were present.

2. During interview on 2/25/15 at 10:10 AM, employee A (director of clinical services / alternate administrator) indicated the IDG meetings are conducted via phone and office with non-employee #3 and employee C (medical director). Employee A indicated the sign in sheet for 1/19/15 is on employee C's desk waiting for signature and the last they checked on this was last week. Employee A indicated employee C is not timely with returning the signed IDT attendance sheets but they do call in via phone. Employee A indicated they call in to the another hospice entity for IDT discussions, and non-employee #22 is the back up for the patients here, and non-employees #3 and #22 are present to cover when employee C does not call in.

3. During interview on 2/25/15 at 10:20 AM, employee A indicated the last time employee C was available for an IDT meeting was maybe sometime last year, and the administrator said they could use an alternate if needed.

4. The hospice's undated policy titled
"Interdisciplinary Group," # HSP2-15B, states "The IDG provides for ensures the ongoing sharing of information between all disciplines providing care and services in all setting, whether the care and services are provided directly or under arrangement."

5. The hospice's policy titled "Interdisciplinary Group," revised 9/30/08, states "1. The role of the IDG will include, but not limited to, the following: participation in the establishment of the Plan of Care, Provision or supervision of hospice care and services, Periodic review and updating the Plan of Care for each patient receiving hospice care, Designation of a registered nurse to coordinate the implementation of the Plan of Care for each patient, Identification of potential problems and recommend resolutions for solving the problem."

6. The hospice's undated policy titled "Medical director and Physician Services," #HSP2-11B.01, HSP4-11A, states "The Medical director will assume overall responsibility for the medical component of the Hospice's patient care program, ... The Medical Director and any physician employees of Hospice may also serve as the physician representatives of the Interdisciplinary
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<td>L 540</td>
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<td>Group (IDG) and/or as an attending physician. Responsibilities of the Medical Director and physician employees of the Hospice include, but are not limited to:  b) Participation in the development, revision, and approval of the interdisciplinary group plan of care,  d) Communication with hospice interdisciplinary group members,  f) attends interdisciplinary group meetings.  In the absence of the Medical Director, a qualified physician will be available to serve as his/her designee.&quot;</td>
<td></td>
<td>04/21/2015</td>
</tr>
<tr>
<td>418.56(a)(1)</td>
<td>APPROACH TO SERVICE DELIVERY</td>
<td>The hospice must designate a registered nurse that is a member of the interdisciplinary group to provide coordination of care and to ensure continuous assessment of each patient's and family's needs and implementation of the interdisciplinary plan of care.</td>
<td>The Plan of care shall be established by the registered nurse in coordination with the hospice interdisciplinary group and in</td>
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<td>Based on clinical record review, document review, hospice policy review, and interview, the hospice failed to ensure the registered nurse that is a member of the interdisciplinary group</td>
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7. During interview on 2/26/15 at 3:45 PM, employees A and H indicated there was no further information to submit for review.

L 540

1 How will the deficiency be corrected?

The Plan of care shall be established by the registered nurse in coordination with the hospice interdisciplinary group and in
(IDG) provided coordination of care and ensured continuous assessments of the patient's and family's needs and implementation of the IDG plan of care in 2 of 4 clinical records reviewed creating the potential to affect all patients of the hospice. (#8 and #11)

Findings include:

1. Clinical record #8, start of care 1/9/15, evidenced a document electronically signed by non-employee #18 dated 1/9/15 titled "(SOC) [start of care] SN [skilled nursing] Clinical Note" stating, "GENITOURINARY Catheter Urethral inserted Latex Foley # 16 fr 10 cc balloon next change due on or about 12/12/2014 ... ASSESSMENT Condition Clients condition is uncomfortable indicating need to alter plan of care Knowledge Deficit pain and anxiety meds ... Goals: ... established optimum skin and wound care. ... CARE PLAN Met SN/CG [caregiver] to cleanse coccyx wound 2-3 x/wk [times per week] with soap and water and apply sacral allevyn ... NARRATIVE SOC for elderly female with end stage lung disease. Awake and alert but very forgetful. Has stage 3 wound to coccyx. Cleansed with soap and water and covered with sacral allevyn. ... Pain 6 upon nurses arrival. Caregiver collaboration with the attending Physician The plan of care will be reviewed, revised and documented as frequently as the patient’s condition requires but no less than every 15 calendar days The Plan of care will be electronically signed an updated at every IDT meeting for all patients and a copy will be sent to the attending Physician. The Registered nurse will provide the coordination of care to ensure continuous assessment of patient/family needs and implement them

2 How will the deficiency be prevented from reoccurring?

An in-service will be held with all IDT members to which will include a RN case manager, Medical Director, a pastoral counselor and a MSW to re instruct on their role and responsibility as part of the IDT including the Registered Nurse's role to provide coordination of care and ensure continuous assessment of patient/family needs and implement the plan of care. An in-service will also be held with all RN case managers regarding the timely development of the patient plan of care in collaboration with the attending physician. All current patient clinical records will be reviewed to ensure the plan of care is accurate, followed and updated according to patient needs 100% of all current patient charts will be audited for 90 days to ensure ongoing compliance. An admission
encouraged to give Q 4 hr [hour] dose of morphine and ativan SL [sublingual] to comfort patient. Has Foley cath in place draining ... clear yellow urine ... ."

A. The record contained a skilled nursing visit note dated 1/15/15 with an electronic signature of employee D (registered nurse), This was 6 days after the initial visit and no coordination of care had been initiated.

1.) On 2/25/15 at 12 PM, employee A indicated supplies were ordered on 1/15/15 and 1/16/15 and the visit was conducted by employee D on 1/15/15. Employee A was unable to locate documentation in the clinical record of any skilled nursing visits prior to 1/15/15 except for the SOC visit dated 1/9/15. Employee A indicated not to be able to locate any documentation about coordination of care.

2.) On 2/25/15 at 11:15 AM, a telephone interview was conducted with employee D. The employee stated, "There was no care plan" and he/she knew what to do at the visit "Per hospice protocol and report." The employee indicated never providing wound care to this patient and stated, "I wasn't aware [patient] had a wound. It was never mentioned to me." The employee

review sheet has been implemented to ensure the Registered nurse is coordinating care amongst disciplines. See attachment A

3 Who will be responsible?
The Executive Director

4 By what date will the deficiency be corrected?

04/21/2015
indicated receiving report and not positive of whom he/she received it from but thinks it was from non-employee #18.

B. The record contained a skilled nursing visit note dated 1/15/15 with an electronic signature of employee L stating, "SN Clinical Note Date 1/15/2015 In 01:03 PM Out 02:03 PM ...

GENITOURINARY Urine Amount Adequate Color Amber Odor Foul Appearance Cloudy Catheter Urethral Inserted Latex Foley #16 fr 10 cc Balloon Inflated to 7.5 cc next change due on or about 2/15/2015 Insertion Area Reddened cg state that catheter had not been changed for 2 months. strong urine odor noted. ...

INTEGUMENTARY Skin Status General skin condition intact specific skin problems noted lesion L [left] buttock lesion R [right] buttock currently using low air loss mattress ... WOUND Wound #1 Type Pressure ulcer did not assess today as no dressing available in home. family states it has not changed for last assessment Location Posterior Buttock Wound size Length did not assess cm [centimeters] Width did not assess cm Depth did not assess cm. ...

CARE PLAN Met ... Insert/Change foley catheter ... Not Met SN/CG to cleanse coccyx wound 2-3 x/wk with soap and water and apply sacral allevyn - 0%
### STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

**NAME OF PROVIDER OR SUPPLIER**: NIGHTINGALE HOSPICE

**STREET ADDRESS, CITY, STATE, ZIP CODE**: 6347 CONSTITUTION DRIVE, FORT WAYNE, IN 46804

#### IDENTIFICATION NUMBER:

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<tr>
<th>X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:</th>
<th>X2) MULTIPLE CONSTRUCTION</th>
<th>X3) DATE SURVEY COMPLETED</th>
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#### SUMMARY STATEMENT OF DEFICIENCIES

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- **C**. On 2/25/15 at 11 AM, employee A indicated hospice services were initiated on 1/9/15 by non-employee #18 and the plan of care should have been initiated on 1/9/15. The director of clinical services indicated he/she reviewed the plan of care on 1/15/15 and that is why it did not get initiated until 1/15/15. The employee indicated non-employee #18 failed to communicate the plan of care to all other disciplines involved in the patient's care.

2. Clinical record #11 contained a hospice plan of care for certification period 2/9 to 5/9/15 with orders for skilled nursing services stating, "21. SN: 2x/wk x 13 wks (2/9/2015 to 5/9/2015) ... HCA: 1x/wk x 1wk (2/11/2015 to 2/14/2015), 3x/wk x 12 wks (2/15/2015 to 5/9/2015) assist with partial/complete bath. assist with personal care MSW: 1x/mo x 3 mos (2/9/2015 to 5/9/2015) ... Clergy: 1x/mo x 3 mos (2/11/2015 to 5/9/2015) ... " The record failed to evidence a registered nurse who is part of

---

**NARRATIVE**

Pt [patient] needed catheter change. Insertion site is red and irritated. replaced with 16 fr 7.5 ml in balloon. VS [vital signs] stable. ... ." The record failed to evidence any coordination of care regarding catheter change.
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

IDENTIFICATION NUMBER: 151598

DATE SURVEY COMPLETED: 02/26/2015

STATEMENT OF DEFICIENCIES

IDENTIFICATION NUMBER:

NAME OF PROVIDER OR SUPPLIER: NIGHTINGALE HOSPICE

STREET ADDRESS, CITY, STATE, ZIP CODE: 6347 CONSTITUTION DRIVE FORT WAYNE, IN 46804

SUMMARY STATEMENT OF DEFICIENCIES

(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

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the IDG provided coordination of care and ensured implementation of the plan of care.

A. The record evidenced a skilled nursing start of care visit note electronically signed by non-employee #17. The non-employee was not part of the IDG.

B. The record evidenced hospice aide visits were conducted on 2/23 and 2/25/15 by non-employee #25.

C. On 2/26/15 at 12:30 PM, a telephone interview was conducted with the patient's family member. The family member indicated not having hospice aide services for weeks 1 and 2 and at no time did an aide attempt to make a visit during those weeks but was informed by hospice staff that they were attempting to get the service started. The family member indicated his/her mother cannot be transported and is a homebound patient that requires supervision 24 hours per day.

D. On 2/25/15 at 4:10 PM, employee A indicated the clinical record did not contain documentation of coordination of care between non-employee #17 and any other disciplines providing services. Employee A indicated the first time the
IDG met to discuss the plan of care was 2/16/15.

3. The policy with a revision date as 9/30/08 titled "INTERDISCIPLINARY GROUP" states, "PROCEDURE 1. The role of the IDG will include, but not limited to, the following: Participating in the establishment of the Plan of Care Provision or supervision of hospice care and services ... Designation of a registered nurse to coordinate the implementation of the Plan of Care for each patient."

418.56(a)(1)(i)-(iv)

APPROACH TO SERVICE DELIVERY

The interdisciplinary group must include, but is not limited to, individuals who are qualified and competent to practice in the following professional roles:
### Statement of Deficiencies and Plan of Correction

**Identification Number:** 151598  
**Date Survey Completed:** 02/26/2015

**Name of Provider or Supplier:** NIGHTINGALE HOSPICE  
**Street Address, City, State, Zip Code:** 6347 CONSTITUTION DRIVE, FORT WAYNE, IN 46804

**Summary Statement of Deficiencies**

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Each deficiency must be preceded by full regulatory or LSC identifying information.

#### Findings include:

1. **IDT Attendance Sign In sheets failed to evidence all required IDT members were in attendance at IDT meetings.**

2. **Clinical record # 10, start of care date 9/23/14, listed employee C, the medical director, as the patient's primary physician. IDT Attendance Sign In sheets failed to evidence all required IDT members were in attendance at IDT meetings.**

   A. The IDT sheet dated 2/16/15 at 5:00 PM, evidenced patient #8 was listed and evidenced non-employee # 22 was listed as the medical director. The sign in sheet dated 2/16/15 failed to evidence a signature for employee C, the Medical Director.

#### How will the deficiency be corrected?

The interdisciplinary group will include but limit to a doctor of medicine or osteopathy who is an employee or under contract with the Hospice, a Registered Nurse, a Social worker and either a pastoral or other counselor. The Plan of care shall be a written and established by the hospice interdisciplinary group in collaboration with the attending Physician. The Plan of care will be reviewed, revised and documented as frequently as the patients condition requires but no less than every 15 calendar days. The Plan of care will be electronically signed and updated at every IDT meeting for all patients and a copy will be sent to the attending Physician.

#### How will the deficiency be prevented from recurring?

An in-service will be held with all IDT members to which will include a RN case manager, Medical Director, a pastoral counselor and a MSW to reinstruct on their role and responsibility as part of the IDT including the Registered Nurse's role to provide coordination of care and
### SUMMARY STATEMENT OF DEFICIENCIES

#### EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION

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<td>ensure continuous assessment of patient/family needs and implement the plan of care. 100% of all current patient charts will be audited quarterly to ensure ongoing compliance. An in-service will be given to all IDT members regarding the required frequency for the IDT to meet to review and update the patients plan of care. All staff will be employed, or contracted when allowed, with the agency. See attachment B, employee list (All employee and contract files kept at the agency and are available for review upon request). The IDT meeting agenda will be sent out to all IDT members the day before the meeting. A sign in sheet which lists the names of all employees by name and discipline is signed at the start of the meeting to ensure all are in attendance. Any employee found in noncompliance will have disciplinary action up to and including termination.</td>
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3 Who is responsible?
The Executive Director

4 By what date will the deficiency be corrected?
04/21/2015

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#### NAME OF PROVIDER OR SUPPLIER
NIGHTINGALE HOSPICE

#### STREET ADDRESS, CITY, STATE, ZIP CODE
6347 CONSTITUTION DRIVE
FORT WAYNE, IN 46804

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B. The IDT sheet dated 1/19/15 at 5:00 PM, evidenced patient #8 was listed and had employee C listed as the medical director. The sign in sheet dated 1/19/15 was signed by employee A, Registered Nurse (RN), but failed to evidence signatures for Medical Director, Social Worker (SW), and Chaplain, employees C, L, H, and I.

C. The IDT sign in sheet dated 12/31/14 at 9:30 AM, failed to evidence Medical Director, SW, and chaplain were present.

D. The IDT sign in sheet dated 12/22/14 failed to evidence the Medical Director and chaplain were present.

E. The IDT sign in sheet dated 12/17/14 failed to evidence the Medical Director and chaplain were present.

F. The IDT sign in sheet dated 12/3/14 failed to evidence the Medical Director, SW, and chaplain were present.

G. The IDT sign in sheet dated 11/24/14 failed to evidence the Medical Director was present.

H. The IDT sign in sheet dated 11/10/14 failed to evidence the Medical Director was present.
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

IDENTIFICATION NUMBER: 151598

A. BUILDING
B. WING

DATE SURVEY COMPLETED: 02/26/2015

NAME OF PROVIDER OR SUPPLIER: NIGHTINGALE HOSPICE
STREET ADDRESS, CITY, STATE, ZIP CODE: 6347 CONSTITUTION DRIVE, FORT WAYNE, IN 46804

ID PREFIX TAG

SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

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J. The IDT sign in sheet dated 10/27/14 failed to evidence the Medical Director was present.

K. The IDT sign in sheet dated 10/14/14 failed to evidence the Medical Director was present.

L. The IDT sign in sheet dated 10/8/14 failed to evidence the Medical Director and chaplain were present.

2. During interview on 2/25/15 at 10:10 AM, employee A (director of clinical services/alternate administrator) indicated the IDG meetings are conducted via phone and office with non-employee #3 and employee C (medical director). Employee A indicated the sign in sheet for 1/19/15 is on employee C’s desk waiting for signature and the last they checked on this was last week. Employee A indicated employee C is not timely with returning the signed IDT attendance sheets but they do call in via phone. Employee A indicated they call in to the another hospice entity for IDT discussions, and non-employee #22 is the back up for the patients here, and non-employees #3 and #22 are present to cover when employee C does not call in.

3. During interview on 2/25/15 at 10:20
AM, employee A indicated the last time employee C was available for an IDT meeting was maybe sometime last year, and the administrator said they could use an alternate if needed.

4. During interview on 2/26/15 at 3:30 PM, employee A (director of clinical services/alternate administrator) indicated all employees are invited to be present for the IDT meetings and usually consist of self, employees H (social worker), I (chaplain), and sometimes non-employee #23 if they are filling in for employee I. Employee A indicated the medical director, employee C (medical director) is present sometimes, if they show up.

5. During interview on 2/24/15 at 11:45 AM, employee A indicated due to only 1 patient at this time, the IDT meetings are conducted via telephone conference with the IDT meetings for the other hospice entity with their medical director, non-employee #22.

6. During phone interview on 2/24/15 at 3:45 PM, employee C indicated they are not sure if they are still the medical director for this hospice because they have been somewhat inactive, and they believe the other hospice entity is handling the IDT. Employee C indicated the last IDT they recalled being involved
with was approximately 3-4 months ago and they have not been actively involved in the last few months. Employee C indicated they were not aware the hospice moved to Crown Point, so was not even aware if they were going to be the medical director there had the hospice been able to stay. Employee C indicated they did not know the hospice was still functioning in Fort Wayne, as they figured it was defunct due to lack of communication. Employee C indicated they were aware of patient #10, as they provided care for this patient, but the patient passed away in December, but also indicated they may have signed some paperwork for patient #8 but they sign so many papers that they could not recall the patient's name. Employee C indicated when they were not available for medical director duties, the physician (non-employee # 22) at the other hospice entity covered for them, and vice versa.

7. During interview on 2/26/15 at 1:20 PM, employee C indicated they reviewed some of the staff for the other hospice entity's medical director if they needed something signed but there has not been much since around the first of this year. Possibly some in January. Employee C indicated they haven to talked with employee A for a few months, and indicated they were not on phone for the
IDT meeting on 1/19/15, indicating it's been months since they were involved with the IDT. Employee C indicated they do not recall being notified of patients #8, 9, and 11. Employee C indicated the hospice used to have physical IDT meetings at the office on Constitution Drive, some were done by phone. Employee C indicated phone IDT attendance involved the hospice sending a sign in sheet for them to sign and return, and about a week or two ago they signed one for one of the other physicians but has not seen any since then. Employee C checked emails and faxes while surveyor present in office, employee C indicated there were no current emails or faxes from the hospice as of today, 2/26/15. Employee C indicated most of this hospice's activity is ran out of the other hospice entity, including to approve and sign all patient care.

8. The hospice's undated policy titled "Interdisciplinary Group," # HSP2-15B, states "The IDG provides for ensures the ongoing sharing of information between all disciplines providing care and services in all setting, whether the care and services are provided directly or under arrangement."

9. The hospice's policy titled...
"Interdisciplinary Group," revised 9/30/08, states "1. The role of the IDG will include, but not limited to, the following: participation in the establishment of the Plan of Care, Provision or supervision of hospice care and services, Periodic review and updating the Plan of Care for each patient receiving hospice care, Designation of a registered nurse to coordinate the implementation of the Plan of Care for each patient, Identification of potential problems and recommend resolutions for solving the problem."

10. The hospice's undated policy titled "Medical director and Physician Services," #HSP2-11B.01, HSP4-11A, states "The Medical director will assume overall responsibility for the medical component of the Hospice's patient care program, ... The Medical Director and any physician employees of Hospice may also serve as the physician representatives of the Interdisciplinary Group (IDG) and/or as an attending physician. Responsibilities of the Medical Director and physician employees of the Hospice include, but are not limited to: ... b) Participation in the development, revision, and approval of the interdisciplinary group plan of care, ... d) Communication with hospice interdisciplinary group members, ... f)
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<td>L 543</td>
<td>418.56(b)</td>
<td>PLAN OF CARE</td>
<td>All hospice care and services furnished to patients and their families must follow an individualized written plan of care established by the hospice interdisciplinary group in collaboration with the attending physician (if any), the patient or representative, and the primary caregiver in accordance with the patient's needs if any of them so desire. Based on clinical record review, policy review, and interview, the hospice failed to ensure all hospice care and services furnished to patients and their families followed an individualized written plan of care established by the hospice.</td>
<td>04/21/2015</td>
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1 How will the deficiency be corrected?

The Registered Nurse will prepare an individualized written plan of care in collaboration with IDT members.
interdisciplinary group with the attending physician (if any), the patient or representative, and the primary caregiver in accordance with the patient's needs in 2 of 4 clinical records reviewed creating the potential to affect all patient's of the hospice. (#8 and #11)

Findings include:

1. Clinical record #8 contained a hospice plan of care for certification period 1/9 to 4/8/15 with orders for skilled nursing services stating, "21. SN: 1x/da [time per day] (1/14/2015 to 1/14/2015), 1x/wk (1/15/2015 to 1/17/2015), 3x/wk x 12 weeks (1/18/2015 to 4/8/2015), PRN [as needed] x5 change in functional status ... Insert/Change Foley Catheter: Type Latex 16 fr 5cc Freq. [frequency] Q [every] month and PRN. ... SN/CG to cleanse coccyx wound 2-3 x/wk with soap and water and apply sacral allevyn. ... HCA: 1x/wk x 1 wk (1/15/2015 to 1/17/2015), 2x/wk x 12 wks (1/18/2015 to 4/8/2015) assist with partial/complete bath. assist with personal care MSW: 1x/mo x 1 mo (1/15/2015 to 2/14/2015) assess for increased caregiver support. Clergy: 1x/mo x 1 mo (1/15/2015 to 2/14/2015) assess for other sources of spiritual support..." The record failed to evidence a skilled nursing visit was conducted on 1/14/15.

2 How will the deficiency be prevented from recurring?

Only those who are named on the employee list or contracted with the agency will be scheduled to do patient visits or provide patient care. A visit frequency checklist will be implemented and monitored weekly to ensure frequency follows the established plan of care. An in-service will be given to all RN case managers to ensure electronic entry correctly reflects patients required frequency. An admission checklist will be implemented to ensure plan of care is initiated timely and according to the orders and patients' needs.

3 Who is responsible?

The Executive Director

4 By what date will the deficiency be corrected?
A. The record contained a skilled nursing visit note dated 1/15/15 with an electronic signature of employee D (registered nurse) stating, "(PRN) SN Clinical Note Date 1/15/2015 In 11:35 AM Out 12:40 PM ... INTEGUMENTARY Skin Status Specific skin problems noted stage 2-3 to sacrum, 13x8, moderate amount of serosang, granulation noted. SN cleansed with mild soap and water and applied optifoam. pt tolerated well, no s/s infection. SN taught wound care to family, s/s infections, effects of incontinence on wound and to notify agency of any worsening and they verbalized understanding. ... CARE PLAN Met SN/CG to cleanse coccyx wound 2-3x/wk with soap and water and apply sacral allevyn ... Not Met Insert/Change Foley Catheter: ... 0% complete. ... NARRATIVE 1/13/15 Visit ... caregiver reports need for some medications, medication refills and ADL [activities of daily living]/incontinence care supplies. SN ordered all as needed. no other needs or concerns identified at this time."

B. On 2/25/15 at 12 PM, employee A (director of clinical services/alternate administrator) indicated supplies were ordered on 1/15/15 and 1/16/15 and the
C. On 2/25/15 at 11:15 AM, a telephone interview was conducted with employee D. The employee stated, "There was no care plan" and he/she knew what to do at the visit "Per hospice protocol and report." The employee indicated never providing wound care to this patient and stated, "I wasn't aware [patient] had a wound. It was never mentioned to me." The employee indicated receiving report and not positive of whom he/she received it from but thinks it was from non-employee #18.

D. The record contained a skilled nursing visit note dated 1/15/15 with an electronic signature of employee D stating, "SN Clinical Note Date 1/15/2015 In 12:35 PM Out 01:00 PM ... GENITOURINARY Catheter Foley patent and draining to gravity. patient denies any pain or discomfort at the cath insertion site. sediment noted in tubing but output WNL [within normal limits]. caregiver denies any s/s [signs and/or symptoms] UTI [urinary tract infection]. INTEGUMENTARY Skin Status Specific skin problems noted stage 2 wound to sacrum. optifoam dressing in place. ... CARE PLAN ... Not Met SN/CG to cleanse coccyx wound 2-3
### NIGHTINGALE HOSPICE

#### SUMMARY STATEMENT OF DEFICIENCIES

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<td>with soap and water and apply sacral allevyn ... 0% complete ... Insert/Change foley catheter ... not needed during this visit - 0% complete. ...</td>
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**E.** The record evidenced a hospice aide visit on 1/19/15 by non-employee #13. The record failed to evidence an aide visit as ordered for 1 time between the dates of 1/15 and 1/17/15.

**F.** On 2/25/15 at 11 AM, employee A indicated hospice services were initiated on 1/9/15 by non-employee #18 and the plan of care should have been initiated on 1/9/15. The director of clinical services indicated he/she reviewed the plan of care on 1/15/15 and that is why it did not get initiated until 1/15/15. The employee indicated non-employee #18 failed to communicate the plan of care to all other disciplines involved in the patient's care.

Clergy: 1x/mo x 3 mos (2/11/2015 to 5/9/2015) ...

The record contained a hospice aide care plan electronically signed by non-employee #17 on 2/11/15. The record evidenced hospice aide visits were conducted on 2/23 and 2/25/15 by non-employee #25. The record failed to evidence an aide visit was conducted week 1 (2/11 to 2/14/15) and failed to evidence 3 aide visits were conducted for the week 2 (2/15 to 2/21/15).

3. The undated policy titled "PATIENT ASSESSMENT & PLAN OF CARE" states, "PURPOSE To identify the patient's needs for care, treatment and/or services within an appropriate time frame based on the patient's needs and complexity of treatment, and in compliance with applicable laws, regulations and standards. To determine the appropriate care, treatment and/or services to meet the patient's initial needs, including support needs, as well as his/her continuing needs while receiving care, treatment and/or services provided by agency personnel. To ensure that an assessment is performed appropriate to the patient's needs and diagnosis and the care, treatment and/or services provided by the agency. ... to ensure that the patient's current needs and/or problems
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

IDENTIFICATION NUMBER: 151598

X2) MULTIPLE CONSTRUCTION
A. BUILDING 00
B. WING

X3) DATE SURVEY COMPLETED 02/26/2015

NAME OF PROVIDER OR SUPPLIER
NIGHTINGALE HOSPICE

STREET ADDRESS, CITY, STATE, ZIP CODE
6347 CONSTITUTION DRIVE
FORT WAYNE, IN 46804

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are continuously evaluated, and the care, treatment and/or services provided are adjusted to address those needs and/or problems. POLICY The initial diagnosis and age appropriate assessment shall be performed by a Registered Nurse: ... If a service discipline cannot meet the time frame for assessment, the patient and the physician must be notified and orders received to delay the initial assessment/evaluation. ... A proposed plan of care, based upon assessment findings, is developed and discussed with the patient/family to ensure that the patient/family/caregiver is involved in decisions about the patient's care ... The comprehensive assessment is to be submitted to the agency office within 24 hours of the completed assessment. ... PROCEDURE: A registered nurse shall complete a comprehensive assessment and reassessment of the patient's needs for care, treatment and/or services, including home health aide services, within the time frames specified above in policy. The completed documentation is submitted to the agency within the time frames specified above in policy. The comprehensive assessment: ... is performed within the registered nurse's scope of practice, state licensure laws, applicable regulations and/or certification of the RN ... The completed assessment paperwork is reviewed in the agency for.
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<td>L 552</td>
<td>04/21/2015</td>
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418.56(d) REVIEW OF THE PLAN OF CARE

The hospice interdisciplinary group (in collaboration with the individual's attending physician, if any) must review, revise and document the individualized plan as frequently as the patient's condition requires, but no less frequently than every 15 calendar days.

Based on clinical record review, interview, document review, and policy review, the hospice failed to ensure the interdisciplinary team (IDT) members reviewed, revised, and documented the plan of care (POC) at least every 15 days.

1 How will the deficiency be corrected?

The plan of care will be reviewed, revised and documented in consultation with the attending physician as frequently as the patient’s condition requires but no
for 1 of 4 clinical records reviewed, creating the potential to affect all the hospice's patients. (#11)

Findings include

1. A document dated 1/19/15 at 5 PM titled "ANNOUNCEMENTS/UPDATES" states, "Admissions: Patient Name: [patient #8] RN: [blank] Date: 1/9/2015 Comments: [blank] ... ." The document failed to evidence all members were present during the meeting and failed to evidence documentation of the patient's progress and response to care.

2. A document dated 2/16/15 at 5 PM titled "ANNOUNCEMENTS/UPDATES" states, "Patients for: IDT Discussion/Bi-Weekly Review: ... Patient Name: [patient #8] RN: [blank] SOC Date: 1/9/2015 Recert Date: [blank] DX: Lung Cancer ... Patient Name: [patient #11] ... ." The document failed to evidence all members were present during the meeting and failed to evidence documentation of the patient's progress and response to care.

A. Clinical record #8 evidenced a start of care date as 1/9/15 and a date of death as 1/20/15.

less than every 15 calendar days The Plan of care will be electronically signed an updated at every IDT meeting for all patients in collaboration with the attending Physician. A system will be in place to communicate and integrate in accordance with our policy and procedure to ensure that the IDT group maintains responsibility for directing coordinating and supervising the care and services provided. All communication will be documented and recorded in the patients' clinical record

2. How will the deficiency be prevented for recurring?

An in-service will be given to all IDT members regarding the required frequency for the IDT to meet to review and update the patients' plan of care and their responsibility to be present and document updates to the patients' plan of care. The IDT meeting agenda will be sent out to all IDT members the day before the meeting. A sign in sheet which lists the names of all employees by name and discipline is signed at the start of the meeting to ensure all are in attendance. Any employee found in noncompliance will have disciplinary action up to and including termination. The attendance and documentation of attendance of IDT members will be monitored for compliance by the Executive Director during each meeting
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<td>B. The hospice failed to provide evidence any IDT meetings between 1/19 and 2/16/15.</td>
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<td>3. During interview on 2/25/15 at 10:20 AM, employee A indicated the last time employee C was available for an IDT meeting was maybe sometime last year, and the administrator said they could use an alternate if needed.</td>
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<td>4. The hospice's undated policy titled &quot;Interdisciplinary Group,&quot; # HSP2-15B, states, &quot;The IDG provides for ensures the ongoing sharing of information between all disciplines providing care and services in all setting, whether the care and services are provided directly or under arrangement.&quot;</td>
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<td>5. The hospice's policy titled &quot;Interdisciplinary Group,&quot; revised 9/30/08, states, &quot;1. The role of the IDG will include, but not limited to, the following: participation in the establishment of the Plan of Care, Provision or supervision of hospice care and services, Periodic review and updating the Plan of Care for each patient receiving hospice care, Designation of a registered nurse to coordinate the implementation of the Plan of Care for each patient, Identification of potential</td>
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3 Who is responsible? The Executive Director

4 By what date will the deficiency be corrected? 04/21/2015
<table>
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<tr>
<th>STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION</th>
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<th>MULTIPLE CONSTRUCTION</th>
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<td>L 554</td>
<td>418.56(e)(1) COORDINATION OF SERVICES The hospice must develop and maintain a system of communication and integration, in accordance with the hospice's own policies and procedures, to- (1) Ensure that the interdisciplinary group maintains responsibility for directing, coordinating, and supervising the care and services provided. Based on document review, policy review, and interview, the hospice failed to develop and maintain a system of communication and integration in accordance with the hospice's own policies and procedures to ensure that the interdisciplinary group maintained responsibility for directing, coordinating,</td>
<td>L 554</td>
<td>1 How will the deficiency be corrected? The stated “non-employees” were actually employed by this agency at the time of survey; the employee list given to the state surveyor at time of survey did not reflect this (see attachment B, employee list, if further evidence is needed. W-2’s can be provided.) The Plan of care</td>
<td>04/21/2015</td>
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6. During interview on 2/26/15 at 3:45 PM, employees A and H indicated there was no further information to submit for review.
## STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

### IDENTIFICATION NUMBER:
151598

### DATE SURVEY COMPLETED:
02/26/2015

### NAME OF PROVIDER OR SUPPLIER:
NIGHTINGALE HOSPICE

### STREET ADDRESS, CITY, STATE, ZIP CODE:
6347 CONSTITUTION DRIVE
FORT WAYNE, IN 46804

### SUMMARY STATEMENT OF DEFICIENCIES

(Each deficiency must be preceded by full regulatory or LSC identifying information)

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<td>will be electronically signed an updated at every IDT meeting for all patients and a copy will be sent to the attending Physician. A system will be in place to communicate and integrate in accordance with our policy and procedure to ensure that the IDT group maintains responsibility for directing coordinating and supervising the care and services provided. All communication will be documented and recorded in the patients clinical record.</td>
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Findings include:

1. During interview on 2/26/15 at 3:30 PM, employee A (director of clinical services / alternate administrator) indicated all employees are invited to be present for the IDT meetings and usually consist of self, employees H (social worker), I (chaplain), and sometimes non-employee #23 if they are filling in for employee I. Employee A indicated the medical director, employee C (medical director) is present sometimes, if they show up.

2. During interview on 2/24/15 at 11:45 AM, employee A indicated due to only 1 patient at this time, the IDT meetings are conducted via telephone conference with the IDT meetings for the other hospice entity with their medical director, non-employee # 22.

3. During phone interview on 2/24/15 at 3:45 PM, employee C indicated they are not sure if they are still the medical director for this hospice because they have been somewhat inactive, and they believe the other hospice entity is handling the IDT. Employee C indicated the last IDT they recalled being involved and supervising the care and services provided.

2 How will the deficiency be prevented from recurring?

An in-service will be given to all skilled staff regarding the agency policy on interdisciplinary communication. An in-service will be done with all RN case managers and IDT members on the admission plan of care protocol and communication expectations and duties An audit will be conducted on 100% of all current patient charts to ensure coordination of care The IDT meeting agenda will be sent out to all IDT members the day before the meeting. A sign in sheet which lists the names of all employees by name and discipline is signed at the start of the meeting to ensure all are in attendance. Any employee found in noncompliance will have disciplinary action up to and including termination. The attendance and documentation of attendance of IDT members will be monitored for compliance by the
with was approximately 3-4 months ago and they have not been actively involved in the last few months. Employee C indicated they were not aware the hospice moved to Crown Point, so was not even aware if they were going to be the medical director there had the hospice been able to stay. Employee C indicated they did not know the hospice was still functioning in Fort Wayne, as they figured it was defunct due to lack of communication. Employee C indicated they were aware of patient #10, as they provided care for this patient, but the patient passed away in December, but also indicated they may have signed some paperwork for patient #8 but they sign so many papers that they could not recall the patient's name. Employee C indicated when they were not available for medical director duties, the physician (non-employee #22) at the other hospice entity covered for them, and vice versa.

4. During interview on 2/26/15 at 1:20 PM, employee C indicated they reviewed some of the staff for the other hospice entity's medical director if they needed something signed but there has not been much since around the first of this year. Possibly some in January. Employee C indicated they haven to talked with employee A for a few months, and indicated they were not on phone for the

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Executive Director during each meeting

3 Who is responsible?
The Executive Director

4 By what date will the deficiency be corrected?

04/21/2015
IDT meeting on 1/19/15, indicating it's been months since they were involved with the IDT. Employee C indicated they do not recall being notified of patients #8, 9, and 11. Employee C indicated the hospice used to have physical IDT meetings at the office on Constitution Drive, some were done by phone. Employee C indicated phone IDT attendance involved the hospice sending a sign in sheet for them to sign and return, and about a week or two ago they signed one for one of the other physicians but has not seen any since then. Employee C checked emails and faxes while surveyor present in office, employee C indicated there were no current emails or faxes from the hospice as of today, 2/26/15. Employee C indicated most of this hospice's activity is ran out of the other hospice entity, including to approve and sign all patient care.

6. During interview on 2/25/15 at 10:10 AM, employee A indicated the IDT meetings are conducted via phone and office with non-employee #3 and employee C. Employee A indicated the sign in sheet for 1/19/15 is on employee C's desk waiting for signature and the last they checked on this was last week. Employee A indicated employee C is not timely with returning the signed IDT.
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**IDENTIFICATION NUMBER:**
151598

**MULTIPLE CONSTRUCTION**

**A. BUILDING**
00

**B. WING**

**DATE SURVEY COMPLETED:**
02/26/2015

**NAME OF PROVIDER OR SUPPLIER**
NIGHTINGALE HOSPICE

**STREET ADDRESS, CITY, STATE, ZIP CODE**
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FORT WAYNE, IN 46804

| X(4) ID | PREFIX | TAG | SUMMARY STATEMENT OF DEFICIENCIES | ID | PREFIX | TAG | PROVIDER'S PLAN OF CORRECTION | COMPLETION DATE |
|---|---|---|---|---|---|---|---|---|---|
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| | | | | | | | | |
| | | | attendance sheets but they do call in via phone. Employee A indicated they call in to the another hospice entity for IDT discussions, and non-employee #22 is the back up for the patients here, and non-employees #3 and #22 are present to cover when employee C does not call in. | | | | | |
| 7. | During interview on 2/25/15 at 10:20 AM, employee A indicated the last time employee C was available for an IDT meeting was maybe sometime last year, and the administrator said they could use an alternate if needed. | | | | | | |
| 8. | The hospice's undated policy titled "Interdisciplinary Group," # HSP2-15B, states, "The IDG provides for ensures the ongoing sharing of information between all disciplines providing care and services in all setting, whether the care and services are provided directly or under arrangement." | | | | | | |
| 9. | The hospice's policy titled "Interdisciplinary Group," revised 9/30/08, states, "I. The role of the IDG will include, but not limited to, the following: participation in the establishment of the Plan of Care, Provision or supervision of hospice care and services, Periodic review and updating the Plan of Care for each patient receiving hospice care, Designation of a | | | | | | |
registered nurse to coordinate the implementation of the Plan of Care for each patient, Identification of potential problems and recommend resolutions for solving the problem."

10. The hospice's undated policy titled "Medical director and Physician Services," #HSP2-11B.01, HSP4-11A, states. "The Medical director will assume overall responsibility for the medical component of the Hospice's patient care program, ... The Medical Director and any physician employees of Hospice may also serve as the physician representatives of the Interdisciplinary Group (IDT) and/or as an attending physician. Responsibilities of the Medical Director and physician employees of the Hospice include, but are not limited to:  ... b) Participation in the development, revision, and approval of the interdisciplinary group plan of care, ... d) Communication with hospice interdisciplinary group members, ... f) attends interdisciplinary group meetings. ... In the absence of the Medical Director, a qualified physician will be available to serve as his/her designee."

11. Clinical record #8, start of care 1/9/15, evidenced a document electronically signed by non-employee #18 dated 1/9/15 titled "(SOC) [start of
### Statement of Deficiencies and Plan of Correction

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**Multiple Construction:**  
A. Building  
B. Wing  

**Date Survey Completed:** 02/26/2015  
**Name of Provider or Supplier:** NIGHTINGALE HOSPICE  
**Street Address, City, State, Zip Code:** 6347 CONSTITUTION DRIVE FORT WAYNE, IN 46804

#### Summary Statement of Deficiencies

**Prefix**  
**Tag**  

**ID**  
**Prefix**  
**Tag**  

**Provider's Plan of Correction**

**Completion Date**

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**Care** SN [skilled nursing] Clinical Note stating, "GENITOURINARY Catheter Urethral inserted Latex Foley # 16 fr 10 cc balloon next change due on or about 12/12/2014 ... ASSESSMENT Condition Clients condition is uncomfortable indicating need to alter plan of care Knowledge Deficit pain and anxiety meds ... Goals: ... established optimum skin and wound care. ... CARE PLAN Met SN/CG [caregiver] to cleanse coccyx wound 2-3 x/wk [times per week] with soap and water and apply sacral allevyn ... NARRATIVE SOC for elderly female with end stage lung disease. Awake and alert but very forgetful. Has stage 3 wound to coccyx. Cleansed with soap and water and covered with sacral allevyn. ... Pain 6 upon nurses arrival. Caregiver encouraged to give Q 4 hr [hour] dose of morphine and ativan SL [sublingual] to comfort patient. Has Foley cath in place draining ... clear yellow urine ... ." The assessment failed to evidence completion by a member of the IDG.

**A.** The record contained a document dated 1/9/15 titled "ADMISSION SUMMARY" stating, "Summation of Care: SN: 'Assess and instruct on needed care, wound care, assess pain/control, assess nutritional status' MSW: 'Assess for increased caregiver support' Clergy:
NAME OF PROVIDER OR SUPPLIER: NIGHTINGALE HOSPICE
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'B' Assess for other spiritual support' ...
Documents Sent: (check off) or NA [not applicable] if not applicable
Medicine/Tx [treatment] sheets [checked]
Plan of Care [checked] ... Signature of Nurse Completing worksheet:
[non-employee #18] ... ."

B. The record contained a hospice plan of care for certification period 1/9 to 4/8/15 with orders for skilled nursing services stating, "21. SN: 1x/da [time per day] (1/14/2015 to 1/14/2015), 1x/wk (1/15/2015 to 1/17/2015), 3x/wk x 12 weeks (1/18/2015 to 4/8/2015), PRN [as needed] x5 change in functional status ... Insert/Change Foley Catheter: Type Latex 16 fr 5cc Freq. [frequency] Q [every] month and PRN. ... SN/CG to cleanse coccyx wound 2-3 x/wk with soap and water and apply sacral allevyn. ...
HCA: 1x/wk x 1wk (1/15/2015 to 1/17/2015), 2x/wk x 12 wks (1/18/2015 to 4/8/2015) assist with partial/complete bath. assist with personal care MSW: 1x/mo x 1mo (1/15/2015 to 2/14/2015) assess for increased caregiver support Clergy: 1x/mo x 1mo (1/15/2015 to 2/14/2015) assess for other sources of spiritual support... " The record failed to evidence a skilled nursing visit was conducted on 1/14/15.

C. The record contained a skilled
nursing visit note dated 1/15/15 with an electronic signature of employee D (registered nurse) stating, "(PRN) SN Clinical Note Date 1/15/2015 In 11:35 AM Out 12:40 PM ...

INTEGUMENTARY Skin Status
Specific skin problems noted stage 2-3 to sacrum, 13x8, moderate amount of serosang, granulation noted. SN cleansed with mild soap and water and applied optifoam. pt tolerated well, no s/s infection. SN taught wound care to family, s/s infections, effects of incontinence on wound and to notify agency of any worsening and they verbalized understanding. ... CARE PLAN Met SN/CG to cleanse coccyx wound 2-3x/wk with soap and water and apply sacral allevyn ... Not Met Insert/Change Foley Catheter: ... 0% complete. ... NARRATIVE 1/13/15 Visit ... caregiver reports need for some medications, medication refills and ADL [activities of daily living]/incontinence care supplies. SN ordered all as needed. no other needs or concerns identified at this time."

1.) On 2/25/15 at 12 PM, employee A indicated supplies were ordered on 1/15/15 and 1/16/15 and the visit was conducted by employee D on 1/15/15. Employee A was unable to locate documentation in the clinical
record of any skilled nursing visits prior to 1/15/15, except for the SOC visit dated 1/9/15.

2.) On 2/25/15 at 11:15 AM, a telephone interview was conducted with employee D. The employee stated, "There was no care plan" and he/she knew what to do at the visit "Per hospice protocol and report." The employee indicated never providing wound care to this patient and stated, "I wasn't aware [patient] had a wound. It was never mentioned to me." The employee indicated receiving report and not positive of whom he/she received it from but thinks it was from non-employee #18.

D. The record contained a skilled nursing visit note dated 1/15/15 with an electronic signature of employee D stating, "SN Clinical Note Date 1/15/2015 In 12:35 PM Out 01:00 PM ... GENITOURINARY Catheter Foley patent and draining to gravity. patient denies any pain or discomfort at the cath insertion site. sediment noted in tubing but output WNL [within normal limits]. caregiver denies any s/s [signs and/or symptoms] UTI [urinary tract infection]. INTEGUMENTARY Skin Status Specific skin problems noted stage 2 wound to sacrum. optifoam dressing in place. ... CARE PLAN ... Not Met
### STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

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  - A. BUILDING: 00
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#### DATE SURVEY COMPLETED:
- 02/26/2015

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#### STREET ADDRESS, CITY, STATE, ZIP CODE:
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- FORT WAYNE, IN 46804

#### SUMMARY STATEMENT OF DEFICIENCIES

**PREFIX**
- TAG

- **ID**

- **PREFIX**

- **TAG**

**DESCRIPTION**

- **SN/CG to cleanse coccyx wound 2-3 x/wk with soap and water and apply sacral allevyn ... 0% complete ...

- Insert/Change foley catheter ... not needed during this visit - 0% complete. ... ."

- E. The record contained a skilled nursing visit note dated 1/15/15 with an electronic signature of employee L stating, "SN Clinical Note Date 1/15/2015 In 01:03 PM Out 02:03 PM ...

- **GENITOURINARY Urine Amount Adequate Color Amber Odor Foul Appearance Cloudy Catheter Urethral Inserted Latex Foley #16 Fr 10 cc Balloon Inflated to 7.5 cc next change due on or about 2/15/2015 Insertion Area Reddened cg state that catheter had not been changed for 2 months. strong urine odor noted. ...

- **INTEGUMENTARY Skin Status General skin condition intact specific skin problems noted lesion L [left] buttock lesion R [right] buttock currently using low air loss mattress ... WOUND Wound #1 Type Pressure ulcer did not assess today as no dressing available in home. family states it has not changed for last assessment Location Posterior Buttock Wound size Length did not assess cm [centimeters] Width did not assess cm Depth did not assess cm. ...**

- **CARE PLAN Met ... Insert/Change foley**
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(X5)
COMPLETION DATE

12. On 2/25/15 at 11:25 AM, employee A indicated the IDG did not meet until 1/19/15 to review the patient's plan of care for patient #8.

13. On 2/25/15 at 4 PM, employee A indicated the IDG did not meet until 2/16/15 to review the patient's plan of care for patient #11.

14. On 2/25/15 at 4:10 PM, employee A indicated the clinical record did not contain documentation of coordination of

F. On 2/25/15 at 11 AM, employee A indicated hospice services were initiated on 1/9/15 by non-employee #18 and the plan of care should have been initiated on 1/9/15. The director of clinical services indicated he/she reviewed the plan of care on 1/15/15 and that is why it did not get initiated until 1/15/15. The employee indicated non-employee #18 failed to communicate the plan of care to all other disciplines involved in the patient's care.

catheter ... Not Met SN/CG to cleanse coccyx wound 2-3 x/wk with soap and water and apply sacral allevyn - 0% complete ... NARRATIVE Pt [patient] needed catheter change. insertion site is red and irritated. replaced with 16 fr 7.5 ml in balloon. VS [vital signs] stable. ...
15. The policy with a revision date as 9/30/08 titled "INTERDISCIPLINARY GROUP" states, "PROCEDURE 1. The role of the IDG will include, but not limited to, the following: Participating in the establishment of the Plan of Care Provision or supervision of hospice care and services ... Designation of a registered nurse to coordinate the implementation of the Plan of Care for each patient ... 3. The director of patient care services of RN [registered nurse] case manager is responsible to bring information regarding patients and their families to the IDG meeting."

418.56(e)(2) COORDINATION OF SERVICES
[The hospice must develop and maintain a system of communication and integration, in accordance with the hospice's own policies and procedures, to-]
(2) Ensure that the care and services are provided in accordance with the plan of care.

Based on clinical record review, policy review, and interview, the hospice failed to ensure a system of communication and integration was developed and maintained to ensure the care and

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<td>L 555</td>
<td>418.56(e)(2) COORDINATION OF SERVICES</td>
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<td>1 How will the deficiency be corrected? The Agency will ensure that the care and services are provided in</td>
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services were provided in accordance with the plan of care in 2 of 4 clinical records reviewed creating the potential to affect all patient's of the hospice. (#8 and #11)

Findings include:

1. During interview on 2/26/15 at 3:30 PM, employee A (director of clinical services / alternate administrator) indicated all employees are invited to be present for the IDT meetings and usually consist of self, employees H (social worker), I (chaplain), and sometimes non-employee #23 if they are filling in for employee I. Employee A indicated the medical director, employee C (medical director) is present sometimes, if they show up.

2. During interview on 2/24/15 at 11:45 AM, employee A indicated due to only 1 patient at this time, the IDT meetings are conducted via telephone conference with the IDT meetings for the other hospice entity with their medical director, non-employee # 22.

3. During phone interview on 2/24/15 at 3:45 PM, employee C indicated they are not sure if they are still the medical director for this hospice because they have been somewhat inactive, and they

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how will the deficiency be prevented from recurring?

An in-service will be given to all skilled staff regarding the agency policy on interdisciplinary communication. An in-service will be done with all RN case managers and IDT members on the plan of care and communication expectations and duties. An audit will be conducted on 100% of all current patient charts to ensure accurate implementation of the plan of care for 90 days or until compliance is achieved.

3 Who is responsible?
The Executive Director

4 By what date will the deficiency be corrected?

04/21/2015
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**NAME OF PROVIDER OR SUPPLIER**

NIGHTINGALE HOSPICE

**STREET ADDRESS, CITY, STATE, ZIP CODE**

6347 CONSTITUTION DRIVE
FORT WAYNE, IN 46804

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Employee C indicated they reviewed some of the staff for the other hospice entity's medical director if they needed something signed but there has not been much since around the first of this year. Possibly some in January. Employee C believe the other hospice entity is handling the IDT. Employee C indicated the last IDT they recalled being involved with was approximately 3-4 months ago and they have not been actively involved in the last few months. Employee C indicated they were not aware the hospice moved to Crown Point, so was not even aware if they were going to be the medical director there had the hospice been able to stay. Employee C indicated they did not know the hospice was still functioning in Fort Wayne, as they figured it was defunct due to lack of communication. Employee C indicated they were aware of patient #10, as they provided care for this patient, but the patient passed away in December, but also indicated they may have signed some paperwork for patient #8 but they sign so many papers that they could not recall the patient's name. Employee C indicated when they were not available for medical director duties, the physician (non-employee # 22) at the other hospice entity covered for them, and vice versa.

4. During interview on 2/26/15 at 1:20 PM, employee C indicated they reviewed some of the staff for the other hospice entity's medical director if they needed something signed but there has not been much since around the first of this year. Possibly some in January. Employee C
indicated they haven't talked with employee A for a few months, and indicated they were not on phone for the IDT meeting on 1/19/15, indicating it's been months since they were involved with the IDT. Employee C indicated they do not recall being notified of patients #8, 9, and 11. Employee C indicated the hospice used to have physical IDT meetings at the office on Constitution Drive, some were done by phone. Employee C indicated phone IDT attendance involved the hospice sending a sign in sheet for them to sign and return, and about a week or two ago they signed one for one of the other physicians but has not seen any since then. Employee C checked emails and faxes while surveyor present in office, employee C indicated there were no current emails or faxes from the hospice as of today, 2/26/15. Employee C indicated most of this hospice's activity is run out of the other hospice entity, including to approve and sign all patient care.

6. During interview on 2/25/15 at 10:10 AM, employee A indicated the IDT meetings are conducted via phone and office with non-employee #3 and employee C. Employee A indicated the sign in sheet for 1/19/15 is on employee C's desk waiting for signature and the last
they checked on this was last week. Employee A indicated employee C is not timely with returning the signed IDT attendance sheets but they do call in via phone. Employee A indicated they call in to the another hospice entity for IDT discussions, and non-employee #22 is the back up for the patients here, and non-employees #3 and #22 are present to cover when employee C does not call in.

7. During interview on 2/25/15 at 10:20 AM, employee A indicated the last time employee C was available for an IDT meeting was maybe sometime last year, and the administrator said they could use an alternate if needed.

8. The hospice's undated policy titled "Interdisciplinary Group," # HSP2-15B, states, "The IDG provides for ensures the ongoing sharing of information between all disciplines providing care and services in all setting, whether the care and services are provided directly or under arrangement."

9. The hospice's policy titled "Interdisciplinary Group," revised 9/30/08, states, "1. The role of the IDG will include, but not limited to, the following: participation in the establishment of the Plan of Care, Provision or supervision of hospice care
The hospice's undated policy titled "Medical director and Physician Services," #HSP2-11B.01, HSP4-11A, states. "The Medical director will assume overall responsibility for the medical component of the Hospice's patient care program, ... The Medical Director and any physician employees of Hospice may also serve as the physician representatives of the Interdisciplinary Group (IDT) and/or as an attending physician. Responsibilities of the Medical Director and physician employees of the Hospice include, but are not limited to: ... b) Participation in the development, revision, and approval of the interdisciplinary group plan of care, ... d) Communication with hospice interdisciplinary group members, ... f) attends interdisciplinary group meetings. ... In the absence of the Medical Director, a qualified physician will be available to serve as his/her designee."

11. Clinical record #8, start of care
NAME OF PROVIDER OR SUPPLIER

NIGHTINGALE HOSPICE

STREET ADDRESS, CITY, STATE, ZIP CODE

6347 CONSTITUTION DRIVE
FORT WAYNE, IN 46804

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<td>REGULATORY OR LSC IDENTIFYING INFORMATION)</td>
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1/9/15, evidenced a document electronically signed by non-employee #18 dated 1/9/15 titled "(SOC) [start of care] SN [skilled nursing] Clinical Note" stating, "GENITOURINARY Catheter Urethral inserted Latex Foley # 16 fr 10 cc balloon next change due on or about 12/12/2014 ... ASSESSMENT Condition Clients condition is uncomfortable indicating need to alter plan of care Knowledge Deficit pain and anxiety meds ... Goals: ... established optimum skin and wound care. ... CARE PLAN Met SN/CG [caregiver] to cleanse coccyx wound 2-3 x/wk [times per week] with soap and water and apply sacral allevyn ... NARRATIVE SOC for elderly female with end stage lung disease. Awake and alert but very forgetful. Has stage 3 wound to coccyx. Cleansed with soap and water and covered with sacral allevyn. ... Pain 6 upon nurses arrival. Caregiver encouraged to give Q 4 hr [hour] dose of morphine and ativan SL [sublingual] to comfort patient. Has Foley cath in place draining ... clear yellow urine ... ". The assessment failed to evidence completion by a member of the IDG.

A. The record contained a document dated 1/9/15 titled "ADMISSION SUMMARY" stating, "Summation of Care: SN: 'Assess and instruct on needed
B. The record contained a hospice plan of care for certification period 1/9 to 4/8/15 with orders for skilled nursing services stating, "21. SN: 1x/da [time per day] (1/14/2015 to 1/14/2015), 1x/wk (1/15/2015 to 1/17/2015), 3x/wk x 12 weks (1/18/2015 to 4/8/2015), PRN [as needed] x5 change in functional stat [status] ... Insert/Change Foley Catheter: Type Latex 16 fr 5cc Freq. [frequency] Q [every] month and PRN. ... SN/CG to cleanse coccyx wound 2-3 x/wk with soap and water and apply sacral allevyn. ... HCA: 1x/wk x 1wk (1/15/2015 to 1/17/2015), 2x/wk x 12 wks (1/18/2015 to 4/8/2015) assist with partial/complete bath. assist with personal care MSW: 1x/mo x 1 mo (1/15/2015 to 2/14/2015) assess for increased caregiver support Clergy: 1x/mo x 1 mo (1/15/2015 to 2/14/2015) assess for other sources of spiritual support... " The record failed to evidence a skilled nursing visit was
C. The record contained a skilled nursing visit note dated 1/15/15 with an electronic signature of employee D (registered nurse) stating, "(PRN) SN Clinical Note Date 1/15/2015 In 11:35 AM Out 12:40 PM ...

INTEGUMENTARY Skin Status
Specific skin problems noted stage 2-3 to sacrum, 13x8, moderate amount of serosang, granulation noted. SN cleansed with mild soap and water and applied optifoam. pt tolerated well, no s/s infection. SN taught wound care to family, s/s infections, effects of incontinence on wound and to notify agency of any worsening and they verbalized understanding. ...

CARE PLAN Met SN/CG to cleanse coccyx wound 2-3x/wk with soap and water and apply sacral allevyn ... Not Met

Insert/Change Foley Catheter: ... 0% complete. ...

NARRATIVE 1/13/15 Visit ...

caregiver reports need for some medications, medication refills and ADL [activities of daily living]/incontinence care supplies. SN ordered all as needed. no other needs or concerns identified at this time."

1.) On 2/25/15 at 12 PM, employee A indicated supplies were ordered on 1/15/15 and 1/16/15 and the...
visit was conducted by employee D on 1/15/15. Employee A was unable to locate documentation in the clinical record of any skilled nursing visits prior to 1/15/15, except for the SOC visit dated 1/9/15.

2.) On 2/25/15 at 11:15 AM, a telephone interview was conducted with employee D. The employee stated, "There was no care plan" and he/she knew what to do at the visit "Per hospice protocol and report." The employee indicated never providing wound care to this patient and stated, "I wasn't aware [patient] had a wound. It was never mentioned to me." The employee indicated receiving report and not positive of whom he/she received it from but thinks it was from non-employee #18.

D. The record contained a skilled nursing visit note dated 1/15/15 with an electronic signature of employee D stating, "SN Clinical Note  Date 1/15/2015 In 12:35 PM  Out 01:00 PM ... GENITOURINARY Catheter Foley patent and draining to gravity. patient denies any pain or discomfort at the cath insertion site. sediment noted in tubing but output WNL [within normal limits]. caregiver denies any s/s [signs and/or symptoms] UTI [urinary tract infection]. INTEGUMENTARY Skin Status
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### SUMMARY STATEMENT OF DEFICIENCIES

(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

Specific skin problems noted stage 2 wound to sacrum. optifoam dressing in place. ... CARE PLAN ... Not Met SN/CG to cleanse coccyx wound 2-3 x/wk with soap and water and apply sacral allevyn ... 0% complete ... Insert/Change foley catheter ... not needed during this visit - 0% complete. ...

E. The record contained a skilled nursing visit note dated 1/15/15 with an electronic signature of employee L stating, "SN Clinical Note Date 1/15/2015 In 01:03 PM Out 02:03 PM ... GENITOURINARY Urine Amount Adequate Color Amber Odor Foul Appearance Cloudy Catheter Urethral Inserted Latex Foley #16 fr 10 cc Balloon Inflated to 7.5 cc next change due on or about 2/15/2015 Insertion Area Reddened cg state that catheter had not been changed for 2 months. strong urine odor noted. ...

INTEGUMENTARY Skin Status General skin condition intact specific skin problems noted lesion L [left] buttock lesion R [right] buttock currently using low air loss mattress ... WOUND Wound #1 Type Pressure ulcer did not assess today as no dressing available in home. family states it has not changed for last assessment Location Posterior Buttock Wound size Length did not
NAME OF PROVIDER OR SUPPLIER: NIGHTINGALE HOSPICE

STREET ADDRESS, CITY, STATE, ZIP CODE: 6347 CONSTITUTION DRIVE
FORT WAYNE, IN 46804

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<td>assess cm [centimeters] Width did not assess cm Depth did not assess cm. ... CARE PLAN Met ... Insert/Change foley catheter ... Not Met SN/CG to cleanse coccyx wound 2-3 x/wk with soap and water and apply sacral allevyn - 0% complete ... NARRATIVE Pt [patient] needed catheter change. insertion site is red and irritated. replaced with 16 fr 7.5 ml in balloon. VS [vital signs] stable. ...</td>
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<td>F. On 2/25/15 at 11 AM, employee A indicated hospice services were initiated on 1/9/15 by non-employee #18 and the plan of care should have been initiated on 1/9/15. The director of clinical services indicated he/she reviewed the plan of care on 1/15/15 and that is why it did not get initiated until 1/15/15. The employee indicated non-employee #18 failed to communicate the plan of care to all other disciplines involved in the patient's care.</td>
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<td>12. On 2/25/15 at 11:25 AM, employee A indicated the IDG did not meet until 1/19/15 to review the patient's plan of care for patient #8.</td>
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<td>13. On 2/25/15 at 4 PM, employee A indicated the IDG did not meet until 2/16/15 to review the patient's plan of care for patient #11.</td>
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### Statement of Deficiencies and Plan of Correction

**Identification Number:** MULTIPLE CONSTRUCTION

**Date Survey Completed:** 02/26/2015

**Name of Provider or Supplier:** NIGHTINGALE HOSPICE

**Street Address, City, State, Zip Code:** 6347 CONSTITUTION DRIVE
FORT WAYNE, IN 46804

### Summary Statement of Deficiencies

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<td>Bldg. 00</td>
<td>418.56(e)(4)</td>
<td>COORDINATION OF SERVICES</td>
<td>(The hospice must develop and maintain a system of communication and integration, in accordance with the hospice's own policies and procedures, to-)</td>
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<td>(4) Provide for and ensure the ongoing sharing of information between all disciplines providing care and services in all settings, whether the care and services are provided directly or under arrangement.</td>
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<td>Based on clinical record review, policy review, and interview, the hospice failed to ensure to develop and maintain a</td>
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<td>1 How will the deficiency be corrected?</td>
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**14.** On 2/25/15 at 4:10 PM, employee A indicated the clinical record did not contain documentation of coordination of care between non-employee #17 and any other disciplines providing services.

**15.** The policy with a revision date as 9/30/08 titled "INTERDISCIPLINARY GROUP" states, "PROCEDURE 1. The role of the IDG will include, but not limited to, the following: Participating in the establishment of the Plan of Care Provision or supervision of hospice care and services ... Designation of a registered nurse to coordinate the implementation of the Plan of Care for each patient ... 3. The director of patient care services of RN [registered nurse] case manager is responsible to bring information regarding patients and their families to the IDG meeting."
**NAME OF PROVIDER OR SUPPLIER**
NIGHTINGALE HOSPICE

**STREET ADDRESS, CITY, STATE, ZIP CODE**
6347 CONSTITUTION DRIVE
FORT WAYNE, IN 46804

### SUMMARY STATEMENT OF DEFICIENCIES

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**Findings include:**

1. Clinical record #8, start of care 1/9/15, evidenced a document electronically signed by non-employee #18 dated 1/9/15 titled "(SOC) [start of care] SN [skilled nursing] Clinical Note" stating, "GENITOURINARY Catheter Urethral inserted Latex Foley # 16 fr 10 cc balloon next change due on or about 12/12/2014 ... ASSESSMENT Condition Clients condition is uncomfortable indicating need to alter plan of care Knowledge Deficit pain and anxiety meds ... Goals: ... established optimum skin and wound care. ... CARE PLAN Met SN/CG [caregiver] to cleanse coccyx wound 2-3 x/wk [times per week] with soap and water and apply sacral allevyn ... NARRATIVE SOC for elderly female with end stage lung disease. Awake and alert but very forgetful. Has stage 3 wound to coccyx. Cleansed with soap and water and covered with sacral allevyn. ... Pain 6 upon nurses arrival. Caregiver

2. How will the deficiency be prevented from recurring?

An in-service will be held with all IDT members to which will include a RN case manager, Medical Director, a pastoral counselor and a MSW to restructure their role and responsibility as part of the IDT including the Registered Nurse's role to provide coordination of care and ensure continuous assessment of patient/family needs and implement the plan of care. And an in-service regarding all members responsibility to communicate amongst each other and the need for all communication
encouraged to give Q 4 hr [hour] dose of morphine and ativan SL [sublingual] to comfort patient. Has Foley cath in place draining ... clear yellow urine ... ."

A. The record contained a document dated 1/9/15 titled "ADMISSION SUMMARY" stating, "Summation of Care: SN: 'Assess and instruct on needed care, wound care, assess pain/control, assess nutritional status' MSW: 'Assess for increased caregiver support' Clergy: 'Assess for other spiritual support' ... Documents Sent: (check off) or NA [not applicable] if not applicable Medicine/Tx [treatment] sheets [checked] Plan of Care [checked] ... Signature of Nurse Completing worksheet: [non-employee #18] ... ."

B. The record contained a hospice plan of care for certification period 1/9 to 4/8/15 with orders for skilled nursing services stating, "21. SN: 1x/da [time per day] (1/14/2015 to 1/14/2015), 1x/wk (1/15/2015 to 1/17/2015), 3x/wk x 12 weeks (1/18/2015 to 4/8/2015), PRN [as needed] x5 change in functional stat [status] ... Insert/Change Foley Catheter: Type Latex 16 fr 5cc Freq. [frequency] Q [every] month and PRN. ... SN/CG to cleanse coccyx wound 2-3 x/wk with soap and water and apply sacral allevyn. ... HCA: 1x/wk x 1wk (1/15/2015 to
### Statement of Deficiencies and Plan of Correction

**Identification Number:** MULTIPLE CONSTRUCTION A. BUILDING 151598

**Date Survey Completed:** 02/26/2015

**Name of Provider or Supplier:** NIGHTINGALE HOSPICE

**Address:** 6347 CONSTITUTION DRIVE

**City, State, Zip Code:** FORT WAYNE, IN 46804

#### Summary Statement of Deficiencies

**Prefix**

**Tag**

1/17/2015), 2x/wk x 12 wks (1/18/2015 to 4/8/2015) assist with partial/complete bath. assist with personal care MSW: 1x/mo x 1 mo (1/15/2015 to 2/14/2015) assess for increased caregiver support Clergy: 1x/mo x 1 mo (1/15/2015 to 2/14/2015) assess for other sources of spiritual support..." The record failed to evidence a skilled nursing visit was conducted on 1/14/15.

C. The record contained a skilled nursing visit note dated 1/15/15 with an electronic signature of employee D (registered nurse) stating, "(PRN) SN Clinical Note Date 1/15/2015 In 11:35 AM Out 12:40 PM ...

**INTEGUMENTARY Skin Status**

Specific skin problems noted stage 2-3 to sacrum, 13x8, moderate amount of serosang, granulation noted. SN cleansed with mild soap and water and applied optifoam. pt tolerated well, no s/s infection. SN taught wound care to family, s/s infections, effects of incontinence on wound and to notify agency of any worsening and they verbalized understanding. ...

**CARE PLAN Met SN/CG to cleanse coccyx wound 2-3x/wk with soap and water and apply sacral allevyn ... Not Met Insert/Change Foley Catheter: ... 0% complete. ... NARRATIVE 1/13/15 Visit ...

**Caregiver reports need for some**
medications, medication refills and ADL [activities of daily living]/incontinence care supplies. SN ordered all as needed. no other needs or concerns identified at this time."

On 2/25/15 at 11:15 AM, a telephone interview was conducted with employee D. The employee stated, "There was no care plan" and he/she knew what to do at the visit "Per hospice protocol and report." The employee indicated never providing wound care to this patient and stated, "I wasn't aware [patient] had a wound. It was never mentioned to me." The employee indicated receiving report and not positive of whom he/she received it from but thinks it was from non-employee #18.

D. The record contained a skilled nursing visit note dated 1/15/15 with an electronic signature of employee D stating, "SN Clinical Note  Date 1/15/2015 In 12:35 PM  Out 01:00 PM ...
GENITOURINARY Catheter Foley patent and draining to gravity. patient denies any pain or discomfort at the cath insertion site. sediment noted in tubing but output WNL [within normal limits]. caregiver denies any s/s [signs and/or symptoms] UTI [urinary tract infection]. INTEGUMENTARY Skin Status Specific skin problems noted stage 2
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SN/CG to cleanse coccyx wound 2-3 x/wk with soap and water and apply sacral allevyn ... 0% complete ...
Insert/Change foley catheter ... not needed during this visit - 0% complete. ...

E. The record contained a skilled nursing visit note dated 1/15/15 with an electronic signature of employee L stating, "SN Clinical Note Date 1/15/2015 In 01:03 PM Out 02:03 PM ...

GENITOURINARY Urine Amount Adequate Color Amber Odor Foul Appearance Cloudy Catheter Urethral Inserted Latex Foley #16 fr 10 cc Balloon Inflated to 7.5 cc next change due on or about 2/15/2015 Insertion Area Reddened cg state that catheter had not been changed for 2 months. strong urine odor noted. ...
INTEGUMENTARY Skin Status General skin condition intact specific skin problems noted lesion L [left] buttock lesion R [right] buttock currently using low air loss mattress ... WOUND Wound #1 Type Pressure ulcer did not assess today as no dressing available in home. family states it has not changed for last assessment Location Posterior Buttock Wound size Length did not assess cm [centimeters] Width did not
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- **Assess cm** Depth did not assess cm. ...
- **CARE PLAN Met** ... Insert/Change foley catheter ... Not Met SN/CG to cleanse coccyx wound 2-3 x/wk with soap and water and apply sacral allevyn - 0% complete ... **NARRATIVE** Pt [patient] needed catheter change. insertion site is red and irritated. replaced with 16 fr 7.5 ml in balloon. VS [vital signs] stable. ...

- **F.** The record contained a skilled nursing visit note dated 1/17/15 with an electronic signature of employee L stating, "(PRN) SN Clinical Note Date 1/17/2015 ... WOUND Wound #1 type Pressure ulcer Stage #3 Location Buttock Exudate 100% saturated dsg. [dressing] bloody Wound size Length same cm Width same cm Depth same cm Other did not assess reported by CG. ... ."

- **G.** On 2/25/15 at 11 AM, employee A indicated hospice services were initiated on 1/9/15 by non-employee #18 and the plan of care should have been initiated on 1/9/15. The director of clinical services indicated he/she reviewed the plan of care on 1/15/15 and that is why it did not get initiated until 1/15/15. The employee indicated non-employee #18 failed to communicate the plan of care to all other disciplines involved in the patient's care.
2. Clinical record #11 contained a hospice plan of care for certification period 2/9 to 5/9/15 with orders for skilled nursing services stating, "21. SN: 2x/wk x 13 wks (2/9/2015 to 5/9/2015) ... HCA: 1x/wk x 1wk (2/11/2015 to 2/14/2015), 3x/wk x 12 wks (2/15/2015 to 5/9/2015) assist with partial/complete bath. assist with personal care MSW: 1x/mo x 3 mos (2/9/2015 to 5/9/2015) ... Clergy: 1x/mo x 3 mos (2/11/2015 to 5/9/2015) ... ." The record failed to evidence a registered nurse whom is part of the IDG provided coordination of care and ensured implementation of the plan of care.

   A. The record evidenced a patient note dated 2/17/15, electronically signed by employee H stating, "Subject ... Initial social work call NOTE Scheduled an initial social work visit for 2/18/2015 at 6:00 ... ."

   B. The record evidenced a clergy clinical note dated 2/20/15, electronically signed by employee I stating, "Source of Info Visit information obtained from: Patient. Family member. Location of visit: Patient Home Initial visit Comment: First visit with [patient] and [daughter]. ... ."
C. The record evidenced hospice aide visits were conducted on 2/23 and 2/25/15 by non-employee #25. The record failed to evidence an aide visit was conducted week 1 (2/11 to 2/14/15) and failed to evidence 3 aide visits were conducted for the week 2 (2/15 to 2/21/15).

D. On 2/26/15 at 12:30 PM, a telephone interview was conducted with the patient's family member. The family member indicated not having hospice aide services for weeks 1 and 2 and at no time did an aide attempt to make a visit during those weeks but was informed by hospice staff that they were attempting to get the service started. The family member indicated his/her mother cannot be transported and is a homebound patient that requires supervision 24 hours per day.

3. The policy with a revision date as 9/30/08 titled "INTERDISCIPLINARY GROUP" states, "PROCEDURE 1. The role of the IDG will include, but not limited to, the following: Participating in the establishment of the Plan of Care Provision or supervision of hospice care and services ... Designation of a registered nurse to coordinate the implementation of the Plan of Care for each patient ... 3. The director of patient
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<td><strong>418.58 QUALITY ASSESSMENT &amp; PERFORMANCE IMPROVEMENT</strong></td>
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| The hospice must develop, implement, and maintain an effective, ongoing, hospice-wide data-driven quality assessment and performance improvement program. The hospice’s governing body must ensure that the program: reflects the complexity of its organization and services; involves all hospice services (including those services furnished under contract or arrangement); focuses on indicators related to improved palliative outcomes; and takes actions to demonstrate improvement in hospice performance. The hospice must maintain documentary evidence of its quality assessment and performance improvement program and be able to demonstrate its operation to CMS.

Based on document review and policy review, the hospice failed to ensure the Quality Assessment and Performance Improvement program (QAPI) had performance improvement projects in place, and failed to evidence outcomes and ongoing plans were discussed, for 1...
Findings include:

1. The document titled "End of year QAPI Meeting," dated 2-2-2015, stated "All staff was in attendance by phone. ..."

2. Old Business- Review of QAPI and Data to be obtained: fall reports, Incident reports, med/treatment errors, Missed visits (Complete form and turn in at the end of the month), Complaint forms, Adverse events, Infection reports, Wounds, Unresolved pain, and Bereavement program. III. New Business - revision of form to include HIS information, There were no complaints for the year of 2014. [employee H] is to update the QAPI form to include HIS file questions."

A. This QAPI meeting note failed to evidence the hospice discussed volunteer program, failed to evidence discussion of previous performance improvement activities and evaluation were reviewed, and failed to evidence discussion of any actions which may have needed to be put in place to improve quality of care.

B. The sign in sheet failed to evidence the administrator (employee B) was present.

How will the deficiency be prevented from recurring?

A QAPI meeting will be held by 04/21/15 to include the agencies outcomes and ongoing plans. An in-service will be given to the governing body, Hospice staff and advisory committee regarding responsibility and purpose of ongoing QAPI program.

3. Who will be responsible?

The Executive Director

4. By what date?

04/21/2015
2. The hospice's undated policy titled "Quality Improvement Program," # HSP6-1A, states, "In keeping with the Agency's mission of providing quality, cost-effective patient care, treatment and services, the performance improvement plan allows for a systematic, coordinated and continuous approach to improving performance, focusing upon the process and functions that address these principles. ... The scope of the organizational performance improvement program includes an overall assessment of the efficacy of performance improvement activities with a focus on continually improving care, treatment and services and patient and staff safety practices. Collaborative and specific indicators of both key processes and outcomes of care are designed, measured and assessed by appropriate departments/services and disciplines in an effort to improve patient/staff safety and organizational performance. These indicators are objective, measurable, based on current knowledge and experience and are structured to produce statistically valid performance measures of care, treatment and services provided. This mechanism also provides for evaluation of improvements and the stability of the improvement over time."

3. During interview on 2/23/15/ at 12:04
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**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**NAME OF PROVIDER OR SUPPLIER:** NIGHTINGALE HOSPICE  
**STREET ADDRESS, CITY, STATE, ZIP CODE:** 6347 CONSTITUTION DRIVE  
FORT WAYNE, IN 46804

**PM, employee B indicated they have not been present at this hospice since August of 2014.**

4. During interview on 2/26/15 at 3:45 PM, employees A and H indicated there was no further information to submit for review.

**418.58(e)(1) EXECUTIVE RESPONSIBILITIES**

The hospice’s governing body is responsible for ensuring the following:

1. That an ongoing program for quality improvement and patient safety is defined, implemented, and maintained, and is evaluated annually.

Based on document review and policy review, governing body failed to ensure the hospice Quality Assessment and Performance Improvement program (QAPI) was maintained for 1 of 1 hospice.

Findings include

1. The document titled "End of year QAPI Meeting," dated 2-2-2015, stated, "All staff was in attendance by phone. ..."  
2. Old Business- Review of QAPI and Data to be obtained: fall reports, Incident reports, Incidents/treatment errors, Missed visits (Complete form and turn in at the

**How will the deficiency be corrected?**  
The Governing Body will ensure a QAPI performance improvement program is in place and will have documentation of outcomes and ongoing plans These will be discussed at minimum on a quarterly basis with the QAPI team The QAPI quarterly meeting minutes will be forwarded and reviewed by the Governing Body for approval 2

**How will the deficiency be prevented from recurring?**  
An inservice will be given to the governing body, Hospice staff and advisory committee regarding responsibility and
end of the month), Complaint forms, Adverse events, Infection reports, Wounds, Unresolved pain, and Bereavement program. III. New Business - revision of form to include HIS information, There were no complaints for the year of 2014. [employee H] is to update the QAPI form to include HIS file questions."

A. This QAPI meeting note failed to evidence the hospice discussed volunteer program, failed to evidence discussion of previous performance improvement activities and evaluation were reviewed, and failed to evidence discussion of any actions which may have needed to be put in place to improve quality of care.

B. The sign in sheet failed to evidence the administrator (employee B) was present.

2. The hospice's undated policy titled "Quality Improvement Program," # HSP6-1A, states, "In keeping with the Agency's mission of providing quality, cost-effective patient care, treatment and services, the performance improvement plan allows for a systematic, coordinated and continuous approach to improving performance, focusing upon the process and functions that address these principles. ... The scope of the purpose of ongoing QAPI program. QAPI meetings will be held quarterly and the meeting minutes will be forwarded to the Governing Board for review and approval. 3. Who will be responsible? The Executive Director 4. By what date? 04/21/2015
organizational performance improvement program includes an overall assessment of the efficacy of performance improvement activities with a focus on continually improving care, treatment and services and patient and staff safety practices. Collaborative and specific indicators of both key processes and outcomes of care are designed, measured and assessed by appropriate departments/services and disciplines in an effort to improve patient/staff safety and organizational performance. These indicators are objective, measurable, based on current knowledge and experience and are structured to produce statistically valid performance measures of care, treatment and services provided. This mechanism also provides for evaluation of improvements and the stability of the improvement over time."

3. During interview on 2/23/15/ at 12:04 PM, employee B indicated they have not been present at this hospice since August of 2014.

4. During interview on 2/26/15 at 3:45 PM, employees A and H indicated there was no further information to submit for review.
Based on clinical record review, document review, policy review, and interview, it was determined the hospice failed to ensure core services were provided by direct employees (see L588).

The cumulative effect of these systemic problems resulted in the hospice's inability to be in compliance with IC 16-25-3 and the Conditions of Participation 42 CFR 418.64 Core Services.

1. How will the deficiency be corrected? All core services will be provided by direct hospice employees including nursing services, medical social services and counseling the Hospice may contract for physician services. All services will be provided timely in accordance with state and federal regulations. How will the deficiency be prevented from recurring? A current direct employee list will be maintained and updated. An inservice will be held for all administrative staff to ensure direct patient staff list is current and accurate. The executive director will review the list to insure accuracy. An inservice will be given to the pastoral care counselor regarding timely assessments of newly admitted patients. 25% of all current patient records will be reviewed for 90 days to ensure compliance of timely visits of counseling services in accordance with state and federal guidelines.

3. Who is responsible? The executive director.

4. By what date will it be corrected? 04/21/2015
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

NAME OF PROVIDER OR SUPPLIER
NIGHTINGALE HOSPICE

STREET ADDRESS, CITY, STATE, ZIP CODE
6347 CONSTITUTION DRIVE
FORT WAYNE, IN 46804

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SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

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PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

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CORE SERVICES
A hospice must routinely provide substantially all core services directly by hospice employees. These services must be provided in a manner consistent with acceptable standards of practice. These services include nursing services, medical social services, and counseling. The hospice may contract for physician services as specified in paragraph (a) of this section.

Based on clinical record review, interview, the hospice failed to ensure all nursing services were provided by direct employees of the hospice for 1 of 1 hospice, and 1 of 4 clinical records reviewed. (#s 10)

Findings include

1. During entrance interview on 2/23/15 at 10:50 AM, employee A (director of clinical services/alternate administrator) indicated the hospice serves Delaware county in addition to the other counties listed, and another hospice entity also serves Delaware county, so the closest nurse will provide services to the patient.

2. During interview on 2/23/15 at 10:00 AM, employee A indicated the hospice's employee list includes three names who provide services here and at another hospice entity. Employee A indicated the highlighted names are dual employees: F (registered nurse), I (chaplain), and K (executive director).

How will the deficiency be corrected?

1. The stated “non-employees” were actually employed by this agency at the time of survey; the employee list given to the state surveyor at time of survey did not reflect this (see attachment B, employee list, if further evidence is needed, W-2’s can be provided.) All core services will be provided by direct hospice employees including nursing services, medical social services and counseling the Hospice may contract for physician services. All employees who service agency patients have an employee file with required credentials. No patient services will be provided by non-agency staff unless contracted per state and federal guidelines.

2. A current direct employee list will be maintained and updated. An in-service will be held for all administrative staff to ensure direct
3. During interview on 12/24/15 at 12:25 PM, employee A indicated non-employee #18 is a nurse from a Home Health entity and every nurse for that agency, another hospice entity, and this location are cross trained to also provide Hospice and Home Health services for each other.

4. On 2/24/15 at 12:27 PM, surveyor requested W2 forms for employees A and D, both Registered Nurses. As of exit on 2/26/15 at 3:45 PM, these were not provided.

5. During interview on 2/24/15 at 12:45 PM, employee A indicated Fort Wayne contracts employees, including nurses, social workers, and chaplains, not just the medical director.

   A. On 2/24/15 at 1:00 PM, employee A provided a document labeled "Staffing Service Agreement," both dated 11/24/08.

   The contract states "between Nightingale Hospice Care, Inc. (Contractor), located at 1036 S. Rangeline Road, Carmel, IN 46032 and Nightingale Hospice Care of Northern Indiana, Inc, located at 1036 S. Rangeline Road, Carmel, IN for the provision of services "Home Health Aide, Skilled patient staff list is current and accurate. The executive director will review the list to insure accuracy.

   3 Who is responsible?

   The Executive director

   4 By what date will it be corrected?

   04/21/2015
### Statement of Deficiencies and Plan of Correction

**Identification Number:** 151598

**Date Survey Completed:** 02/26/2015

**Name of Provider or Supplier:** Nightingale Hospice

**Street Address, City, State, Zip Code:** 6347 Constitution Drive, Fort Wayne, IN 46804

### Summary Statement of Deficiencies

1. **Nursing, Physical Therapy, Occupational Therapy, and Speech Therapy staffing upon request of Agency.**

2. The hospice's undated policy titled "Furnishing of Core Services," # HSP2-1A, states "All of the Core Services, which includes Nursing Services, Medical Social Services, Physician Services, Chaplain services, and Counseling Services, are routinely furnished directly by employees of Nightingale Hospice Care. Procedure:
   1. Hospice will routinely provide Nursing, Medical Social, Physician, and Counseling Services as core services."

3. During interview on 2/26/15 at 3:45 PM, employees A and H indicated there was no further information to submit for review.
### Statement of Deficiencies and Plan of Correction

**Identification Number:** MULTIPLE CONSTRUCTION A. BUILDING 00

**Date Survey Completed:** 02/26/2015

**Name of Provider or Supplier:** NIGHTINGALE HOSPICE

**Street Address, City, State, Zip Code:** 6347 CONSTITUTION DRIVE

**FORT WAYNE, IN 46804**

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<td>418.64(d)(3)</td>
<td>COUNSELING SERVICES</td>
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<td>(3) Spiritual counseling</td>
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(i) Provide an assessment of the patient's and family's spiritual needs.
(ii) Provide spiritual counseling to meet these needs in accordance with the patient's and family's acceptance of this service, and in a manner consistent with patient and family beliefs and desires.
(iii) Make all reasonable efforts to facilitate visits by local clergy, pastoral counselors, or other individuals who can support the patient's spiritual needs to the best of its ability.
(iv) Advise the patient and family of this service.

Based on clinical record review, policy review, and interview, the hospice failed to ensure spiritual counseling was provided timely to meet the needs of the patient and family in 1 of 4 patient records reviewed. (#11)

Findings include:

1. Clinical record #11, start of care 2/9/15, contained a hospice plan of care for certification period 2/9 to 5/9/15 with orders for counseling services stating,

   - How will the deficiency be corrected?
   - All services will be provided timely in accordance with state and federal regulations
   - How will the deficiency be prevented from recurring?
   - An in-service will be given to the pastoral care counselor regarding timely assessments of newly admitted patients 100% of all current patient records will be reviewed for 90 days or until compliance is achieved of

   **Compliance Date:** 04/21/2015
"21. ... Clergy: 1x/mo [times per month] x 3 mos [months] (2/11/2015 to 5/9/2015) ... " The record failed to evidence the chaplain visited the patient and family within five days of admission.

A. The record contained a document dated 2/9/15, electronically signed by non-employee #17, stating, "SUBJECTIVE Family/Caregiver reports: General concerns: comfortable state. ... Spiritual concern: no concerns identified. ... COMPREHENSIVE SPIRITUAL Family/caregiver verbalizes concerns about: no concerns identified. ... "

B. The record evidenced a document dated 2/20/15, electronically signed by employee I (chaplain) stating, "SOURCE OF INFO Visit information obtained from: Patient. Family Member. Location of Visit: Patient Home initial Visit Comment: First visit with [patient] and [his/her] [family member. ... CARE Spiritual Care provided: Life review Spiritual Assessment pray with patient/family was effective in helping patient/family progress to desired goal as evidenced by: Active participation of patient/family. continue intervention: yes. ... "

C. On 2/26/15 at 12:30 PM, a timely visits of counseling services in accordance with state and federal guidelines

3 Who is responsible? The executive director

4 By what date will it be corrected? 04/21/2015
telephone interview was conducted with the patient's family member. The family member indicated acceptance of spiritual counseling services upon admission but did not have a visit until "just last week" (week of 2/15 to 2/21/15).

2. On 2/25/15 at 11:40 AM, employee A (director of clinical services / alternate administrator) indicated the clergy's first contact was via telephone call on 1/19/15 and it was not within 5 days of admission.

3. The undated policy titled "SPIRITUAL COUNSELING" states, "PURPOSE: To ensure care is provided to patient and/or caregivers in accordance with the applicable laws, regulations and recognized professional practice standards. POLICY: Spiritual Counseling services or the arrangement for such are routinely furnished by the Chaplain of the hospice program as part of the hospice core services. The hospice spiritual care services will support the spiritual needs of patients and families. PROCEDURE: Spiritual counseling services will be offered to both patient and family while patient is enrolled in the hospice program. Chaplain will schedule and visit with the patient and family within five (5) days of admission to hospice. An initial spiritual care
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

IDENTIFICATION NUMBER: 151598

DATE SURVEY COMPLETED: 02/26/2015

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

ID PREFIX TAG

SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE CORRECTIVE ACTION SHOULD BE CROSS-REFERENCES TO THE APPROPRIATE DEFICIENCY)

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Based on policy review, volunteer information review, employee file review, and interview, it was determined the hospice failed to ensure a volunteer program was maintained and utilized to provide volunteer services (L 642); failed to ensure the hospice maintained and provided a volunteer orientation and training program (L 643); failed to ensure volunteers were used in day-to-day administrative and/or direct patient care.

4. During interview on 2/26/15 at 3:45 PM, employees A and H indicated there was no further information to submit for review.

1. How will the deficiency be corrected? The Hospice will ensure that the volunteer program will be maintained and utilized to patients and families. The Hospice will provide a volunteer orientation and training program to ensure volunteers are in place and utilized in both administrative and/or direct patient care roles. The Hospice will maintain a volunteer staff sufficient to provide administrative and direct patient care equally at least 5% of the total direct care hours provided by the hospice staff. The...
roles (L 644); failed to ensure ongoing efforts to recruit and retain volunteers (L 645); failed to evidence documents of cost savings through the use of volunteers (L 646); and failed to ensure the use of administrative volunteers and/or direct patient care volunteers equaling 5% of total patient care hours for 1 of 1 hospice (L 647).

The cumulative effect of these systemic problems resulted in the hospice's inability to be in compliance with IC 16-25-3 and the Conditions of Participation 42 CFR 418.78 Volunteers. Hospice agency has assigned a volunteer coordinator to coordinate and document the type of services and time worked to ensure compliance with volunteer policies and procedures to ensure that the volunteer program remains in place. The hospice will document the active and ongoing efforts to recruit and retain volunteers and all volunteer records will be maintained at the office. How will the deficiency be corrected? An inservice will be given to the volunteer coordinator on all aspects of volunteer responsibilities and all state and federal guidelines. Volunteers will be acquired and oriented and trained according to the regulatory guidelines. The volunteer qualification information will be kept at the agency along with agency personnel files. The cost savings report will be developed and completed monthly according to the standard an inservice will be given to the volunteer coordinator on how to prepare and record needed information which will be forwarded to the executive director monthly to ensure report is completed and the required standards are met. Recruitment procedures have been implemented by the volunteer coordinator and status will be reported to the executive director and will be included in the QAPI quarterly reports.

3. Who will be responsible?
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

IDENTIFICATION NUMBER: 151598

A BUILDING

WING

DATE SURVEY COMPLETED: 02/26/2015

NAME OF PROVIDER OR SUPPLIER: NIGHTINGALE HOSPICE

STREET ADDRESS, CITY, STATE, ZIP CODE: 6347 CONSTITUTION DRIVE
FORT WAYNE, IN 46804

SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

L 642

Bldg. 00

418.78 VOLUNTEERS
The hospice must use volunteers to the extent specified in paragraph (e) of this section. These volunteers must be used in defined roles and under the supervision of a designated hospice employee.

Based on policy review and interview, the hospice failed to ensure the volunteer program remained in place and utilized volunteers in defined roles for 1 of 1 hospice.

Findings include

1. On 2/26/15 at 10:30 AM, surveyor asked for volunteer records from August 2014 through present. At 10:30 AM, employee A (director of clinical services / alternate administrator) indicated the hospice does not have any patient volunteers because patients have refused volunteer services. Employee A indicated all the volunteer information is somewhere at another hospice entity.

2. The hospice's undated policy titled "Volunteers, Recruitment and Retention of," # HSP4-12B, HSP4-12B.01, states, "1. Nightingale Hospice will maintain an

Provider's Plan of Correction
(EACH CORRECTIVE ACTION SHOULD BE CROSS-REferenced TO THE APPROPRIATE DEFICIENCY)

The Executive Director

4 By what date will it be corrected?
04/21/2015

The Hospice will ensure that the volunteer program will be maintained and utilized to patients and families. The Hospice will provide a volunteer orientation and training program to ensure volunteers are in place and utilized in both administrative and/or direct patient care roles. The Hospice will maintain a volunteer staff sufficient to provide administrative and direct patient care equally at least 5% of the total direct care hours provided by the hospice staff. The Hospice agency has assigned a volunteer coordinator to coordinate and document the type of services and time worked to ensure compliance with volunteer policies and procedures to ensure that the volunteer program remains in place. The hospice will document the active and ongoing efforts to recruit and retain volunteers and all volunteer records will be maintained at the office.

How will the deficiency be corrected?
04/21/2015

The Hospice will ensure that the volunteer program will be maintained and utilized to patients and families. The Hospice will provide a volunteer orientation and training program to ensure volunteers are in place and utilized in both administrative and/or direct patient care roles. The Hospice will maintain a volunteer staff sufficient to provide administrative and direct patient care equally at least 5% of the total direct care hours provided by the hospice staff. The Hospice agency has assigned a volunteer coordinator to coordinate and document the type of services and time worked to ensure compliance with volunteer policies and procedures to ensure that the volunteer program remains in place. The hospice will document the active and ongoing efforts to recruit and retain volunteers and all volunteer records will be maintained at the office.

How will the deficiency be corrected?
04/21/2015
Statement of Deficiencies and Plan of Correction

Identification Number: X1) PROVIDER/SUPPLIER/CLIA

Provider/Supplier: NIGHTINGALE HOSPICE

STREET ADDRESS, CITY, STATE, ZIP CODE
6347 CONSTITUTION DRIVE
FORT WAYNE, IN 46804

DATE SURVEY COMPLETED: X3) 02/26/2015

NAME OF PROVIDER OR SUPPLIER
NIGHTINGALE HOSPICE

SUMMARY STATEMENT OF DEFICIENCIES
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PROVIDER'S PLAN OF CORRECTION
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2. How will the deficiency be corrected?
An inservice will be give to the volunteer coordinator on all aspects of volunteer responsibilities and all state and federal guidelines. Volunteers will be acquired and oriented and trained according to the regulatory guidelines. The volunteer qualification information will be kept at the agency along with agency personnel files. The cost savings report will be developed and completed monthly according to the standard and an inservice will be given to the volunteer coordinator on how to prepare and record needed information which will be forwarded to the executive director monthly to ensure report is completed and the required standards are met. Recruitment procedures have been implemented by the volunteer coordinator and status will be reported to the executive director and will be included in the QAPI quarterly reports.

3. Who is responsible?
The Executive Director

4. By what date will it be corrected?
04/21/2015
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and contract staff. 5. Administrative support referenced above may mean support of the patient care activities of the hospice (i.e. clerical duties in the office) rather than general support activities (i.e. fund raising). ... 7. The volunteer Coordinator will record, when applicable, any expansion of care or services achieved through the use of volunteers including the types of services and time worked.

4. The hospice's undated policy titled "Volunteer, Assignment and Role of," #HSP4-110, states, "1. Nightingale Hospice will use volunteers in defined roles under the supervision of the Volunteer Coordinator. 2. Volunteers will receive appropriate orientation and training that is consistent with acceptable standards of hospice's practice. 3. Volunteers may be used in administrative or direct patient care roles."

5. The hospice's job description titled "Volunteer Coordinator," # 402A, states, "The person in this position supervises and coordinates the activities of Hospice volunteers in both patient care and in non-patient care settings. Responsibilities: Select and assign volunteers for newly admitted patients/family, with input from the Interdisciplinary Team. Keep accurate
documentation of volunteer assignment, including documentation of hours served on a monthly and quarterly basis. ... Plan and implement the volunteer training course. ... Recruit and assign volunteers to work in the office, as needed. Maintain accurate records on volunteers and volunteer assignments, as required. ... Ensure compliance with volunteer policies/procedures.

6. On 2/26/15 at 3:45 PM, employee A indicated they had no further information to submit for review. During interview on 2/26/15 at 3:45 PM, employees A and H indicated there was no further information to submit for review.

Based on employee file review, policy review, and interview, the hospice failed to ensure the volunteer program remained consistent with hospice industry standards.

The hospice must maintain, document and provide volunteer orientation and training that is consistent with hospice industry standards.

L. 643

418.78(a) TRAINING

Based on employee file review, policy review, and interview, the hospice failed to ensure the volunteer program remained consistent with hospice industry standards.

How will the deficiency be corrected? The Hospice will ensure that the volunteer program will be maintained and utilized to patients and families.

04/21/2015
in place, including recruitment and orientation, and failed to retain volunteer records at the office for 1 of 1 hospice.

Findings include

1. During interview on 2/23/15 at 11:50 AM, employee A (director of clinical services / alternate administrator) indicated due to the shortage of patients, the hospice is not currently trying to recruit volunteers, and the administrative volunteer moved to South Carolina in July or August of 2014.

2. On 2/26/15 at 10:30 AM, surveyor asked for volunteer records from August 2014 through present. At 10:30 AM, employee A indicated the hospice does not have any patient volunteers because patients have refused volunteer services. Employee A indicated all the volunteer information is somewhere at another hospice entity.

3. During interview on 2/26/15 at 10:45 AM, employee A indicated they had a patient volunteer prior to the move to Crown Point, but after the move back to Fort Wayne, the volunteer files did not return, including cost savings documents.

4. During interview on 2/26/15 at 11:05 AM, employee H (social worker) Hospice will provide a volunteer orientation and training program to ensure volunteers are in place and utilized in both administrative and/or direct patient care roles. The Hospice will maintain a volunteer staff sufficient to provide administrative and direct patient care equally at least 5% of the total direct care hours provided by the hospice staff. The Hospice agency has assigned a volunteer coordinator to coordinate and document the type of services and time worked to ensure compliance with volunteer policies and procedures to ensure that the volunteer program remains in place. The hospice will document the active and ongoing efforts to recruit and retain volunteers and all volunteer records will be maintained at the office. How will the deficiency be corrected? An inservice will be given to the volunteer coordinator on how to prepare and record needed information which will be kept at the agency along with agency personnel files.
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**INDICATED THEY WERE HIRED TO ALSO BE THE VOLUNTEER AND BEREAVEMENT COORDINATOR IN ADDITION TO THE SOCIAL WORKER POSITION.**

Employee H indicated they have not done anything in these roles except read the books they were handed, because employee A keeps telling them they will go over the volunteer stuff later.

Employee H indicated the hospice has not hired a receptionist at this office so they are stuck here answering phones.

Employee H indicated the only orientation they received at this office was on 1/22/15, and all other orientation was conducted at another hospice location.

5. Employee H's file failed to evidence any job descriptions for social worker, volunteer coordinator, and bereavement coordinator.

6. During interview on 2/26/15 at 11:53 AM, employee A indicated that employee H is the volunteer and bereavement coordinator.

7. During interview on 2/2/15 at 12:00 PM, employee A indicated there was a volunteer who brought blankets in on 9/22/14 but the hospice did not have any patients so the blankets were sent to another hospice agency. Employee A indicated they volunteer their time to

forwarded to the executive director monthly to ensure report is completed and the required standards are met. Recruitment procedures have been implemented by the volunteer coordinator and status will be reported to the executive director and will be included in the QAPI quarterly reports. New Volunteer training sessions will be provided as often as necessary to ensure qualified volunteers are available.

**Who is responsible?**

The executive Director

**By what date will it be corrected?**

04/21/2015
answer the phones, but they were told this does not count. Employee A indicated they do have a volunteer orientation coming up once the weather breaks. Employee A indicated the previous volunteer coordinator was employee G through 2/6/15, and employee G was also the volunteer coordinator for another hospice location.

8. On 2/26/15 at 3:35 PM, employee A provided a list of volunteer names and their files. These were volunteers N, O, P, and Q. All files contained minimal information and failed to evidence they were current volunteers. Employee A indicated the other hospice location sent volunteer N's file.

A. Volunteer file N was dated 2/26/14.
B. Volunteer file O was dated 4/22/14.
C. Volunteer file P was dated 1/18/14.
D. Volunteer file Q was dated 3/7/14.

9. As of 2/26/15 at 3:45 PM, the hospice failed to evidence any volunteer activity prior to 3/26/14.

10. The hospice's undated policy titled "Volunteers, Recruitment and Retention of," # HSP4-12B, HSP4-12B.01, states.
"1. Nightingale Hospice will maintain an ongoing effort to recruit and retain volunteers through Hospice brochures and newsletters, education to the community, newspaper publications, and radio and television appearances as appropriate and annual recognition of volunteers. 2. Recruitment of volunteers may come through the following methods: ... 3. Efforts to retain volunteers includes, but is not limited to the following: ... d. Correspondence with the Volunteer Coordinator to provide supports, appreciation for the volunteer. ... 4. Nightingale Hospice will document the active and ongoing efforts to retain volunteers."

11. The hospice's undated policy titled "Volunteer Cost Saving and Level of Activity," # HSP4-12C, HSP4-12D, states. "1. The Volunteer Coordinator will identify the necessary positions that are occupied by volunteer. ... 3. Documentation will include the work time spent by volunteers occupying those positions and estimates of the dollar costs that Hospice would have incurred if paid employees occupied those positions during the same time frame. 4. Hospice will maintain a volunteer staff sufficient to provide administrative or direct patient care in an amount that, at a minimum, equals 5 (five) percent of the total patient care.

12. THE HOSPICE'S UNDATED POLICY TITLED "VOLUNTEER, ASSIGNMENT AND ROLE OF," #HSP4-110, STATES, "1. NIGHTINGALE HOSPICE WILL USE VOLUNTEERS IN DEFINED ROLES UNDER THE SUPERVISION OF THE VOLUNTEER COORDINATOR. 2. VOLUNTEERS WILL RECEIVE APPROPRIATE ORIENTATION AND TRAINING THAT IS CONSISTENT WITH ACCEPTABLE STANDARDS OF HOSPICE'S PRACTICE. 3. VOLUNTEERS MAY BE USED IN ADMINISTRATIVE OR DIRECT PATIENT CARE ROLES."

13. THE HOSPICE'S JOB DESCRIPTION TITLED "VOLUNTEER COORDINATOR," # 402A, STATES, "THE PERSON IN THIS POSITION SUPERVISES AND COORDINATES THE ACTIVITIES OF HOSPICE VOLUNTEERS IN BOTH PATIENT CARE AND IN NON-PATIENT CARE SETTINGS. RESPONSIBILITIES: SELECT AND ASSIGN VOLUNTEERS FOR NEWLY ADMITTED PATIENTS/FAMILY, WITH INPUT FROM THE

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Interdisciplinary Team. Keep accurate documentation of volunteer assignment, inducing documentation of hours served on a monthly and quarterly basis. ... Plan and implement the volunteer training course. ... Recruit and assign volunteers to work in the office, as needed. Maintain accurate records on volunteers and volunteer assignments, as required. ... Ensure compliance with volunteer policies/procedures."

14. During interview on 2/26/15 at 3:45 PM, employees A and H indicated there was no further information to submit for review.

Based on policy review and interview, the hospice failed to ensure the volunteer program remained in place, failed to evidence use of and recruitment of volunteers, and failed to retain volunteer records at the office for 1 of 1 hospice.

1 How will the deficiency be corrected?

The Hospice will ensure that the volunteer program will be maintained and utilized to patients and families. The Hospice will provide a volunteer orientation and training program to ensure volunteers are in place and
Findings include

1. During interview on 2/23/15 at 11:50 AM, employee A (director of clinical services / alternate administrator) indicated due to the shortage of patients, the hospice is not currently trying to recruit volunteers, and the administrative volunteer moved to South Carolina in July or August of 2014.

2. On 2/26/15 at 10:30 AM, surveyor asked for volunteer records from August 2014 through present. At 10:30 AM, employee A indicated the hospice does not have any patient volunteers because patients have refused volunteer services. Employee A indicated all the volunteer information is somewhere at another hospice entity.

3. As of 2/26/15 at 3:45 PM, the hospice failed to evidence any volunteer activity prior to 3/26/14.

4. The hospice's undated policy titled "Volunteers, Recruitment and Retention of," # HSP4-12B, HSP4-12B.01, states, "1. Nightingale Hospice will maintain an ongoing effort to recruit and retain volunteers through Hospice brochures and newsletters, education to the community, newspaper publications, and utilized in both administrative and/or direct patient care roles. The Hospice will maintain a volunteer staff sufficient to provide administrative and direct patient care equally at least 5% of the total direct care hours provided by the hospice staff. The Hospice agency has assigned a volunteer coordinator to coordinate and document the type of services and time worked to ensure compliance with volunteer policies and procedures to ensure that the volunteer program remains in place. The hospice will document the active and ongoing efforts to recruit and retain volunteers and all volunteer records will be maintained at the office.

2. How will the deficiency be corrected?
An inservice will be given to the volunteer coordinator on all aspects of volunteer responsibilities and all state and federal guidelines. Volunteers will be acquired and oriented and trained according to the regulatory guidelines. The volunteer qualification information will be kept at the agency along with agency personnel files. The cost savings report will be developed and completed monthly according to the standard. An inservice will be given to the volunteer coordinator on how to prepare and record needed information which will be forwarded to the executive.
radio and television appearances as appropriate and annual recognition of volunteers.  2. Recruitment of volunteers may come through the following methods: ...  3. Efforts to retain volunteers includes, but is not limited to the following: ... d. Correspondence with the Volunteer Coordinator to provide supports, appreciation for the volunteer. ...  4. Nightingale Hospice will document the active and ongoing efforts to retain volunteers."

5. The hospice's undated policy titled "Volunteer Cost Saving and Level of Activity," # HSP4-12C, HSP4-12D, states, "1. The Volunteer Coordinator will identify the necessary positions that are occupied by volunteer. ...  3. Documentation will include the work time spent by volunteers occupying those positions and estimates of the dollar costs that Hospice would have incurred if paid employees occupied those positions during the same time frame.  4. Hospice will maintain a volunteer staff sufficient to provide administrative or direct patient care in an amount that, at a minimum, equals 5 (five) percent of the total patient care hours of all paid hospice employees and contract staff.  5. Administrative support referenced above may mean support of the patient care activities of the hospice (i.e. clerical duties in the...
office) rather than general support activities (i.e. fund raising). ... 7. The volunteer Coordinator will record, when applicable, any expansion of care or services achieved through the use of volunteers including the types of services and time worked."

6. The hospice's undated policy titled "Volunteer, Assignment and Role of," #HSP4-110, states, "1. Nightingale Hospice will use volunteers in defined roles under the supervision of the Volunteer Coordinator. 2. Volunteers will receive appropriate orientation and training that is consistent with acceptable standards of hospice's practice. 3. Volunteers may be used in administrative or direct patient care roles."

7. The hospice's job description titled "Volunteer Coordinator," # 402A, states, "The person in this position supervises and coordinates the activities of Hospice volunteers in both patient care and in non-patient care settings. Responsibilities: Select and assign volunteers for newly admitted patients/family, with input from the Interdisciplinary Team. Keep accurate documentation of volunteer assignment, inducing documentation of hours served on a monthly and quarterly basis. ... Plan and implement the volunteer
training course. ... Recruit and assign volunteers to work in the office, as needed. Maintain accurate records on volunteers and volunteer assignments, as required. ... Ensure compliance with volunteer policies/procedures."

8. During interview on 2/26/15 at 3:45 PM, employees A and H indicated there was no further information to submit for review.

**418.78(c)**

**RECRUITING AND RETAINING**

The hospice must document and demonstrate viable and ongoing efforts to recruit and retain volunteers.

Based on policy review and interview, the hospice failed to ensure the recruiting and retention of volunteers and failed to retain volunteer records at the office for 1 of 1 hospice.

Findings include

1. During interview on 2/23/15 at 11:50 AM, employee A (director of clinical services / alternate administrator) indicated due to the shortage of patients...
the hospice is not currently trying to recruit volunteers, and the administrative volunteer moved to South Carolina in July or August of 2014.

2. On 2/26/15 at 10:30 AM, surveyor asked for volunteer records from August 2014 through present. At 10:30 AM, employee A indicated the hospice does not have any patient volunteers because patients have refused volunteer services. Employee A indicated all the volunteer information is somewhere at another hospice entity.

3. As of 2/26/15 at 3:45 PM, the hospice failed to evidence any volunteer activity prior to 3/26/14.

4. The hospice's undated policy titled "Volunteers, Recruitment and Retention of," # HSP4-12B, HSP4-12B.01, states, "1. Nightingale Hospice will maintain an ongoing effort to recruit and retain volunteers through Hospice brochures and newsletters, education to the community, newspaper publications, and radio and television appearances as appropriate and annual recognition of volunteers. 2. Recruitment of volunteers may come through the following methods: ... 3. Efforts to retain volunteers includes, but is not limited to the following: ... d. Correspondence

provided by the hospice staff. The Hospice agency has assigned a volunteer coordinator to coordinate and document the type of services and time worked to ensure compliance with volunteer policies and procedures to ensure that the volunteer program remains in place. The hospice will document the active and ongoing efforts to recruit and retain volunteers and all volunteer records will be maintained at the office.

2 How will the deficiency be corrected?
An inservice will be given to the volunteer coordinator on all aspects of volunteer responsibilities and all state and federal guidelines. Volunteers will be acquired and oriented and trained according to the regulatory guidelines. The volunteer qualification information will be kept at the agency along with agency personnel files. Recruitment procedures have been implemented by the volunteer coordinator and status will be reported to the executive director and will be included in the QAPI quarterly reports. New Volunteer training sessions will be provided as often as necessary to ensure qualified volunteers are available. Communication with volunteers will be maintained to provide support and appreciation for their time and to maintain availability status and volunteer communication logs will be...
with the Volunteer Coordinator to provide supports, appreciation for the volunteer. ... 4. Nightingale Hospice will document the active and ongoing efforts to retain volunteers.”

5. The hospice's undated policy titled "Volunteer Cost Saving and Level of Activity," # HSP4-12C, HSP4-12D, states, "1. The Volunteer Coordinator will identify the necessary positions that are occupied by volunteer. ... 3. Documentation will include the work time spent by volunteers occupying those positions and estimates of the dollar costs that Hospice would have incurred if paid employees occupied those positions during the same time frame. 4. Hospice will maintain a volunteer staff sufficient to provide administrative or direct patient care in an amount that, at a minimum, equals 5 (five) percent of the total patient care hours of all paid hospice employees and contract staff. 5. Administrative support referenced above may mean support of the patient care activities of the hospice (i.e. clerical duties in the office) rather than general support activities (i.e. fund raising). ... 7. The volunteer Coordinator will record, when applicable, any expansion of care or services achieved through the use of volunteers including the types of services and time worked."
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7. The hospice's job description titled "Volunteer Coordinator," # 402A, states, "The person in this position supervises and coordinates the activities of Hospice volunteers in both patient care and in non-patient care settings. Responsibilities: Select and assign volunteers for newly admitted patients/family, with input from the Interdisciplinary Team. Keep accurate documentation of volunteer assignment, inducing documentation of hours served on a monthly and quarterly basis. ... Plan and implement the volunteer training course. ... Recruit and assign volunteers to work in the office, as needed. Maintain accurate records on volunteers and volunteer assignments, as required. ... Ensure compliance with volunteer policies/procedures."

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### SUMMARY STATEMENT OF DEFICIENCIES

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**NIGHTINGALE HOSPICE**

- **STREET ADDRESS, CITY, STATE, ZIP CODE:**
  - 6347 Constitution Drive
  - Fort Wayne, IN 46804
8. During interview on 2/26/15 at 3:45 PM, employees A and H indicated there was no further information to submit for review.

418.78(d) COST SAVING

The hospice must document the cost savings achieved through the use of volunteers. Documentation must include the following:

1. The identification of each position that is occupied by a volunteer.
2. The work time spent by volunteers occupying those positions.
3. Estimates of the dollar costs that the hospice would have incurred if paid employees occupied the positions identified in paragraph (d)(1) of this section for the amount of time specified in paragraph (d)(2) of this section.

Based on policy review and interview, the hospice failed to ensure the volunteer program remained in place, failed to ensure cost saving documents were maintained, and failed to retain volunteer records at the office for 1 of 1 hospice.

Findings include

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<td>The hospice will document the cost savings achieved through the use of volunteers. Documentation will include the identification of each position occupied by a volunteer, the work time spent by volunteers occupying those positions, and estimates of the dollar costs that the hospice would have incurred if paid employees occupied the positions identified in paragraph (d)(1) of this section for the amount of time specified in paragraph (d)(2) of this section.</td>
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<td>The Volunteer coordinator will maintain the volunteer records.</td>
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<td>3</td>
<td>Who is responsible? The executive Director</td>
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<td>3. During interview on 2/26/15 at 11:05 AM, employee H (social worker) indicated they were hired to also be the volunteer and bereavement coordinator in addition to the social worker position. Employee H indicated they have not done anything in these roles except read the books they were handed, because employee A keeps telling them they will go over the volunteer stuff later. Employee H indicated the hospice has not hired a receptionist at this office so they are stuck here answering phones. Employee H indicated the only orientation they received at this office was on 1/22/15, and all other orientation</td>
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NIGHTINGALE HOSPICE
6347 CONSTITUTION DRIVE
FORT WAYNE, IN 46804

was conducted at another hospice location.

4. During interview on 2/26/15 at 11:53 AM, employee A indicated employee H is the volunteer and bereavement coordinator.

5. As of 2/26/15 at 3:45 PM, the hospice failed to evidence any volunteer activity prior to 3/26/14.

6. The hospice's undated policy titled "Volunteers, Recruitment and Retention of," # HSP4-12B, HSP4-12B.01, states, "1. Nightingale Hospice will maintain an ongoing effort to recruit and retain volunteers through Hospice brochures and newsletters, education to the community, newspaper publications, and radio and television appearances as appropriate and annual recognition of volunteers. 2. Recruitment of volunteers may come through the following methods: ... 3. Efforts to retain volunteers includes, but is not limited to the following: ... d. Correspondence with the Volunteer Coordinator to provide supports, appreciation for the volunteer. ... 4. Nightingale Hospice will document the active and ongoing efforts to retain volunteers."

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"Volunteer Cost Saving and Level of Activity," # HSP4-12C, HSP4-12D, states, "1. The Volunteer Coordinator will identify the necessary positions that are occupied by volunteer. ... 3. Documentation will include the work time spent by volunteers occupying those positions and estimates of the dollar costs that Hospice would have incurred if paid employees occupied those positions during the same time frame. 4. Hospice will maintain a volunteer staff sufficient to provide administrative or direct patient care in an amount that, at a minimum, equals 5 (five) percent of the total patient care hours of all paid hospice employees and contract staff. 5. Administrative support referenced above may mean support of the patient care activities of the hospice (i.e. clerical duties in the office) rather than general support activities (i.e. fund raising). ... 7. The volunteer Coordinator will record, when applicable, any expansion of care or services achieved through the use of volunteers including the types of services and time worked."

8. The hospice's undated policy titled "Volunteer, Assignment and Role of," #HSP4-110, states, "1. Nightingale Hospice will use volunteers in defined roles under the supervision of the Volunteer Coordinator. 2. Volunteers
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**NAME OF PROVIDER OR SUPPLIER**

NIGHTINGALE HOSPICE

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**SUMMARY STATEMENT OF DEFICIENCIES**

Each deficiency must be preceded by full regulatory or LSC identifying information.

**PROVIDER'S PLAN OF CORRECTION**

Each corrective action should be referenced to the appropriate deficiency.

1. Volunteers may be used in administrative or direct patient care roles.

2. Volunteers will receive appropriate orientation and training that is consistent with acceptable standards of hospice's practice.

9. The hospice's job description titled "Volunteer Coordinator," # 402A, states, "The person in this position supervises and coordinates the activities of Hospice volunteers in both patient care and in non-patient care settings. Responsibilities: Select and assign volunteers for newly admitted patients/family, with input from the Interdisciplinary Team. Keep accurate documentation of volunteer assignment, inducing documentation of hours served on a monthly and quarterly basis. ... Plan and implement the volunteer training course. ... Recruit and assign volunteers to work in the office, as needed. Maintain accurate records on volunteers and volunteer assignments, as required. ... Ensure compliance with volunteer policies/procedures."

10. During interview on 2/26/15 at 3:45 PM, employees A and H indicated there was no further information to submit for review.
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

IDENTIFICATION NUMBER: 151598

NAME OF PROVIDER OR SUPPLIER: NIGHTINGALE HOSPICE

STREET ADDRESS, CITY, STATE, ZIP CODE: 6347 CONSTITUTION DRIVE, FORT WAYNE, IN 46804

PREVIEW

(418.78(e) LEVEL OF ACTIVITY

Volunteers must provide day-to-day administrative and/or direct patient care services in an amount that, at a minimum, equals 5 percent of the total patient care hours of all paid hospice employees and contract staff. The hospice must maintain records on the use of volunteers for patient care and administrative services, including the type of services and time worked.

Based on policy review and interview, the hospice failed to ensure the use of administrative volunteers and/or direct patient care volunteers equaling 5% of total patient care hours for 1 of 1 hospice.

Findings include

1. During interview on 2/23/15 at 11:50 AM, employee A (director of clinical services / alternate administrator) indicated due to the shortage of patients, the hospice is not currently trying to recruit volunteers, and the administrative volunteer moved to South Carolina in July or August of 2014.

2. On 2/26/15 at 10:30 AM, surveyor asked for volunteer records from August 2014 through present. At 10:30 AM, employee A indicated the hospice does not have any patient volunteers because

How will the deficiency be corrected? The Hospice will ensure that the volunteer program will be maintained and utilized to patients and families. The Hospice will provide a volunteer orientation and training program to ensure volunteers are in place and utilized in both administrative and/or direct patient care roles. The Hospice will maintain a volunteer staff sufficient to provide administrative and direct patient care equally at least 5% of the total direct care hours provided by the hospice staff. The Hospice agency has assigned a volunteer coordinator to coordinate and document the type of services and time worked to ensure compliance with volunteer policies and procedures to ensure that the volunteer program remains in place. The hospice will document the active and ongoing efforts to recruit and retain volunteers and all volunteer records will be maintained at the hospice

COMPLETION DATE: 04/21/2015
patients have refused volunteer services. Employee A indicated all the volunteer information is somewhere at another hospice entity.

3. As of 2/26/15 at 3:45 PM, the hospice failed to evidence any volunteer activity prior to 3/26/14.

4. The hospice's undated policy titled "Volunteers, Recruitment and Retention of," # HSP4-12B, HSP4-12B.01, states, "1. Nightingale Hospice will maintain an ongoing effort to recruit and retain volunteers through Hospice brochures and newsletters, education to the community, newspaper publications, and radio and television appearances as appropriate and annual recognition of volunteers. 2. Recruitment of volunteers may come through the following methods: ... 3. Efforts to retain volunteers includes, but is not limited to the following: ... d. Correspondence with the Volunteer Coordinator to provide supports, appreciation for the volunteer. ... 4. Nightingale Hospice will document the active and ongoing efforts to retain volunteers."

5. The hospice's undated policy titled "Volunteer Cost Saving and Level of Activity," # HSP4-12C, HSP4-12D, states, "1. The Volunteer Coordinator office 2 How will the deficiency be corrected? An inservice will be given to the volunteer coordinator on all aspects of volunteer responsibilities and all state and federal guidelines. Volunteers will be acquired and oriented and trained according to the regulatory guidelines. The volunteer qualification information will be kept at the agency along with agency personnel files. The cost savings report will be developed and completed monthly according to the standard. An inservice will be given to the volunteer coordinator on how to prepare and record needed information which will be forwarded to the executive director monthly to ensure report is completed and the required standards are met. Recruitment procedures have been implemented by the volunteer coordinator and status will be reported to the executive director and will be included in the QAPI quarterly reports. New Volunteer training sessions will be provided as often as necessary to ensure qualified volunteers are available. An inservice will be given to the volunteer coordinator on preparing, recording and documenting 3 Who is responsible? The executive Director 4 By what date will it be corrected? 04/21/2015
will identify the necessary positions that are occupied by volunteer. ... 3. Documentation will include the work time spent by volunteers occupying those positions and estimates of the dollar costs that Hospice would have incurred if paid employees occupied those positions during the same time frame. 4. Hospice will maintain a volunteer staff sufficient to provide administrative or direct patient care in an amount that, at a minimum, equals 5 (five) percent of the total patient care hours of all paid hospice employees and contract staff. 5. Administrative support referenced above may mean support of the patient care activities of the hospice (i.e. clerical duties in the office) rather than general support activities (i.e. fund raising). ... 7. The volunteer Coordinator will record, when applicable, any expansion of care or services achieved through the use of volunteers including the types of services and time worked.

6. The hospice's undated policy titled "Volunteer, Assignment and Role of," #HSP4-110, states, "1. Nightingale Hospice will use volunteers in defined roles under the supervision of the Volunteer Coordinator. 2. Volunteers will receive appropriate orientation and training that is consistent with acceptable standards of hospice's practice. 3.
Volunteers may be used in administrative or direct patient care roles."

7. The hospice's job description titled "Volunteer Coordinator," # 402A, states, "The person in this position supervises and coordinates the activities of Hospice volunteers in both patient care and in non-patient care settings. Responsibilities: Select and assign volunteers for newly admitted patients/family, with input from the Interdisciplinary Team. Keep accurate documentation of volunteer assignment, inducing documentation of hours served on a monthly and quarterly basis. ... Plan and implement the volunteer training course. ... Recruit and assign volunteers to work in the office, as needed. Maintain accurate records on volunteers and volunteer assignments, as required. ... Ensure compliance with volunteer policies/procedures."

8. During interview on 2/26/15 at 3:45 PM, employees A and H indicated there was no further information to submit for review.
Based on document review, policy review, and interview, it was determined the hospice failed to organize, manage, and administer its resource to provide the hospice care and services to patients, caregivers and families necessary for the palliation and management of the terminal illness and related conditions for in 2 of 4 clinical records reviewed (see L 649); failed to provide hospice care that optimizes comfort and dignity and is consistent with patient and family needs and goals in 2 of 4 clinical records reviewed (see L 650); and failed to ensure the appointed administrator is responsible for the day-to-day operations (see L 651); and failed to ensure employee files contained the Hospice philosophy orientation for 2 of 12 employee files reviewed, creating the potential to affect all the hospice's employees (See L 661, L 662, and L 663)

The cumulative effect of these systemic problems resulted in the hospice's inability to be in compliance with IC 16-25-3 and the Conditions of Participation 42 CFR 418.100 Organization and Administration of Services.

1. How will the deficiency be corrected? The hospice will organize, manage and administer its resources to provide the hospice care and services to patients, caregivers and families necessary for the palliation and management of the terminal illness and related conditions for in 2 of 4 clinical records reviewed (see L 649); failed to provide hospice care that optimizes comfort and dignity and is consistent with patient and family needs and goals in 2 of 4 clinical records reviewed (see L 650); and failed to ensure the appointed administrator is responsible for the day-to-day operations (see L 651); and failed to ensure employee files contained the Hospice philosophy orientation for 2 of 12 employee files reviewed, creating the potential to affect all the hospice's employees (See L 661, L 662, and L 663)

2. How will the deficiency will be prevented from recurring? An organizational chart will be developed and updated with all staff positions including the Executive Director which will demonstrate the chain of command to be able to more efficiently be able to manage our resources in providing Hospice care. All employees will be inserviced on Hospice philosophy and the competency evaluation will be placed in the personnel file. Audits will be conducted quarterly on personnel files to ensure competencies are completed and placed in the personnel files. 25% of all patient records will be audited for the next 90 days to ensure management of terminal illness takes place according to patients plan of care.

3. Who is responsible?

04/21/2015 12:00:00AM
STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION

IDENTIFICATION NUMBER: 151598

NAME OF PROVIDER OR SUPPLIER
NIGHTINGALE HOSPICE

STREET ADDRESS, CITY, STATE, ZIP CODE
6347 CONSTITUTION DRIVE
FORT WAYNE, IN 46804

418.100 ORGANIZATION AND ADMINISTRATION OF SERVICES
The hospice must organize, manage, and administer its resources to provide the hospice care and services to patients, caregivers and families necessary for the palliation and management of the terminal illness and related conditions.

Based on clinical record review, policy review, and interview, the hospice failed to organize, manage, and administer its resource to provide the hospice care and services to patients, caregivers, and families necessary for the palliation and management of the terminal illness and related conditions for in 2 of 4 clinical records reviewed. (#8 and #11)

Findings include:

1. Clinical record #8 contained a hospice plan of care for certification period 1/9 to 4/8/15 with orders for skilled nursing services stating, "21. SN: 1x/da [time per day] (1/14/2015 to 1/14/2015), 1x/wk (1/15/2015 to 1/17/2015), 3x/wk x 12 weeks (1/18/2015 to 4/8/2015), PRN [as needed] x5 change in functional stat

How will the deficiency be corrected?
The hospice will organize, manage and administer its resources to provide the hospice care and services to patients, caregivers and families necessary for the palliation and management of the terminal illness and related conditions. The governing body will assume full legal authority and make sure the appointed administrator is responsible for the day to day operations. All employee files will contain the Hospice philosophy orientation.

How the deficiency will be prevented from recurring?
An organizational chart will be developed and updated with all staff positions including the administrator.

04/21/2015
[status] ... Insert/Change Foley Catheter: Type Latex 16 fr 5cc Freq. [frequency] Q [every] month and PRN. ... SN/CG to cleanse coccyx wound 2-3 x/wk with soap and water and apply sacral allevyn. ... HCA: 1x/wk x 1wk (1/15/2015 to 1/17/2015), 2x/wk x 12 wks (1/18/2015 to 4/8/2015) assist with partial/complete bath. assist with personal care MSW: 1x/mo x 1mo (1/15/2015 to 2/14/2015) assess for increased caregiver support Clergy: 1x/mo x 1mo (1/15/2015 to 2/14/2015) assess for other sources of spiritual support..." The record failed to evidence a skilled nursing visit was conducted on 1/14/15.

A. The record contained a skilled nursing visit note dated 1/15/15 with an electronic signature of employee D (registered nurse) stating, "(PRN) SN Clinical Note Date 1/15/2015 In 11:35 AM Out 12:40 PM ...

INTEGUMENTARY Skin Status Specific skin problems noted stage 2-3 to sacrum, 13x8, moderate amount of serosang, granulation noted. SN cleansed with mild soap and water and applied optifoam. pt tolerated well, no s/s infection. SN taught wound care to family, s/s infections, effects of incontinence on wound and to notify agency of any worsening and they verbalized understanding. ... CARE which will demonstrate the chain of command to be able to more efficiently be able to manage our resources in providing Hospice care All employees will be in serviced on Hospice philosophy Audits will be conducted quarterly on personnel files to ensure competencies are completed and placed in the personnel files 100% of all patient records will be audited for the next 90 days to ensure management of terminal illness takes place according to patients plan of care

3. Who is responsible?
The Executive Director

4 By what date will the deficiency be corrected? 04/21/2015
## STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

### NAME OF PROVIDER OR SUPPLIER
NIGHTINGALE HOSPICE

### STREET ADDRESS, CITY, STATE, ZIP CODE
6347 CONSTITUTION DRIVE
FORT WAYNE, IN 46804

### PREVIOUS VERSIONS OBSOLETE
Event ID: D56O11  Facility ID: 007361

### PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:
151598

### MULTIPLE CONSTRUCTION DATE SURVEY COMPLETED
02/26/2015

### BUILDING 00

### WING

### STATEMENT OF DEFICIENCIES

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### SUMMARY STATEMENT OF DEFICIENCIES

**PLAN Met SN/CG to cleanse coccyx wound 2-3x/wk with soap and water and apply sacral allevyn ... Not Met**

**Insert/Change Foley Catheter: ... 0% complete. ... NARRATIVE 1/13/15 Visit ... caregiver reports need for some medications, medication refills and ADL [activities of daily living]/incontinence care supplies. SN ordered all as needed. no other needs or concerns identified at this time.**

1. On 2/25/15 at 12 PM, employee A indicated supplies were ordered on 1/15/15 and 1/16/15 and the visit was conducted by employee D on 1/15/15. Employee A was unable to locate documentation in the clinical record of any skilled nursing visits prior to 1/15/15, except for the SOC visit dated 1/9/15.

2. On 2/25/15 at 11:15 AM, a telephone interview was conducted with employee D. The employee stated, "There was no care plan" and he/she knew what to do at the visit "Per hospice protocol and report." The employee indicated never providing wound care to this patient and stated, "I wasn't aware [patient] had a wound. It was never mentioned to me." The employee indicated receiving report and not positive of whom he/she received it from...
but thinks it was from non-employee #18.

B. The record contained a skilled nursing visit note dated 1/15/15 with an electronic signature of employee D stating, "SN Clinical Note  Date 1/15/2015 In 12:35 PM Out 01:00 PM ... GENITOURINARY Catheter Foley patent and draining to gravity. patient denies any pain or discomfort at the cath insertion site. sediment noted in tubing but output WNL [within normal limits]. caregiver denies any s/s [signs and/or symptoms] UTI [urinary tract infection]. INTEGUMENTARY  Skin Status Specific skin problems noted stage 2 wound to sacrum. optifoam dressing in place. ... CARE PLAN ... Not Met SN/CG to cleanse coccyx wound 2-3 x/wk with soap and water and apply sacral allevyn ... 0% complete ... Insert/Change foley catheter ... not needed during this visit - 0% complete. ... ."

C. The record contained a skilled nursing visit note dated 1/15/15 with an electronic signature of employee L stating, "SN Clinical Note  Date 1/15/2015 In 01:03 PM Out 02:03 PM ... GENITOURINARY Urine Amount Adequate  Color Amber  Odor Foul Appearance Cloudy Catheter Urethral Inserted Latex Foley #16 fr 10 cc
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**NAME OF PROVIDER OR SUPPLIER**

**ADDRESS**

| NIGHTINGALE HOSPICE | 6347 CONSTITUTION DRIVE | FORT WAYNE, IN 46804 |

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**IDENTIFICATION NUMBER:** 151598

**DATE SURVEY COMPLETED:** 02/26/2015

**B. WING**

**STATEMENT OF DEFICIENCIES**

**PREFIX**

**TAG**

**ID**

**PROVIDER’S PLAN OF CORRECTION**

**COMPLETION DATE**

- **Balloon Inflated to 7.5 cc next change due on or about 2/15/2015 Insertion**
- **Area Reddened cg state that catheter had not been changed for 2 months. strong urine odor noted. ...**
- **INTEGUMENTARY Skin Status**
  - General skin condition intact specific skin problems noted lesion L [left] buttock lesion R [right] buttock currently using low air loss mattress ... WOUND
  - **Wound #1 Type Pressure ulcer did not assess today as no dressing available in home. family states it has not changed for last assessment Location Posterior Buttock Wound size Length did not assess cm [centimeters] Width did not assess cm Depth did not assess cm. ...**
  - **CARE PLAN Met ... Insert/Change foley catheter ... Not Met SN/CG to cleanse coccyx wound 2-3 x/wk with soap and water and apply sacral allevyn - 0% complete ... NARRATIVE Pt [patient] needed catheter change. insertion site is red and irritated. replaced with 16 fr 7.5 ml in balloon. VS [vital signs] stable. ... ."**

**D.** The record contained a skilled nursing visit note dated 1/17/15 with an electronic signature of employee L stating. "(PRN) SN Clinical Note Date 1/17/2015 ... WOUND Wound #1 type Pressure ulcer Stage #3 Location Buttock Exudate 100% saturated dsg.
E. The record evidenced a hospice aide care plan with a date of last update as 1/15/15, signed by non-employee #18. The record evidenced a hospice aide visit on 1/19/15 by non-employee #13. The record failed to evidence an aide visit as ordered for 1 time between the dates of 1/15 and 1/17/15.

F. On 2/25/15 at 11 AM, employee A indicated hospice services were initiated on 1/9/15 by non-employee #18 and the plan of care should have been initiated on 1/9/15. The director of clinical services indicated he/she reviewed the plan of care on 1/15/15 and that is why it did not get initiated until 1/15/15. The employee indicated non-employee #18 failed to communicate the plan of care to all other disciplines involved in the patient's care.

2. Clinical record #11 contained a hospice plan of care for certification period 2/9 to 5/9/15 with orders for skilled nursing services stating, "21. SN: 2x/wk x 13 wks (2/9/2015 to 5/9/2015)...
HCA: 1x/wk x 1wk (2/11/2015 to 2/14/2015), 3x/wk x 12 wks (2/15/2015 to 5/9/2015) assist with partial/complete
A. The record contained a hospice aide care plan electronically signed by non-employee #17 on 2/11/15. The record evidenced hospice aide visits were conducted on 2/23 and 2/25/15 by non-employee #25. The record failed to evidence an aide visit was conducted week 1 (2/11 to 2/14/15) and failed to evidence 3 aide visits were conducted for the week 2 (2/15 to 2/21/15).

On 2/25/15 at 4:15 PM, employee A indicated the patient/caregiver was not home during the aide's attempts to provide the ordered visits for weeks 1 and 2. Employee A indicated the patient's family member "always has the patient out running around."

B. The record contained a document dated 2/9/15, electronically signed by non-employee #17, stating, "SUBJECTIVE Family/Caregiver reports: General concerns: comfortable state. ... Spiritual concern: no concerns identified. ... COMPREHENSIVE SPIRITUAL Family/caregiver verbalizes concerns about: no concerns identified. ..."
On 2/26/15 at 12:30 PM, a telephone interview was conducted with the patient's family member. The family member indicated not having hospice aide services for weeks 1 and 2 and at no time did an aide attempt to make a visit during those weeks but was informed by hospice staff that they were attempting to get the service started. The family member indicated his/her mother cannot be transported and is a homebound patient that requires supervision 24 hours per day. The family member indicated acceptance of spiritual counseling services upon admission but did not have a visit until "just last week" (week of 2/15 to 2/21/15).

3. During interview on 2/23/15 at 11:50 AM, employee A (director of clinical services / alternate administrator) indicated they oversee the day to day operations here. Employee A indicated the administrator (employee B) is at another hospice entity daily but comes to Fort Wayne immediately if needed.

4. During interview on 12/23/15 at 12:04 PM, employee B (administrator) indicated they are the administrator for the Fort Wayne office, but they have not been present in the Fort Wayne office since August. Employee B indicated that
employee A oversees the day to day operations for Fort Wayne, but employee B is always available via telephone.

5. The undated policy titled "PATIENT ASSESSMENT & PLAN OF CARE" states, "PURPOSE To identify the patient's needs for care, treatment and/or services within an appropriate time frame based on the patient's needs and complexity of treatment, and in compliance with applicable laws, regulations and standards. To determine the appropriate care, treatment and/or services to meet the patient's initial needs, including support needs, as well as his/her continuing needs while receiving care, treatment and/or services provided by agency personnel. To ensure that an assessment is performed appropriate to the patient's needs and diagnosis and the care, treatment and/or services provided by the agency. ... to ensure that the patient's current needs and/or problems are continuously evaluated, and the care, treatment and/or services provided are adjusted to address those needs and/or problems. POLICY The initial diagnosis and age appropriate assessment shall be performed by a Registered Nurse: ... If a service discipline cannot meet the time frame for assessment, the patient and the physician must be notified and orders received to delay the initial
### Statement of Deficiencies and Plan of Correction

**Identification Number:**

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**Name of Provider or Supplier:** Nightingale Hospice

**Street Address, City, State, Zip Code:**

6347 Constitution Drive
FORT WAYNE, IN 46804

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**Summary Statement of Deficiencies**

(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

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**Provider's Plan of Correction**

(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

**Assessment/Evaluation:** ... A proposed plan of care, based upon assessment findings, is developed and discussed with the patient/family to ensure that the patient/family/caregiver is involved in decisions about the patient's care ... The comprehensive assessment is to be submitted to the agency office within 24 hours of the completed assessment. ...

**Procedure:** A registered nurse shall complete a comprehensive assessment and reassessment of the patient's needs for care, treatment and/or services, including home health aide services, within the time frames specified above in policy. The completed documentation is submitted to the agency within the time frames specified above in policy. The comprehensive assessment: ... is performed within the registered nurse's scope of practice, state licensure laws, applicable regulations and/or certification of the RN ... The completed assessment paperwork is reviewed in the agency for completeness and accuracy before a plan of care is developed. ...

6. The undated policy titled "Scope of Services" states, "Policy: Services provided directly or under contractual agreement to patients serviced by the agency are monitored by the agency. ... The patient shall be accepted by the agency only if the agency is capable of
providing qualified staff and services to meet the patient's identified needs. Patients will be accepted for care and services in accordance with the following standards: The care and services required by the patient are consistent with the agency's mission and scope of service. ... DESCRIPTION OF SERVICES: ... Services available through the agency include: Registered nurses ...

7. During interview on 2/26/15 at 3:45 PM, employees A and H indicated there was no further information to submit for review.

L 651

Bldg. 00

418.100(b) GOVERNING BODY AND ADMINISTRATOR

A governing body (or designated persons so functioning) assumes full legal authority and responsibility for the management of the hospice, the provision of all hospice services, its fiscal operations, and continuous quality assessment and performance improvement. A qualified administrator appointed by and reporting to the governing body is responsible for the day-to-day operation of the hospice. The administrator must be a hospice employee...
and possess education and experience required by the hospice's governing body.

Based on policy review and interview, the hospice failed to ensure the appointed administrator is responsible for the day-to-day operations of the hospice for 1 of 1 hospice, creating the potential to affect all the hospice's patients. (employee B)

Findings include

1. During interview on 2/23/15 at 11:50 AM, employee A (director of clinical services / alternate administrator) indicated they oversee the day to day operations here. Employee A indicated the administrator (employee B) is at another hospice entity daily but comes to Fort Wayne immediately if needed.

2. During interview on 12/23/15 at 12:04 PM, employee B (administrator) indicated they are the administrator for the Fort Wayne office, but they have not been present in the Fort Wayne office since August. Employee B indicated that employee A oversees the day to day operations for Fort Wayne, but employee B is always available via telephone.

3. The hospice's undated policy titled "Agency Administration," # HSP1-4A;

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1 How will the deficiency be corrected?

The hospice will organize, manage and administer its resources to provide the hospice care and services to patients, caregivers and families necessary for the palliation and management of the terminal illness and related conditions. The governing body will assume full legal authority and make sure the appointed administrator is responsible for the day to day operations. The Administrator or in the absence of the administrator, the alternate administrator will be responsible for the day to day operations of the hospice agency.

2 How the deficiency will be prevented from recurring?

An organizational chart will be developed and updated with all staff positions including the administrator which will demonstrate the chain of command to be able to more efficiently be able to manage our resources in providing Hospice care. The role of the administrator and alternate administrator will be discussed in quarterly Professional advisory committee meeting to ensure administrator responsibilities are being met. The Governing board will actively oversee the administrator.
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| HSP1-4B | states, "The Governing Board shall appoint a full-time Administrator who shall have full authority and responsibility for management of Agency affairs. The Administrator's responsibilities and authority are delineated in the job description."
| | 5. The hospice's undated policy titled "Compliance with Federal, State & Local Laws," # HSP1-1A.01; HSP1-1B, states, "The agency complies with all applicable federal, state and local laws and regulations regarding all aspects of hospice business practices. These laws and regulations include, but are not limited to, the following: ... Centers for Medicare and Medicaid Services Regulations, ... HIPAA Regulations, ... Occupational Licensure Laws and accepted standards of practice, City, county, and state required business licenses. The Administrator is ultimately responsible for ensuring Agency compliance with all applicable laws and regulations and accepted professional standards and practices. ... Accepted standards of practice and occupational licensure acts are utilized by the Agency" | contact with the Governing Board on a daily basis via email, phone or face to face encounters to ensure responsibilities are being met
| | 3. Who is responsible? | The Executive Director
| | 4 By what date will the deficiency be corrected? | 04/21/2015
to guide the provision of care and services, and are available for reference by Agency personnel."

6. During interview on 2/26/15 at 3:45 PM, employees A and H indicated there was no further information to submit for review.

If a hospice operates multiple locations, it must meet the following requirements:
(1) Medicare approval.
   (i) All hospice multiple locations must be approved by Medicare before providing hospice care and services to Medicare patients.

Based on interview, the hospice failed to ensure a hospice location had been approved by Medicare and Licensed in accordance with State licensure laws for 1 of 1 hospice.

Findings include

1. During interview on 2/23/15 at 10:50
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**IDENTIFICATION NUMBER:** 151598

**NAME OF PROVIDER OR SUPPLIER:** NIGHTINGALE HOSPICE

**STREET ADDRESS, CITY, STATE, ZIP CODE:** 6347 CONSTITUTION DRIVE, FORT WAYNE, IN 46804

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<td>AM, employee A (director of clinical services / alternate administrator) indicated the office moved to Crown Point before they had approval to move, so they just moved back to Fort Wayne. Employee A indicated the Fort Wayne office had moved to Crown Point around the end of October 2014 and moved back in the beginning of December. Employee A indicated there is not an office in Merrillville since they could not stay in that area, so all patient records were moved back to Fort Wayne. Employee A indicated the nurse and chaplain were seeing patients here within the hospice's approved counties for services, but that no patients were receiving services from Crown Point as another Nightingale hospice serves that area.</td>
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</table>

2. During interview on 2/23/15 at 12:04 PM, employee B indicated the Fort Wayne hospice moved back from Crown Point once they found out they were not approved for the counties they had moved to, and no patients were provided services in any counties not approved for. Employee B indicated the hospice moved to Crown Point on November 15, 2014, and came back on Wednesday that same week, the 18th or the 19th. Employee B indicated the hospice was discussing hiring a new medical director for Crown Point, otherwise the current Medical Director from ISDH was responsible.

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<td>from ISDH</td>
<td>Who is responsible?</td>
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<td>The governing Board</td>
<td>4 By what date? 04/21/2015</td>
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### Statement of Deficiencies and Plan of Correction

**Identification Number:** MULTIPLE CONSTRUCTION 151598 02/26/2015

**Name of Provider or Supplier:** NIGHTINGALE HOSPICE

**Street Address, City, State, Zip Code:** 6347 CONSTITUTION DRIVE, FORT WAYNE, IN 46804

---

**Summary Statement of Deficiencies:**

1. Director, employee C, had not been terminated. Employee B indicated apparently the distance for the hospice license and counties served was too far away. Employee B indicated the employees also work for another Nightingale hospice at another location and are paid from both branches based on if they are salary pay, or per visit pay.

2. During interview on 2/26/15 at 3:45 PM, employees A and H indicated there was no further information to submit for review.

3. Based on employee file review, policy review, and interview, the hospice failed to ensure employee files contained the Hospice philosophy orientation for 2 of 12 employee files reviewed, creating the potential to affect all the hospice's employees. (F and H)

**Prefix:** L 661  
**Tag:** Bldg. 00

**Regulatory or LSC Identifying Information:**

**Training:** 418.100(g)(1)  
(1) A hospice must provide orientation about the hospice philosophy to all employees and contracted staff who have patient and family contact.

**Corrective Action Plan:**

1. How will the deficiency be corrected? All employee records will contain hospice philosophy orientation prior to any hands on patient contact. All documentation will be maintained in the personnel record and kept up to date.

2. How will the deficiency be prevented from recurring? An inservice and orientation will be given to the volunteer coordinator on job description and responsibilities. All employee records will be reviewed to ensure compliance.
Findings include:

1. Employee file F, date of hire (DOH) 2/2/15, failed to contain any documents.

2. Employee H's file, the social worker, DOH 1/19/15, contained a document titled "Orientation Checklist Licensed Personnel," # HSP4-4A, dated 1/19/15. This check list failed to evidence the Hospice philosophy was reviewed. The employee file failed to contain any further documentation.

   A. During interview on 2/26/15 at 11:05 AM, employee H indicated the only orientation they received at this hospice was on 1/19/15, and was general paperwork.

   B. During interview on 2/26/15 at 11:53 AM, employee A indicated the volunteer coordinator is employee H, in addition to employee H being the bereavement coordinator in conjunction with employee I.

3. The hospice's undated policy titled "Orientation Program," # HSP4-4A, states "All new employees participate in a general orientation program appropriate to the classification of the employee before assuming any job responsibilities or duties. The Executive Director ensure all documentation is up to date and contains the complete and appropriate documentation according to state and federal guidelines. Any employee record found to not have up to date and current evidence of required education or competency will be removed from patient contact until education and credentials are updated. 25% of all employee records will be audited after initial audit for the next 90 days to ensure compliance. Who will be responsible? The Executive Director. By what date? 04/21/2015
Director/Director of Human Resources is responsible for coordinating the Agency's general orientation program. Other appropriately trained/experienced personnel may conduct the orientation program. ... Introduction to Hospice-client/patient/family/caregiver as a unit of service.

4. The hospice's undated policy titled "Personnel File Management," # HSP4-1A.01, states "All Agency employees, including contract personnel, will have a personnel file. The Administrator/designee is responsible for maintaining up-to-date personnel files for each employee and for ensuring the security of all personnel information. ... Complete and up-to-date personnel records are available for inspection by federal, state regulatory agencies and accreditation organizations. ... Personnel File Contents: Section I-Employee Data, Employment Application, Resume, Withholding Allowance Certificate (W-4), dated and signed, Contract if applicable, Employment Reference Checks (2). Section II-Employee Qualifications, Driver's License, Automobile Insurance, Professional Licenses, if applicable, CPR certification as required by the job description, New employee Orientation checklist. Section III-Competence, Performance
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**Evaluations, Competence Evaluation, Inservice Training Records. Section IV-Miscellaneous, Commendations, Disciplinary Actions. Separate Confidential Files, A. I-9 Citizenship Verification, B. Medical/Health file, Medical history Form, Hepatitis B acceptance/Declination Form (if applicable), TB skin test results/Chest x-ray results and/or an annual verification that the employee is free of TB symptoms, Any other health-related documents i.e. return to work permission, Criminal Background and National Sex Offender Registry Check results (if required by law)."

5. During interview on 2/26/15 at 3:45 PM, employees A and H indicated there was no further information to submit for review.

L 662 418.100(g)(2) TRAINING (2) A hospice must provide an initial orientation for each employee that addresses the employee's specific job duties.

Based on employee file review, policy review, and interview, the hospice failed to ensure employee files contained the Hospice philosophy orientation for 2 of 12 employee files reviewed. (F and H)

| L 662 | 1 How will the deficiency be corrected? All employees records will contain hospice philosophy orientation and competency check lists prior to any hands on patient contact. All documentation will be maintained |
| L 662 | 04/21/2015 |

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: D56011 Facility ID: 007361 If continuation sheet Page 156 of 193
Findings include

1. Employee file F (registered nurse), date of hire (DOH) 2/2/15, failed to contain any documents.

2. Employee H's file, the social worker, DOH 1/19/15, contained a document titled "Orientation Checklist Licensed Personnel," # HSP4-4A, dated 1/19/15. This checklist failed to evidence the Hospice philosophy was reviewed. The employee file failed to contain any further documentation.

   A. During interview on 2/26/15 at 11:05 AM, employee H indicated the only orientation they received at this hospice was on 1/19/15, the rest was conducted at another hospice location. Employee H indicated they were not oriented to the Bereavement Coordinator and Volunteer coordinator positions.

   B. During interview on 2/26/15 at 11:53 AM, employee A indicated the volunteer coordinator is employee H, in addition to employee H being the bereavement coordinator in conjunction with employee I.

   C. On 2/26/15 at 11:30 AM, employee H provided a copy of an email in the personnel record and kept up to date. 2. How will the deficiency be prevented from recurring. An inservice and orientation will be given to the volunteer coordinator on job description and responsibilities to all roles including the bereavement coordinator role. An inservice will be given to all staff regarding job descriptions and competency. All employee records will be reviewed to ensure all documentation is up to date and contains the complete and appropriate documentation according to state and federal guidelines. Any employee record found to not have up to date and current evidence of required education or competency will be removed from patient contact until education and credentials are updated. 25% of all employee records will be audited after initial audit for the next 90 days to ensure compliance 3. Who will be responsible? The Executive Director 4. By what date? 04/21/2015
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<td>from employee M to employee B dated January 5, 2015 4:22 PM that states &quot;I told [employee] because there is only one patient in Fort Wayne that [employee] would be traveling to Carmel more than [employee] will be going to FW. [employee] is swilling to assume the role of volunteer coordinator for FW and Carmel.&quot;</td>
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</table>
|     |        |     | 4. The hospice's undated policy titled "Orientation Program," # HSP4-4A, states "All new employees participate in a general orientation program appropriate to the classification of the employee before assuming any job responsibilities or duties. The Executive Director/Director of Human Resources is responsible for coordinating the Agency's general orientation program. Other appropriately trained/experienced personnel may conduct the orientation program. ... Introduction to Hospice-client/patient/family/caregiver as a unit of service."
|     |        |     | 5. The hospice's undated policy titled "Personnel File Management," # HSP4-1A.01, states "All Agency employees, including contract personnel, will have a personnel file. The Administrator/designee is responsible for maintaining up-to-date personnel files for each employee and for ensuring the
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security of all personnel information. ... Complete and up-to-date personnel records are available for inspection by federal, state regulatory agencies and accreditation organizations. ... Personnel File Contents: Section I-Employee Data, Employment Application, Resume, Withholding Allowance Certificate (W-4), dated and signed, Contract if applicable, Employment Reference Checks (2). Section II-Employee Qualifications, Driver's License, Automobile Insurance, Professional Licenses, if applicable, CPR certification as required by the job description, New employee Orientation checklist. Section III- Competence, Performance Evaluations, Competence Evaluation, Inservice Training Records. Section IV- Miscellaneous, Commendations, Disciplinary Actions. Separate Confidential Files, A. I-9 Citizenship Verification, B. Medical/Health file, Medical history Form, Hepatitis B acceptance/Declination Form (if applicable), TB skin test results/Chest x-ray results and/or an annual verification that the employee is free of TB symptoms, Any other health-related documents i.e. return to work permission, Criminal Background and National Sex Offender Registry Check results (if required by law)."

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security of all personnel information. ... Complete and up-to-date personnel records are available for inspection by federal, state regulatory agencies and accreditation organizations. ... Personnel File Contents: Section I-Employee Data, Employment Application, Resume, Withholding Allowance Certificate (W-4), dated and signed, Contract if applicable, Employment Reference Checks (2). Section II-Employee Qualifications, Driver's License, Automobile Insurance, Professional Licenses, if applicable, CPR certification as required by the job description, New employee Orientation checklist. Section III- Competence, Performance Evaluations, Competence Evaluation, Inservice Training Records. Section IV- Miscellaneous, Commendations, Disciplinary Actions. Separate Confidential Files, A. I-9 Citizenship Verification, B. Medical/Health file, Medical history Form, Hepatitis B acceptance/Declination Form (if applicable), TB skin test results/Chest x-ray results and/or an annual verification that the employee is free of TB symptoms, Any other health-related documents i.e. return to work permission, Criminal Background and National Sex Offender Registry Check results (if required by law)."
### Statement of Deficiencies and Plan of Correction

**Identification Number:** MULTIPLE CONSTRUCTION A. BUILDING 00

**Date Survey Completed:** 02/26/2015

#### Name of Provider or Supplier

**NIGHTINGALE HOSPICE**

**Street Address, City, State, Zip Code:** 6347 CONSTITUTION DRIVE
FORT WAYNE, IN 46804

#### Summary Statement of Deficiencies

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<tr>
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<td>L 663</td>
<td>418.100(g)(3)</td>
<td>TRAINING</td>
<td><strong>How will the deficiency be corrected?</strong> All employees records will contain hospice philosophy orientation prior to any patient contact. All documentation will be maintained in the personnel record and kept up to date. All employees will have competency evaluations on file prior to any patient contact. <strong>How will the deficiency be prevented from recurring?</strong> All employee records will be reviewed to ensure all documentation is up to date and accurate.</td>
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</table>

#### Findings

1. Employee file F (registered nurse), date of hire (DOH) 2/2/15, failed to complete orientation. Based on employee file review, policy review, and interview, the hospice failed to ensure employee files contained orientation documentation for 1 of 12 employee files reviewed. **How will the deficiency be corrected?** All employees records will contain hospice philosophy orientation prior to any patient contact. All documentation will be maintained in the personnel record and kept up to date. All employees will have competency evaluations on file prior to any patient contact. **How will the deficiency be prevented from recurring?** All employee records will be reviewed to ensure all documentation is up to date and accurate.

**Completion Date:** 04/21/2015
2. The hospice's undated policy titled "Orientation Program," # HSP4-4A, states "All new employees participate in a general orientation program appropriate to the classification of the employee before assuming any job responsibilities or duties. The Executive Director/Director of Human Resources is responsible for coordinating the Agency's general orientation program. Other appropriately trained/experienced personnel may conduct the orientation program. ... Introduction to Hospice-client/patient/family/caregiver as a unit of service."

3. The hospice's undated policy titled "Personnel File Management," # HSP4-1A.01, states "All Agency employees, including contract personnel, will have a personnel file. The Administrator/designee is responsible for maintaining up-to-date personnel files for each employee and for ensuring the security of all personnel information. ... Complete and up-to-date personnel records are available for inspection by federal, state regulatory agencies and accreditation organizations. ... Personnel File Contents: Section I-Employee Data, Employment Application, Resume, Withholding Allowance Certificate contains the complete and appropriate documentation according to state and federal guidelines any employee record found to not have up to date and current evidence of required education or competency will be removed from patient contact until education and credentials are updated 25% of all employee records will be audited after initial audit for the next 90 days to ensure compliance 3 Who will be responsible? The Executive Director 4 By what date? 04/21/2015
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

IDENTIFICATION NUMBER: 151598

A. BUILDING
B. WING

DATE SURVEY COMPLETED: 02/26/2015

NAME OF PROVIDER OR SUPPLIER
NIGHTINGALE HOSPICE

STREET ADDRESS, CITY, STATE, ZIP CODE
6347 CONSTITUTION DRIVE
FORT WAYNE, IN 46804

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(W-4), dated and signed, Contract if applicable, Employment Reference Checks (2). Section II-Employee Qualifications, Driver's License, Automobile Insurance, Professional Licenses, if applicable, CPR certification as required by the job description, New employee Orientation checklist. Section III- Competence, Performance Evaluations, Competence Evaluation, Inservice Training Records. Section IV- Miscellaneous, Commendations, Disciplinary Actions. Separate Confidential Files, A. I-9 Citizenship Verification, B. Medical/Health file, Medical history Form, Hepatitis B acceptance/Declination Form (if applicable), TB skin test results/Chest x-ray results and/or an annual verification that the employee is free of TB symptoms, Any other health-related documents i.e. return to work permission, Criminal Background and National Sex Offender Registry Check results (if required by law)."

4. During interview on 2/26/15 at 3:45 PM, employees A and H indicated there was no further information to submit for review.
Based on contract review, policy review, and interview, it was determined the hospice failed to ensure the Medical Director contract designated another physician to assume the role if the Medical Director is not available (L665).

The cumulative effect of these systemic problems resulted in the hospice's inability to be in compliance with IC 16-25-3 and the Conditions of Participation 42 CFR 418.102 Medical Director.

1. How will the deficiency be corrected?
The hospice will designate a hospice physician to assume the responsibilities of the medical director in the absence of the medical director. Copies of all physicians contracts will be maintained and available to ISDH.

2. How will the deficiency be prevented? Physician contracts will be reviewed by the executive director to ensure availability and discuss responsibilities of the roles. Communication with the executive director will be ongoing to ensure availability.

3. Who will be responsible? The Executive Director.

4. By what date will deficiency be corrected? 04/21/2015.
osteopathy who is an employee, or is under contract with, the hospice. When the medical director is not available, a physician designated by the hospice assumes the same responsibilities and obligations as the medical director.

Based on contract review, policy review, and interview, the hospice failed to ensure the Medical Director contract designated another physician to assume the role if the Medical Director is not available, for 1 of 1 contract reviewed, and 1 of 1 hospice.

Findings include

1. During phone interview on 2/24/15 at 3:45 PM, employee C (medical director) indicated they are not sure if they are still the medical director for this hospice because they have been somewhat inactive, and they believe the other hospice location is handling the Interdisciplinary Team (IDT). Employee C indicated the last IDT they recalled being involved with was approximately 3-4 months ago and they have not been actively involved in the last few months. Employee C indicated they were not aware the hospice moved to Crown Point, so was not even aware if they were going to be the medical director there had the hospice been able to stay. Employee C indicated they did not know the hospice

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<th>L 665</th>
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<th>1. How will the deficiency be corrected?</th>
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<td>The hospice will designate a hospice physician to assume the responsibilities of the medical director in the absence of the medical director. Agency policy states, in the absence of the Medical Director a qualified physician will be available to serve as his/her designee. The Hospice has a contracted Medical Director and a contracted Associate Medical Director. Copies of all physicians contracts will be maintained and available to ISDH (See Attachment D, Medical Director Contracts)</td>
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<td>2 How will the deficiency be prevented?</td>
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<td>Physician contracts will be reviewed by the executive director to ensure availability and discuss responsibilities of the roles Communication with the executive director will be ongoing to ensure availability</td>
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<td>3. Who will be responsible?</td>
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<td>The Executive Director</td>
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was still functioning in Fort Wayne, as they figured it was defunct due to lack of communication. Employee C indicated they were aware of patient #10, as they provided care for this patient, but the patient passed away in December, but also indicated they may have signed some paperwork for patient #8 but they sign so many papers that they could not recall the patient's name. Employee C indicated when they were not available for medical director duties, the physician (non-employee # 22) at hospice entity covered for them, and vice versa.

2. During interview on 2/26/15 at 1:20 PM, employee C indicated they reviewed some of the staff for the other Nightingale location's medical director if they needed something signed but there has not been much since around the first of this year. Possibly some in January. Employee C indicated they haven't talked with employee A for a few months, and indicated they were not on phone for the IDT meeting on 1/19/15, indicating it's been months since they were involved with the IDT. Employee C indicated they do not recall being notified of patients # 8, 9, and 11. Employee C indicated the hospice used to have physical IDT meetings at the office on Constitution Drive, some were done by phone. Employee C indicated phone IDT

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4. By what date will deficiency be corrected?  
04/21/2015
attendance involved the hospice sending a sign in sheet for them to sign and return, and about a week or two ago they signed one for one of the other physicians but has not seen any since then. Employee C checked emails and faxes while surveyor present in office, employee C indicated there were no current emails or faxes from the hospice as of today, 2/26/15. Employee C indicated most of this hospice's activity is run out of the other Nightingale hospice agency owned by employee B, including to approve and sign all patient care.

3. The Medical Director contract for employee C, dated 9/11/13 failed to evidence a physician was designated to cover this role should the employee C be unavailable.

4. During interview on 2/26/15 at 3:30 PM, employee A (director of clinical services/alternate administrator) indicated all employees are invited to be present for the IDT meetings and usually consist of self, employees H, I, and sometimes non-employee #23 if they are filling in for employee I. Employee A indicated the medical director, employee C is present sometimes, if they show up.

5. During interview on 2/24/15 at 11:45 AM, employee A indicated due to only 1
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|   |   |   | REGULATORY OR LSC IDENTIFYING INFORMATION) |   |   |   | CROSS-REFERENCED TO THE APPROPRIATE |
|   |   |   |                                             |   |   |   | DEFICIENCY)                        |
|   |   |   |                                             |   |   |   |                                |

Patient at this time, the IDT meetings are conducted via telephone conference with the IDT meetings for the other hospice entity with their medical director, non-employee # 22.

6. The document titled "Employment Agreement for Medical Director Services," dated 8/1/14 for non-employee #3 failed to evidence the contract is for Nightingale Hospice Care of Northern Indiana, Inc D/B/A (doing business as) Nightingale Hospice.

7. The hospice's undated policy titled "Medical director and Physician Services," #HSP2-11B.01, HSP4-11A, states "The Medical director will assume overall responsibility for the medical component of the Hospice's patient care program, ... The Medical Director and any physician employees of Hospice may also serve as the physician representatives of the Interdisciplinary Group (IDT) and/or as an attending physician. Responsibilities of the Medical Director and physician employees of the Hospice's include, but are not limited to: ... b) Participation in the development, revision, and approval of the interdisciplinary group plan of care, ... d) Communication with hospice interdisciplinary group members, ... f) attends interdisciplinary group meetings.
Based on observation, clinical record review, policy review, and interview, it was determined the hospice failed to ensure a clinical record contained correct clinical information that is available to the patient's attending physician and hospice (L 671); failed to ensure the election statements signed by the patients identified the hospice agency elected to provide care (L 673); failed to ensure all entries to the clinical record were appropriately dated in accordance with hospice policy and currently accepted standards (L 679); and failed to ensure the confidentiality of patient records and information (L 680).

The cumulative effect of these systemic failures is noted as a significant issue that affects the quality of care provided by the hospice.

8. During interview on 2/26/15 at 3:45 PM, employees A and H indicated there was no further information to submit for review.

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1. **How will the deficiency be corrected?** All clinical records will contain correct clinical information that is available to the patients attending physician and hospice, ensure the election statement signed by the patient identifies the hospice agency elected to provide care, and ensure all entries to the clinical record are appropriately dated in accordance with state and federal guidelines, and the agency will ensure the confidentiality of patient records and information.

2. **How will the deficiency prevented to recurring?**
   - An inservice will be given to all personnel to ensure that the clinical records are properly maintained and all personnel are aware of the policies and procedures related to patient records and confidentiality.
   - The lease with the space in Crown Point has been terminated. All personnel files shall be kept current and include all state and federal qualification requirements.

In the absence of the Medical Director, a qualified physician will be available to serve as his/her designee.
Problems resulted in the hospice's inability to be in compliance with IC 16-25-3 and the Conditions of Participation 42 CFR 418.104: Clinical Records.

Skilled staff regarding consent for election of Medicare hospice benefit. All current patient records will be reviewed to ensure Nightingale Hospice is listed as the provider of care. 25% of all clinical records will be reviewed for 90 days to ensure compliance. An Inservice will be given to all skilled field staff regarding timely and accurate completion of all clinical documentation 25% of all clinical records will be reviewed for 90 days to ensure compliance. All records will kept at the CMS approved location in a locked area. An audit will be done on all employee files to ensure they are complete with all state and federally required credentials including licensure and education qualifications and criminal background checks. Any employee whose record is found not in compliance will not have any patient contact until record is update and complete.

25% of all personnel files will be audited for 90 days to ensure ongoing compliance 3. Who is responsible? The Executive Director 4. By what date corrected? 04/21/2015

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<td>L 673, 418.104(a)(2) CONTENT [Each patient's record must include the following:] (2) Signed copies of the notice of patient rights in accordance with §418.52 and election statement in accordance with</td>
</tr>
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</table>
Based on document review and interview, the hospice failed to ensure the election statements signed by the patients identified the hospice agency elected to provide care for 1 of 4 clinical records reviewed, creating the potential to affect all the hospice's patients. (# 10)

Findings include

1. The Consent for Election of Medicare Hospice Benefit statement signed on 9/23/14 for patient # 10 contained a Nightingale Hospice logo in the upper left hand corner. This form failed to evidence the name of the hospice provider selected to provide care.

2. During interview on 2/26/15 at 3:45 PM, employees A and H indicated there was no further information to submit for review.

§418.24.

1. How will the deficiency be corrected? All clinical records will contain correct clinical information that is available to the patients attending physician and hospice, ensure the election statement signed by the patient identifies the hospice agency elected to provide care, and ensure all entries to the clinical record are appropriately dated in accordance with state and federal guidelines, and the agency will ensure the confidentiality of patient records and information.

2. How will the deficiency prevented to recurring? An inservice will be given to all skilled staff regarding consent for election of Medicare hospice benefit. All current patient records will be reviewed to ensure Hospice name is listed as the provider of care and the name of the attending physician is also listed. 25% of all clinical records will be reviewed for 90 days to ensure compliance.

3. Who is responsible? The Executive Director.

4. By what date corrected? 04/21/2015
accepted standards of practice.

2. During interview on 2/26/15 at 10:05 AM, employee A indicated they had a text message on their phone from employee D about the 3 skilled nurse visits from 1/15/15 for patient # 8. The text message was dated 1/15/15 at 4:40 PM and stated "I need 2 visits I made to [patient 8] dropped on either today or tomorrow for visits made on 1/13 and 1/14."

3. During interview on 2/26/15 at 3:45 PM, employees A and H indicated there was no further information to submit for review.

1. How will the deficiency be corrected? All clinical records will contain correct clinical information that is available to the patients attending physician and hospice, ensure the election statement signed by the patient identifies the hospice agency elected to provide care as well as the attending physician, and ensure all entries to the clinical record are appropriately dated in accordance with state and federal guidelines, and the agency will ensure the confidentiality of patient records and information.

2. How will the deficiency be prevented from recurring? An Inservice will be given to all skilled field staff regarding timely and accurate completion of all clinical documentation. 25% of all clinical records will be reviewed for 90 days to ensure compliance.

3. Who is responsible? The Executive Director.

4. By what date corrected? 04/21/2015

418.104(c)

PROTECTION OF INFORMATION

The clinical record, its contents and the information contained therein must be safeguarded against loss or unauthorized use. The hospice must be in compliance with the Department's rules regarding personal health information as set out at 45 CFR parts 160 and 164.

Based on observation at office located at Crown Point Indiana, clinical record review, document review, policy review,

1. How will the deficiency be corrected? The lease with the space in Crown Point has been corrected as of 04/21/2015.
and interview, the hospice failed to ensure the confidentiality of patient records and information for 4 of 4 clinical records and records from another hospice were not shared creating the potential to affect all the hospice's patients. (#s 1, 2, 3, and 4)

Finding

1. Confidential medical information found in an unlocked office at the Crown Point office location at second observation (#3) were confidential medical documents for patient #1 and other patients. The office was located at 9150 E 109th Avenue Suite #3A, Crown Point.

2. This was the first observation. The agency address was located inside a brick 3 story office building at 9150 E 109th Avenue Suite # 3 A, Crown Point. On arrival at the agency address on 2/23/15 at 8:30 AM, entering the front door, there was a large sign with the names and floors of the business entities located in the building at 9150 E 109th Avenue, Crown Point. The hospice name was not observed on this signage. Surveyor took the elevator, located next to the sign, to the 3rd floor. To the left of the elevator was a corridor, and immediately to the right of the corridor terminated HIPPA compliance will be maintained on all levels regarding patient information. 2

How the deficiency will be prevented from recurring? All records will be kept at the CMS approved location in a locked area. An inservice will be done with staff regarding HIPPA compliance 3. Who is responsible? The Executive Director 4. By what date corrected? 04/21/2015
### Statement of Deficiencies and Plan of Correction

**Identification Number:** MULTIPLE CONSTRUCTION 00

---

**Name of Provider or Supplier:** NIGHTINGALE HOSPICE

**Street Address, City, State, ZIP Code:** 6347 CONSTITUTION DRIVE
FORT WAYNE, IN 46804

---

#### Summary Statement of Deficiencies

**(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)**

<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
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<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
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1. **A Building, 00 Wing**

was a glass door with the name of another agency and daily hours of operation listed as 8:30 AM - 4:30 PM Monday-Friday and a phone number 219-310-8537. Inside the glass door was a hallway with two suites. No one answered when the surveyor knocked on the door.

2. This was the second observation. On 2/23/15 at 9:06 AM, the surveyor visited the office at 9150 E 10th Avenue, Crown Point, on the 3rd floor for a second time. The front door to these suites was unlocked. The suite mentioned in the complaint was to the far right of the entry. The surveyor knocked on the door. There was no answer. The surveyor opened the door and asked if anyone was inside. No one answered. Inside this office were a conference room, three individual offices, a kitchen area with a copy machine, and a storage room. One office had a fax machine and large L shaped desk and file cabinet. Inside the file cabinet were two large lists of patients. One list was dated 2003 (Document A) and one was dated 12/3/14 (Document B). Inside the desk drawer were resumes of applicants for nursing and marketing positions and other documents C - F and H and J. Another office contained a large box with marketing material and a letter from...
Non-employee #1 of the Ft. Wayne office (Document #I). The storage room was filled with medical supplies including syringes and blood specimen tubes. There was also a box with blank chart documents with the name of the Ft. Wayne hospice or the Ft. Wayne hospice phone number on the documents including document #G.

4. An agency document titled "Information sheet" with the name of patient #1 scratched out but still legible included the patient's address, date of birth, diagnosis of liver cancer, Medicare number (scratched out but still legible), and other information about this patient. This document was found in the office desk drawer of the unlocked office. This is document #C listed above.

5. On 2/23/15 at 11:45 AM, Employee A, RN, from the Ft. Wayne office via telephone call, indicated the Crown Point office should have been locked up to protect what had been left behind in the unattended office when the contents of the office were moved back to Ft. Wayne. She indicated the office had been used by Nightingale Hospice.

6. The agency document titled "Patient and Family Orientation for Hospice care" with no date included a section titled ...
### Statement of Deficiencies and Plan of Correction

**Identification Number:** MULTIPLE CONSTRUCTION

**Date Survey Completed:** 02/26/2015

**Name of Provider or Supplier:** NIGHTINGALE HOSPICE

**Street Address, City, State, Zip Code:** 6347 CONSTITUTION DRIVE, FORT WAYNE, IN 46804

### Summary Statement of Deficiencies

**Prefix** | **Tag** | **ID** | **Provider's Plan of Correction**
---|---|---|---

1. **"Patient Bill of Rights and responsibilities."** This document stated, "The patient has the right to expect confidentiality of all records, communications, and personal information related to the patient's care, in accordance with HIPAA regulations, Federal and state laws... the patient has the right to confidentiality of written, verbal and electronic information about the patient's health, social and financial circumstances."

2. The agency policy titled "Record retention and security" with a copyright date of 2007 - 2010 stated, "Purpose: to safeguard the integrity of hard copy [paper] and computerized patient records and date through administrative and technical controls. Policy... the agency has developed and implemented systems and processes to protect the integrity of hard copy and computerized patient records and data. The administrator has been charged with the responsibility for oversight of the above systems and processes. All agency personnel, Governing body and professional advisory committee members are expected to adhere to the agency's privacy policy... hard copies of patient records and data are stored in a secure area under lock and key... fireproof, lockable filing cabinet after normal..."
business hours. If the room(s) in which the records are stored unattended during regular business hours, the doors to these rooms must be locked. After regular business hours, all patient records and data is returned to the appropriate storage areas and those storage areas are locked."

8. The agency policy titled "Privacy and confidentiality of information" with a copyright date of 2007 - 2010 stated, "Confidentiality of date and information within the agency applies across all systems and automated, paper and verbal communications, as well as to clinical service, financial and business records, and employee - specific information ... all patient personal and health information and billing data is considered confidential and will be disclosed at the direction of Administration only when appropriately authorized to so by the patient or his / her legal representative."

9. During interview on 2/23/15 at 11:47 AM, employee A (director of clinical services/alternate administrator) indicated the switchboard/call center operators (located at another hospice entity) have access to all of the hospice's census, they only get face sheet with address, phone number, and the nurse assigned to the patients.
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

IDENTIFICATION NUMBER: 151598

MULTIPLE CONSTRUCTION
A. BUILDING
B. WING

DATE SURVEY COMPLETED: 02/26/2015

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

NIGHTINGALE HOSPICE
6347 CONSTITUTION DRIVE
FORT WAYNE, IN 46804

A. On 2/23/15 at 11:48 AM, employee A showed the screen shot of information accessible to the switchboard/call center operators for patient phone calls that come in, including after hours calls routed through India. The screen shot evidenced the switchboard/call center is able to see: Name/Address, Medical record number, date of birth, Insurance provider, phone number, and primary nurse.

B. During interview on 2/23/15 at 12:04 PM, employee B (administrator), indicated the call center is located at the central office in another hospice entity. Employee B indicated that office directs phone calls to the Fort Wayne employees when needed. Employee B indicated the call center has access to patients' address, power of attorney, physician and employee assigned to the patient but not clinical information. Employee B indicated they would have to go through Health Insurance Portability and Accountability Act (HIPAA) stuff first to provide any clinical information if requested by a patient or caregiver, but they prefer these requests all be routed through the patients' nurses. Employee B indicated after hours calls have to go through the same access.

C. During interview on 2/24/15 at
11:45 AM, employee A indicated patient #8 was admitted on 1/9/15 by employee D, as that RN was filling in for employee A, but they took the information to another hospice office. Employee A indicated due to Fort Wayne having only 1 active patient, the Interdisciplinary Group (IDG) meetings are combined with the other hospice office and the medical directors there (non-employees # 3 and 22) conduct the meetings and discuss patients for both locations, and some are done via phone. Employee A indicated the medical director for Fort Wayne was present via phone on 1/19/15 IDG.

D. Two IDG notes with patient #8 listed, and dated 1/19/15 at 5:00 PM failed to evidence Fort Wayne's medical director (employee C) was present either in person or via phone, and non-employee # 22 is listed at the top of the Attendance sign in sheet.

E. During interview on 2/24/15 at 12:45 PM, employee A indicated Fort Wayne contracts all employees, including home care aides, nurses, social workers, chaplains, and other services, not just the medical directors.

F. The IDG sheet dated 2/16/15 at 5:00 PM, evidenced discussion of patient #8 and evidenced non-employee # 22 listed
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**IDENTIFICATION NUMBER:** 151598

**MULTIPLE CONSTRUCTION**

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**DATE SURVEY COMPLETED:** 02/26/2015

**NAME OF PROVIDER OR SUPPLIER:** NIGHTINGALE HOSPICE

**STREET ADDRESS, CITY, STATE, ZIP CODE:** 6347 CONSTITUTION DRIVE FORT WAYNE, IN 46804

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**SUMMARY STATEMENT OF DEFICIENCIES**

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as the medical director. The sign in sheet dated 2/16/15 failed to evidence a signature for employee C. The Patients for discussion list evidence patients #8 and 11, in addition to 22 non-patients of this hospice.

**G.** The IDG sheet dated 12/31/14 at 9:30 AM, evidenced patients #9 and 10 were discussed, in addition to 5 non-patients of this hospice, and evidenced the medical director in attendance was non-employee #3.

**H.** The IDG sheet dated 12/22/14 at 5:00 PM, evidenced patients #9 and 10 were discussed, in addition to 21 non-patients of this hospice, and evidenced the medical director in attendance was non-employee #22.

**I.** The IDG sheet dated 12/17/14 at 9:00 AM, evidenced patients #9 and 10 were discussed, in addition to 9 non-patients of this hospice, and evidenced the medical director in attendance was non-employee #3.

**J.** The IDG sheet dated 12/3/14 at 3:30 PM, evidenced patients #9 and 10 were discussed, in addition to 10 non-patients of this hospice, and evidenced the medical director in attendance was non-employee #22.

**IDENTIFICATION NUMBER:** MULTIPLE CONSTRUCTION

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**DATE SURVEY COMPLETED:** 02/26/2015

**NAME OF PROVIDER OR SUPPLIER:** NIGHTINGALE HOSPICE

**STREET ADDRESS, CITY, STATE, ZIP CODE:** 6347 CONSTITUTION DRIVE FORT WAYNE, IN 46804

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**G.** The IDG sheet dated 12/31/14 at 9:30 AM, evidenced patients #9 and 10 were discussed, in addition to 5 non-patients of this hospice, and evidenced the medical director in attendance was non-employee #3.

**H.** The IDG sheet dated 12/22/14 at 5:00 PM, evidenced patients #9 and 10 were discussed, in addition to 21 non-patients of this hospice, and evidenced the medical director in attendance was non-employee #22.

**I.** The IDG sheet dated 12/17/14 at 9:00 AM, evidenced patients #9 and 10 were discussed, in addition to 9 non-patients of this hospice, and evidenced the medical director in attendance was non-employee #3.

**J.** The IDG sheet dated 12/3/14 at 3:30 PM, evidenced patients #9 and 10 were discussed, in addition to 10 non-patients of this hospice, and evidenced the medical director in attendance was non-employee #22.
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<td>NIGHTINGALE HOSPICE</td>
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<tr>
<td>K.</td>
<td>The IDG sheet dated 11/24/14 at 5:00 PM, evidenced patients # 9 and 10 were discussed, in addition to 19 non-patients of this hospice, and evidenced the medical director in attendance was non-employee # 22.</td>
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<td>L.</td>
<td>The IDG sheet dated 11/10/14 at 5:00 PM, evidenced patient # 10 was discussed, in addition to 23 non-patients of this hospice, and evidenced the medical director in attendance was non-employee # 22.</td>
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<tr>
<td>M.</td>
<td>The IDG sheet dated 10/27/14 at 5:00 PM, evidenced patient # 10 was discussed, in addition to 18 non-patients of this hospice, and evidenced the medical director in attendance was non-employee # 22.</td>
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<td>N.</td>
<td>The IDG sheet dated 10/14/14, evidenced patient # 10 was discussed, in addition to 18 non-patients of this hospice, and evidenced the medical director in attendance was non-employee # 22.</td>
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<td>O.</td>
<td>The IDG sheet dated 10/8/14 evidenced patient # 10 was discussed, in addition to 29 non-patients of this hospice, and evidenced the medical director in attendance was non-employee</td>
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# 3.

10. During interview on 2/25/15 at 10:10 AM, employee A indicated the IDG meetings are conducted via phone and office with non-employee #3 and employee C. Employee A indicated the sign in sheet for 1/19/15 is on employee C's desk waiting for signature and the last they checked on this was last week. Employee A indicated employee C is not timely with returning the signed IDG attendance sheets but they do call in via phone. Employee A indicated they call in to another hospice entity location for IDG discussions, and non-employee #22 is the back up for the patients here, and non-employees #3 and #22 are present to cover when employee C does not call in.

11. The document titled "Employment Agreement for Medical Director Services," dated 8/1/14 for non-employee #3 failed to evidence the contract is for Nightingale Hospice Care of Northern Indiana, Inc D/B/A (doing business as) Nightingale Hospice.

12. The hospice's undated admission packet titled "Patient & Family Orientation for Hospice Care," states, "XI. Patient Bill of Rights and Responsibilities ... The patient has a right to the following: ... Expect
confidentiality of all records, communications and personal information related to the patient's care, in accordance with HIPAA regulations, Federal and State Laws or third party contractors, and to obtain a paper copy of the agency's "Notice of Privacy Practice."

13. During interview on 2/26/15 at 3:45 PM, employees A and H indicated there was no further information to submit for review.

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<td>L 787</td>
<td>Bldg. 00</td>
<td>418.114(b)(3) PERSONNEL QUALIFICATION</td>
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[The following qualifications must be met:] Social worker. A person who-

(i) (A) Has a Master of Social Work (MSW) degree from a school of social work accredited by the Council on Social Work Education; or

(B) Has a baccalaureate degree in social work from an institution accredited by the Council on Social Work Education; or a baccalaureate degree in psychology, sociology, or other field related to social work and is supervised by an MSW as described in 418.114(b)(3)(i)(A); and
STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION

IDENTIFICATION NUMBER: 151598

MULTIPLE CONSTRUCTION
A. BUILDING 00
B. WING

DATE SURVEY COMPLETED 02/26/2015

NAME OF PROVIDER OR SUPPLIER
NIGHTINGALE HOSPICE

6347 CONSTITUTION DRIVE
FORT WAYNE, IN 46804

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<td>(ii)</td>
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<td>Has one year of social work experience in a health care setting; or</td>
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<td>(iii)</td>
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<td>Has a baccalaureate degree from a school of social work accredited by the Council on Social Work Education, is employed by the hospice before December 2, 2008, and is not required to be supervised by an MSW.</td>
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Based on employee file review, policy review, and interview, the hospice failed to ensure employee files contained the required documents for 1 of 12 employee files reviewed. (H)

Findings include

1. During interview on 2/23/15 at 1:30 PM, employee A (director of clinical services/alternate administrator) indicated Indiana employees for Nightingale go to the other hospice location for orientation, and that location performs all the criminal background checks, then sends the employee files here.

2. Employee H's file, the social worker, DOH 1/19/15, contained a document titled "Orientation Checklist Licensed Personnel," # HSP4-4A, dated 1/19/15. The employee file failed to contain any further documentation, including degree.

   During interview on 2/26/15 at 11:05 AM, employee H indicated the only orientation they received at this hospice was on 1/19/15, and that was general

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<td>L 787</td>
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<td>1 How will the deficiency be corrected? All personnel files shall be kept current and include all state and federal qualification requirements 2 How will the deficiency be prevented from recurring? An audit will be done on all employee files to ensure they are complete with all state and federally required credentials including licensure and education qualifications and criminal background checks. Any employee whose record is found not in compliance will not have any patient contact until record is updated and complete 25% of all personnel files will be audited for 90 days to ensure ongoing compliance 3. Who is responsible? The Executive Director 4. By what date corrected? 04/21/2015</td>
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04/21/2015 12:00:00AM

Facility ID: 007361

Event ID: D56O11
### Statement of Deficiencies and Plan of Correction

#### Identification Number:
(X1) PROVIDER/SUPPLIER/CLIA
151598

#### Multiple Construction
(X2) MULTIPLE CONSTRUCTION
A. BUILDING 00
B. WING

#### Date Survey Completed
(X3) DATE SURVEY COMPLETED
02/26/2015

#### Name of Provider or Supplier
NIGHTINGALE HOSPICE

#### Street Address, City, State, Zip Code
6347 CONSTITUTION DRIVE
FORT WAYNE, IN 46804

### Summary Statement of Deficiencies
Each deficiency must be preceded by full regulatory or LSC identifying information.

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#### Provider's Plan of Correction
Each corrective action should be cross-referenced to the appropriate deficiency.

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3. The hospice's undated policy titled "Personnel File Management," # HSP4-A01, states "All Agency employees, including contract personnel, will have a personnel file. The Administrator/designee is responsible for maintaining up-to-date personnel files for each employee and for ensuring the security of all personnel information. ... Complete and up-to-date personnel records are available for inspection by federal, state regulatory agencies and accreditation organizations. ... Personnel File Contents: Section I-Employee Data, Employment Application, Resume, Withholding Allowance Certificate (W-4), dated and signed, Contract if applicable, Employment Reference Checks (2). Section II-Employee Qualifications, Driver's License, Automobile Insurance, Professional Licenses, if applicable, CPR certification as required by the job description, New employee Orientation checklist. Section III- Competence, Performance Evaluations, Competence Evaluation, Inservice Training Records. Section IV- Miscellaneous, Commendations, Disciplinary Actions. Separate Confidential Files, A. I-9 Citizenship Verification, B. Medical/Health file, Medical history Form, Hepatitis B
acceptance/Declination Form (if applicable), TB skin test results/Chest x-ray results and/or an annual verification that the employee is free of TB symptoms, Any other health-related documents i.e. return to work permission, Criminal Background and National Sex Offender Registry Check results (if required by law).

4. During interview on 2/26/15 at 3:45 PM, employees A and H indicated there was no further information to submit for review.

418.114(d)(1)
CRIMINAL BACKGROUND CHECKS
The hospice must obtain a criminal background check on all hospice employees who have direct patient contact or access to patient records. Hospice contracts must require that all contracted entities obtain criminal background checks on contracted employees who have direct patient contact or access to patient records.

Based on employee file review, policy review, and interview, the hospice failed to ensure criminal background checks were completed by the hospice for 2 of 12 employee files reviewed. (F and H)

Findings include
1. During interview on 2/23/15 at 1:30 PM, employee A indicated Indiana employees for Nightingale go to the other hospice location for orientation, and that location performs all the criminal background checks, then sends the employee files here. Employee A indicated employee F is a dual employee between this hospice and another hospice location.

2. Employee file F (registered nurse), date of hire (DOH) 2/2/15, failed to contain any documents.

3. Employee H's file, the social worker, DOH 1/19/15, contained a document titled "Orientation Checklist Licensed Personnel," # HSP4-4A, dated 1/19/15. The employee file failed to contain any further information.

   During interview on 2/23/15 at 1:30 PM, employee A indicated the file for employee H is at another hospice location.

4. The hospice's undated policy titled "Personnel File Management," # HSP4-1A.01, states, "All Agency employees, including contract personnel, will have a personnel file. The Administrator/designee is responsible for..."
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Maintaining up-to-date personnel files for each employee and for ensuring the security of all personnel information. Complete and up-to-date personnel records are available for inspection by federal, state regulatory agencies and accreditation organizations. Personnel File Contents: Section I-Employee Data, Employment Application, Resume, Withholding Allowance Certificate (W-4), dated and signed, Contract if applicable, Employment Reference Checks (2). Section II-Employee Qualifications, Driver's License, Automobile Insurance, Professional Licenses, if applicable, CPR certification as required by the job description, New employee Orientation checklist. Section III - Competence, Performance Evaluations, Competence Evaluation, Inservice Training Records. Section IV - Miscellaneous, Commendations, Disciplinary Actions. Separate Confidential Files, A. I-9 Citizenship Verification, B. Medical/Health file, Medical history Form, Hepatitis B acceptance/Declination Form (if applicable), TB skin test results/Chest x-ray results and/or an annual verification that the employee is free of TB symptoms, Any other health-related documents i.e. return to work permission, Criminal Background and National Sex Offender Registry Check results (if
5. During interview on 2/26/15 at 3:45 PM, employees A and H indicated there was no further information to submit for review.

Based on employee file review, policy review, and interview, the hospice failed to ensure employee files contained criminal background checks for 2 of 12 employee files reviewed, creating the potential to affect all the hospice's employees. (F and H)

Findings include

1. Employee file F (registered nurse), date of hire (DOH) 2/2/15, failed to contain any documents.

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<th>ID</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
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<tbody>
<tr>
<td>L 796</td>
<td>Bldg. 00</td>
<td>418.114(d)(2)</td>
<td>CRIMINAL BACKGROUND CHECKS Criminal background checks must be obtained in accordance with State requirements. In the absence of State requirements, criminal background checks must be obtained within three months of the date of employment for all states that the individual has lived or worked in the past 3 years. Based on employee file review, policy review, and interview, the hospice failed to ensure employee files contained criminal background checks for 2 of 12 employee files reviewed, creating the potential to affect all the hospice's employees. (F and H) Findings include 1. Employee file F (registered nurse), date of hire (DOH) 2/2/15, failed to contain any documents.</td>
<td>04/21/2015</td>
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</table>
2. Employee H's file, the social worker, DOH 1/19/15, contained a document titled "Orientation Checklist Licensed Personnel," # HSP4-4A, dated 1/19/15. The employee file failed to contain any further documentation.

   During interview on 2/23/15 at 1:30 PM, employee A indicated the file for employee H is at another hospice location.

3. The hospice's undated policy titled "Personnel File Management," # HSP4-1A.01, states, "All Agency employees, including contract personnel, will have a personnel file. The Administrator/designee is responsible for maintaining up-to-date personnel files for each employee and for ensuring the security of all personnel information. ... Complete and up-to-date personnel records are available for inspection by federal, state regulatory agencies and accreditation organizations. ... Personnel File Contents: Section I-Employee Data, Employment Application, Resume, Withholding Allowance Certificate (W-4), dated and signed, Contract if applicable, Employment Reference Checks (2). Section II-Employee Qualifications, Driver's License, Automobile Insurance, Professional Licenses, if applicable, CPR certification files will be audited for 90 days to ensure ongoing compliance.

   3. Who is responsible? The Executive Director
   4. By what date corrected? 04/21/2015
as required by the job description, New employee Orientation checklist. Section III- Competence, Performance Evaluations, Competence Evaluation, Inservice Training Records. Section IV- Miscellaneous, Commendations, Disciplinary Actions. Separate Confidential Files, A. I-9 Citizenship Verification, B. Medical/Health file, Medical history Form, Hepatitis B acceptance/Declination Form (if applicable), TB skin test results/Chest x-ray results and/or an annual verification that the employee is free of TB symptoms, Any other health-related documents i.e. return to work permission, Criminal Background and National Sex Offender Registry Check results (if required by law)."

4. During interview on 2/26/15 at 3:45 PM, employees A and H indicated there was no further information to submit for review.

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<tr>
<th>ID</th>
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<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
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<tr>
<td>L 799</td>
<td>418.116(a)</td>
<td>MULTIPLE LOCATIONS</td>
<td>Every hospice must comply with the requirements of §420.206 of this chapter regarding disclosure of ownership and control information. All hospice multiple locations must be approved by Medicare</td>
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### STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

**IDENTIFICATION NUMBER:** 151598  
**MULTIPLE CONSTRUCTION**  
**A. BUILDING** 00  
**B. WING**  
**DATE SURVEY COMPLETED:** 02/26/2015

#### NAME OF PROVIDER OR SUPPLIER

**NIGHTINGALE HOSPICE**  
**STREET ADDRESS, CITY, STATE, ZIP CODE:**  
6347 CONSTITUTION DRIVE  
FORT WAYNE, IN 46804

#### SUMMARY STATEMENT OF DEFICIENCIES

Each deficiency must be preceded by full regulatory or LSC identifying information.

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</table>
| L 799| 1      |     | How will the deficiency be corrected?  
The lease with the space in Crown Point has been terminated  
2 How will you prevent the deficiency from recurring?  
The office will remain in the CMS approved location  
No move will occur without prior state and federal approval  
3 Who is responsible?  
The governing board  
4 By what date? 04/21/2015 |

Based on interview, the hospice failed to ensure a hospice location had been approved by Medicare for 1 of 1 hospice.

Findings include:

1. During interview on 2/23/15 at 10:50 AM, employee A (director of clinical services / alternate administrator) indicated the office moved to Crown Point before they had approval to move, so they just moved back to Fort Wayne. Employee A indicated the Fort Wayne office had moved to Crown Point around the end of October 2014 and moved back in the beginning of December. Employee A indicated there is not an office in Merrillville since they could not stay in that area, so all patient records were moved back to Fort Wayne. Employee A indicated the nurse and chaplain were seeing patients here within the hospice's approved counties for services, but that no patients were receiving services from Crown Point as another Nightingale hospice serves that area.

2. During interview on 2/23/15 at 12:04 PM, employee B indicated the Fort Wayne hospice moved back from Crown Point once they found out they were not and licensed in accordance with State licensure laws, if applicable, before providing Medicare reimbursed services.
approved for the counties they had moved to, and no patients were provided services in any counties not approved for. Employee B indicated the hospice moved to Crown Point on November 15, 2014, and came back on Wednesday that same week, the 18th or the 19th. Employee B indicated the hospice was discussing hiring a new medical director for Crown Point, otherwise the current Medical Director, employee C, had not been terminated. Employee B indicated apparently the distance for the hospice license and patient counties served was too far away. Employee B indicated the employees also work for another Nightingale hospice at another location and are paid from both branches based on if they are salary pay, or per visit pay.

3. During interview on 2/26/15 at 3:45 PM, employees A and H indicated there was no further information to submit for review.
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<td>X</td>
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<td>(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</td>
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**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**IDENTIFICATION NUMBER:** 151598

**MULTIPLE CONSTRUCTION**

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**DATE SURVEY COMPLETED:** 02/26/2015

**NAME OF PROVIDER OR SUPPLIER:** NIGHTINGALE HOSPICE

**STREET ADDRESS, CITY, STATE, ZIP CODE:**

6347 CONSTITUTION DRIVE
FORT WAYNE, IN 46804

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**Event ID:** D56O11
**Facility ID:** 007361
**If continuation sheet:** No
**Page:** 193 of 193