STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	151501	A. BUILDING 00 B. WING	06/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CENTER FOR HOSPICE AND PALLIATIVE CARE INC, THE	111 SUNNYBROOK CT SOUTH BEND, IN 46637

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E 0000 Bldg. 00	An Emergency Preparedness Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 418.113. Survey dates: 6/12-6/15/18, 6/18-6/20/18 Facility number: 5934 Provider number: 151501 Census: 405 At this Emergency Preparedness survey, Community Home Health was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 418.113.	E 0000		
L 0000 Bldg. 00	This visit was for a federal re-certification and state licensure with complaint survey of a hospice agency. Complaint #IN00239980; unsubstantiated, with unrelated deficiencies cited Complaint #IN00221773; unsubstantiated Survey dates: 6/12-/15/18, 6/18-6/20/18 Facility ID: 5934 Provider number: 151501 Unduplicated admissions past 12 months: 1,670 Census: 405	L 0000		

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

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	Records reviewed: 20 Home visits: 5			
L 0530 Bldg. 00	418.54(c)(6) CONTENT OF COMPREHENSIVE ASSESSMENT [The comprehensive assessment must take into consideration the following factors:] (6) Drug profile. A review of all of the patient's prescription and over-the-counter drugs, herbal remedies and other alternative treatments that could affect drug therapy. This includes, but is not limited to, identification of the following: (i) Effectiveness of drug therapy (ii) Drug side effects (iii) Actual or potential drug interactions (iv) Duplicate drug therapy (v) Drug therapy currently associated with laboratory monitoring. Based on observation, record review, and interview, the agency failed to ensure all ordered medications were included on the medication profile in 7 of 7 patients with pulmonary diagnoses of 20 records reviewed. (#1, 2, 3, 10, 11, 18, 20) Findings include: 1. An agency policy, dated 2/17, titled, "Medication Review and Electronic Profiling" and stated " ... 2. The Admission Nurse will review this list for accuracy, repeated therapies, and any other relevant considerations related to medication therapy meeting the patient's individualized needs. 3. This review will include all prescription and over-the-counter medications, dose, frequency, and route of administration .... "	L 0530	L530 (A) The order sheet for the hospice inpatient unit (IPU) and hospice home care patients have been updated to include oxygen, liters, nasal cannula/mask, frequency, and indication. (B) Approved by the Hospice Medical Director for implementation for IPU and hospice home care patients. The DON will be responsible for monitoring these corrective actions to ensure this deficiency is corrected and will not recur.	07/20/2018

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	2. During a home visit at the hospice inpatient unit, on 6/13/18 at 8:45 AM, the patient was observed to be using oxygen per nasal cannula. Clinical record review of patient number one, election date 6/9/16, for benefit period 3/31/18 to 5/29/18 and benefit period 5/30/18 to 7/28/18, included diagnoses of essential hypertension, major depressive disorder, peripheral vascular disease, atherosclerotic heart disease, and atrial fibrillation. Review of an IDT (interdisciplinary team) care plan, dated 6/12/18, stated the patient was admitted to the hospice inpatient unit on 6/11/18 with orders to include, " ... Oxygen for comfort per physicians order of 2-4 L [liters], nasal cannula .... " The current medication list failed to include oxygen. 3. During a home visit on 6/13/18 at 1:15 PM, the patient was observed using oxygen per nasal cannula and to become short of breath when speaking at length. Clinical record review of patient number two, election date 12/7/17, for benefit period 3/7/18 to 6/4/18, included a diagnosis of COPD [chronic obstructive pulmonary disease]. The IDT care plan for the benefit period stated, " ... [patient] is on oxygen at 2.5 liters [L] per n/c [nasal cannula] .... " The current medication list failed to include oxygen. 4. During a home visit on 6/13/18 at 12:00 PM, the patient was observed using oxygen and was anxious when it was removed for his bath. Clinical record review of patient number three,		(C) Cerner electronic medical record Medication Profile updated to include oxygen therapy. The Assistant DON will be responsible for implementation. (D) Patients presently in the IPU or hospice home care with oxygen therapy to have order added to the Medication Profile, and physician signature obtained. The Medication Profile, reconciliation, and the oxygen therapy initiated on the nursing care plan to meet patient's individualized needs will occur the week of 07/16/18-07/20/18 at the Interdisciplinary Team (IDT) meetings. All of the Patient Care Coordinators will be responsible for monitoring their nurses' compliance with this requirement. (E) Admission nurses will begin ordering and profiling oxygen on the medication order sheet at the time of admission. The Assistant DON will be responsible for monitoring this corrective action. (F) Reviewed policies and procedures related to managing drugs and biologicals for the IPU and hospice home care patients on 07/09/18. Policies and procedures were updated to incorporate oxygen therapy. To be implemented in "draft" format until final approval by the Board of Directors.	

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	election date 12/1/17, for benefit period 3/1/18 to 5/29/18, included diagnoses Mucopurulent chronic bronchitis and Idiopathic pulmonary fibrosis. The IDT care plan for the benefit period stated, " .... has had a significant decline by March 2017, he required 24/7 oxygen ... is dependent on oxygen at 2-3 liters at rest and 6-7 with activity .... " The care plan and current medication list failed to include oxygen. 5. Clinical record review of patient number 10, election date 1/7/17, for benefit period 4/25/18 to 6/23/18, included a diagnosis of ALS [Amyotrophic Lateral Sclerosis]. The IDT care plan for the benefit period stated, " .... Pt [patient] now using oxygen at 2 liters via NC intermittently throughout the day for 1-2 hours at a time .... ". The current medication list failed to include oxygen. 6. Clinical record review of patient number 11, election date 3/1/18, for benefit period 3/1/18 to 5/29/18, included a diagnosis of COPD. The IDT care plan for benefit period stated, " .... he complains of shortness of breath and is on 2.5 liters NC .... ". The current medication list failed to include oxygen. 7. Clinical record review of patient number 18, election date 3/1/18, for benefit period 3/1/18 to 5/29/18, included diagnoses COPD, Obstructive sleep apnea, and chronic respiratory failure with hypoxia [lack of oxygen]. Skilled nurse visits on 3/1, 3/8, and 3/29/18 stated, " .... Respiratory treatments: Oxygen, C-pap, 4 L/Min [liters per minute] by nasal cannula .... " The IDT care plan for the benefit period of 3/1/18 to 5/29/18 stated, " .... [patient]'s biox [bioximeter,			

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	measures pulse and oxygen saturation] has been dropping into the 80s when he is not wearing the O2 [oxygen]. ... does not wear it when he smokes .... ". The current medication list failed to include oxygen. 8. Clinical record review of patient number 20, election date 3/30/18, for benefit period 3/30/18 to 6/27/18, included diagnoses Idiopathic pulmonary fibrosis, COPD, Obstructive sleep apnea, and Pulmonary hypertension. The IDT care plan for this benefit period stated, "[pt] has been oxygen dependent for the past year using 4 L at rest, 6 L with activity .... ". The current medication list failed to include oxygen. 9. During the exit conference on 6/20/18, the medical director indicated the agency was not aware that oxygen should be included on the medication list.			
L 0533 Bldg. 00	418.54(d) UPDATE OF COMPREHENSIVE ASSESSMENT The update of the comprehensive assessment must be accomplished by the hospice interdisciplinary group (in collaboration with the individual's attending physician, if any) and must consider changes that have taken place since the initial assessment. It must include information on the patient's progress toward desired outcomes, as well as a reassessment of the patient's response to care. The assessment update must be accomplished as frequently as the condition of the patient requires, but no less frequently than every 15 days. Based on record review, the agency failed to ensure the comprehensive assessment included	L 0533	L533 (A) The policy and procedure and	07/17/2018

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	updates of wound assessments in 1 of 5 patients with wounds in a sample of 20 records reviewed. (#6) Finding includes: 1. An agency policy, revised 5/16, titled, "Comprehensive Assessment of the Patient", stated, " ... 4. Comprehensive assessment updates will be conducted by the IDT [interdisciplinary team] in collaboration/ consultation with the patient's attending physician/ nurse practitioner (if any). Updates to the comprehensive assessment will consider all changes that have occurred since the initial assessment, progress toward desired outcomes, and response to care provided by the IDT .... " 2. An agency policy, revised 3/17, titled, "Skin and Wound Care", stated, " ... Purpose: To ensure a uniform and consistent process for: integumentary assessment, documentation, skin care, related comfort measures, and wound care. ... 4. Wounds will be assessed at a minimum of every seven days by an RN [registered nurse] and measurement documented in EMR [electronic medical record] .... " 3. Record review of patient number 6, election date, 3/3/18, contained an IDT care plan with comprehensive assessment updates for benefit periods 3/3/18 to 5/31/18 and 6/1/18 to 8/29/18 with diagnoses of Cerebral atherosclerosis, adult failure to thrive, and major depression. An RN entry on 4/18/18 stated, " ... IDT for Hospitalization for Hip Fracture 4/15/18 and A-fib [Atrial fibrillation] 4/17/18. ... The patient fell on 4/15/18 while being assisted out of a car, as a result of the fall she broke her hip. The team		formulary were reviewed to assure the protocols met the current standards of care related to skin and wound care. This was completed with the DON, Assistant DON, Quality Assurance/Medical Records Coordinator, and the Clinical Staff Educator. (B) Education program initiated for all nurses on Skin and Wound Care on 07/09/18. All nurses are to complete: · Self-learning packet on wound and skin care. · Review PowerPoint on wound and skin care as a reference. · Update all care plans for patients with either an actual or potential skin problem. · Complete Braden Risk Assessment in accordance with Agency policy and protocols and document accordingly. Responsibility of Patient Care Coordinators that the nurses complete the validation by 07/17/18. (C) The Interdisciplinary Team (IDT) at the 14 day reviews will address wound measurements to increase the team members' involvement of the outcomes related to wound and skin care. The Patient Care Coordinators will be responsible in collaboration with the medical staff.	

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	determined that the fall and fracture were not related to the patient's terminal diagnosis and the ambulance transport and hospital treatment for the fracture would not be covered by [agency]. On 4/17/18 it was found that the patient had gone into A-fib and had a low HGB/ HCT [hemoglobin/ hematocrit] she had been transferred to the HV [sic] floor and also received 2 units of PRBC [packed red blood cells] .... " The patient returned home on 4/24/18. In an updated comprehensive assessment by a skilled nurse, dated 4/30/18, stated in the integumentary assessment, " ... right hip, surgical wound open to air, no s/s of infection. call placed to attending to get order to remove staples .... " The visit note failed to evidence a description or measurement of the surgical wound. In an updated comprehensive assessment, dated 5/4/18, the RN [registered nurse] stated, " .... since last review patient has returned home from hospital. Staples removed from right hip without difficulty, surgical wound healing without s/s [signs/symptoms] of infection ... no other significant changes .... " A focused SNV visit on 5/7/18, stated in the integumentary assessment, " ... Rt hip surgical site. drsg clean, dry and intact, pink with slight redness at incision line .... " The visit note failed to evidence measurements or further descriptions of the wound. A focused SNV on 5/9/18, stated in the assessment, " ... changed dressing to R hip, incision line well approximated, no redness or drainage .... " The visit note failed to evidence a description or measurement of the wound.		(D) All nursing care plans with potential or actual skin problems to be monitored concurrently for documentation and wound measurements every seven (7) days. This is to occur at the Interdisciplinary Team (IDT) meetings beginning 07/16/18. The Patient Care Coordinators will be responsible for monitoring their nurses' compliance with this standard.	

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	A SNV on 5/11/18, stated in the integumentary assessment, " ... Rt hip surgical site drsg clean, dry and intact. ... Notes: Dressing D & I [dry and intact], loose along distal edge, reinforced with tape after viewing incision. Healing without sign of infection .... " The visit note failed to evidence a wound description or measurement. A SNV note on 5/14/18, stated in the integumentary assessment, " ... Rt hip wound, incision healing, appears intact, without s/s of infection .... " The visit note failed to evidence a wound description or measurement. A SNV note on 5/15/18, stated in the assessment, " ... Narrative note: focused visit - bowels, and overall condition .... " The visit note failed to evidence an integumentary assessment/ wound description or measurement. A SNV note on 5/16/18, failed to evidence an integumentary assessment/ wound description or measurement. A SNV note on 5/18/18, failed to evidence an integumentary assessment/ wound description or measurement. A SNV note on 5/21/18, stated in the integumentary assessment, " ... incision to right hip healing without sign of infection. 2 small gap areas along incision. Dressing removed with scant pink drainage Area cleaned with normal saline, clean dressing applied .... " A narrative note stated, " ... Plan for next visit: Physical assessment, assess right hip incision, assess need for refills of meds or supplies. Take normal saline and gauzed [sic] 4x4 gauze to next visit for wound cleaning .... " The visit note failed to evidence a description of the wound.			

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A SNV note on 5/23/18, stated in a wound assessment, " ... new wound, Coccyx wound, pressure ulcer .... ". The visit note failed to evidence descriptions or measurements of the "new" wound or the previous surgical wound.

A SNV note on 5/25/18, stated in a wound assessment, " ... coccyx wound, pressure ulcer Stage 2: partial thickness skin loss involving epidermis and/or dermis. The ulcer is superficial and presents clinically as an abrasion, blister or shallow crater, surrounding area normal, drainage purulent green with stains ... note: order Flagyl [antibiotic].... " The visit note failed to evidence measurements of the wound.

A SNV note on 5/30/18 stated in the integumentary assessment, " ... wounds/ decubitus, coccyx wound pressure ulcer Stage 2 ... color pink/red, sero-sanguineous drainage stains ... [agency] will change dressing daily/ PRN [as needed]. Cleanse wound with NS, apply calcium alginate, and cover with mepilex. Notes: wound free from s/s of infection, crushed flagyl applied to wound .... " The visit note failed to evidence measurements of this wound or previous surgical wound.

In an updated comprehensive assessment dated 5/31/18, the RN stated " ... since last review patient has developed a stage II wound to his/ her coccyx. Patient was semi-comatose at SNV [skilled nurse visit] yesterday ... no other significant changes .... " There was no documentation regarding the right hip wound from the previous update.

A SNV note on 6/1/18, stated in a wound assessment " .... coccyx ulcer stage 2, pink/ red,

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	sero-sanguineous, stains, wound cleansed with NS, crushed flagyl applied, covered with mepiliex .... " The visit note failed to evidence measurements of the wound. In an undated comprehensive assessment dated 6/4/18, stated in a wound assessment " ... coccyx ulcer stage 2, pink/ red, sero-sanguineous, stains, wound cleansed with NS, crushed flagyl applied, covered with mepiliex .... " The visit note failed to evidence measurements of the wound. A SNV note on 6/6/18 stated in a wound assessment, " ... coccyx ulcer stage 2, pink/ red, sero-sanguineous, stains, wound cleansed with NS, crushed flagyl applied, covered with mepiliex .... " The visit note failed to evidence measurements of the wound. In an updated comprehensive assessment on 6/11/18 stated in the integumentary assessment " ... coccyx wound stage 2, pink/ red, sero-sanguineous, drainage dampens, perform pressure ulcer/ wound care per physician orders. The visit note failed to evidence measurement of the wound. A SNV note on 6/13/18 stated in the wound assessment " ... coccyx wound, pressure ulcer, Stage 4: full thickness skin loss with extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures, pink/ red, 2 inch by 2 inch area of necrosis .... ". In an updated comprehensive assessment, dated 6/14/18, the RN stated, " .... no significant changes since last review .... " There was no documentation updating the patient's coccyx wound or surgical wound. In an updated comprehensive assessment dated 6/14/18, the RN stated " ... no significant changes			

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	since last review .... " There was no documentation updating the patient's coccyx wound or surgical wound. 3. A "Nursing Skill Validations 2017" form indicated employee M, a registered nurse, had been educated on decubitus wounds and staging of wounds. A "Nursing Orientation" form, dated 4/15/15, indicated employee M had been oriented on skin and wound care. 4. During an interview on 6/19/18 at 3:40 PM, employee N stated he/ she would not "necessarily expect descriptions or measurements for surgical wounds". 5. During the exit conference on 6/20/18, the director of nursing and patient care coordinator acknowledged lack of wound descriptions.			
L 0548 Bldg. 00	418.56(c)(3) CONTENT OF PLAN OF CARE [The plan of care must include all services necessary for the palliation and management of the terminal illness and related conditions, including the following:] (3) Measurable outcomes anticipated from implementing and coordinating the plan of care. Based on record review, the agency failed to ensure the plan of care was updated to include measurable outcomes of all wounds in 1 of 5 patients with wounds from a sample of 20 records reviewed. (#6) Finding included: 1. An agency policy, revised 6/16, titled, "Plan of Care", stated, " ... 6. Revisions to the plan of care	L 0548	L548 1.The Interdisciplinary Team (IDT) at the 14 day reviews will address wound measurements to increase the team members' involvement of the outcomes related to wound and skin care. The Patient Care Coordinators will be responsible in collaboration with the medical staff.	07/16/2018

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	are based on information from the patient's updated comprehensive assessment and the patient's progress toward outcomes specified in the plan. 7. Changes to the plan of care are documented in the plan and communicated to members of the IDT .... " 2. Record review of patient number 6, election date, 3/3/18, contained a plan of care for benefit periods 3/3/18 to 5/31/18 and 6/1/18 to 8/29/18 with diagnoses of cerebral atherosclerosis, adult failure to thrive, and major depression. The period reviewed, 4/22/18 to 6/23/18, contained records that indicated the patient fell and fractured his/ her hip on 4/15/18, requiring surgery for repair. The patient returned home on 4/24/18. In an updated IDT care plan, dated 5/4/18, the RN [registered nurse] stated, " .... since last review patient has returned home from hospital. Staples removed from right hip without difficulty, surgical wound healing without s/s [signs/symptoms] of infection ... no other significant changes." The plan of care failed to be updated to include measurable outcomes of the surgical wound. In an updated IDT care plan, dated 5/31/18, the RN stated, " ... since last review patient has developed a stage II wound to his/ her coccyx. Patient was semi-comatose at SNV [skilled nurse visit] yesterday ... no other significant changes. There was no documentation regarding the right hip wound from the previous update. The plan of care failed to be updated to include measurable outcomes of the surgical wound. In an updated IDT care plan, dated 6/14/18, the RN stated, " .... no significant changes since last review .... ". A SNV on 6/13/18 stated in the wound assessment, " .... coccyx wound, pressure		All nursing care plans with potential or actual skin problems to be monitored concurrently for documentation and wound measurements every seven (7) days. This is to occur at the Interdisciplinary Team (IDT) meetings beginning 07/16/18. The Patient Care Coordinators will be responsible for monitoring their nurses' compliance with this standard. The Patient Care Coordinators will monitor the number of medical records in compliance with the standards at each 14-day review during the Interdisciplinary Team meeting. This will be submitted to the Quality Assurance Department and a weekly report will be published to the Nursing Leadership Team to identify trends and areas of improvement. The Quality Assurance/ Medical Records Coordinator will be responsible for monitoring compliance and ensure the deficiency is corrected. The evidence of compliance with wound and skin care will be reported to the Quality Improvement Committee. This will be evidence of improvements with documentation of wound measurements. The DON is responsible for ensuring the documentation is present and individual nurses' performance is	

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	ulcer, Stage 4: full thickness skin loss with extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures, pink/red, 2 inch by 2 inch area of necrosis .... " The plan of care failed to be updated to include measurable outcomes of the surgical and coccyx wound. 3. During the exit conference on 6/20/18, the staff had no further information.		reviewed. Wounds and skin care indicators will be an ongoing criterion to be reported to the Quality Improvement Committee on a continual basis. The DON and Quality Assurance/Medical Records Coordinator will be responsible to report findings quarterly until the Quality Improvement Committee deems the issues resolved.	
L 0549 Bldg. 00	418.56(c)(4) CONTENT OF PLAN OF CARE [The plan of care must include all services necessary for the palliation and management of the terminal illness and related conditions, including the following:] (4) Drugs and treatment necessary to meet the needs of the patient. Based on record review, interview, and observation, the agency failed to ensure all ordered medications were included on the medication profile in 7 of 7 patients with pulmonary diagnoses of 20 records reviewed. (#1, 2, 3, 10, 11, 18, 20) Findings include: 1. An agency policy, dated 2/17, titled, "Medication Review and Electronic Profiling" and stated, " ... 2. The Admission Nurse will review this list for accuracy, repeated therapies, and any other relevant considerations related to medication therapy meeting the patient's individualized needs. 3. This review will include all prescription and over-the-counter medications,	L 0549	L549 The Quality Assurance (QA) Dept. will review all new admissions concurrently to assure orders for oxygen have been ordered and have been signed by the attending physician. Any variances in practice will be reported to the Assistant DON on a daily basis for follow-up and intervention. The Quality Assurance/ Medical Records Coordinator will monitor compliance with this requirement. This will occur daily until it is reported to the Quality Improvement Committee. Oxygen therapy indicators will be	07/23/2018

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	dose, frequency, and route of administration .... " 2. During a home visit at the hospice inpatient unit, on 6/13/18 at 8:45 AM, the patient was observed to be using oxygen per nasal cannula. Clinical record review of patient number one, election date 6/9/16, for benefit period 3/31/18 to 5/29/18 and benefit period 5/30/18 to , included diagnoses essential hypertension, major depressive disorder, peripheral vascular disease, atherosclerotic heart disease, and atrial fibrillation. An IDT (interdisciplinary team) care plan, dated 6/12/18, stated the patient was admitted to the hospice inpatient unit on 6/11/18 with orders to include, " ... Oxygen for comfort per physicians order of 2-4 L [liters], nasal cannula .... " The care plan and a current medication list failed to include oxygen. 3. During a home visit on 6/13/18 at 1:15 PM, the patient was observed using oxygen per nasal cannula and became short of breath when speaking at length. Clinical record review of patient number two, election date 12/7/17, for benefit period 3/7/18 to 6/4/18, included a diagnosis of COPD [chronic obstructive pulmonary disease]. The IDT care plan for the benefit period stated, " ... [patient] is on oxygen at 2.5 liters [L] per n/c [nasal cannula] .... " The care plan and current medication list failed to include oxygen. 4. During a home visit on 6/13/18 at 12:00 PM, the patient was observed using oxygen and was anxious when it was removed for his bath. Clinical record review of patient number three,		ongoing criterion to be reported to the Quality Improvement Committee on a continual basis going forward. The DON and Quality Assurance/Medical Records Coordinator will be responsible to report findings quarterly until the Quality Improvement Committee deems the issue resolved and in compliance. The results of concurrent monitoring to be reported at the Quality Improvement Committee at its quarterly meetings. During Interdisciplinary Team (IDT) meetings beginning 07/15/18, all new admissions and 14 day reviews will be reviewed and monitored of Medication Profile and appropriately initiating the nursing care plan based on the patient and family goals related to respiratory status. The Patient Care Coordinators will submit a report to Quality Assurance. The Assistant DON will monitor for compliance to ensure this deficiency is corrected and will not recur. Education to all Case Managers, triage nurses, visit nurses, and admission nurses on the revised Cerner electronic medical record (EMR) entry for oxygen therapy. The DON will assure 100% participation in the education and	

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	election date 12/1/17, for benefit period 3/1/18 to 5/29/18, included diagnoses Mucopurulent chronic bronchitis and Idiopathic pulmonary fibrosis. The IDT care plan for the benefit period stated, " ... has had a significant decline by March 2017, he required 24/7 oxygen ... is dependent on oxygen at 2-3 liters at rest and 6-7 with activity .... " The care plan and current medication list failed to include oxygen. 5. Clinical record review of patient number 10, election date 1/7/17, for benefit period 4/25/18 to 6/23/18, included a diagnosis of ALS [Amyotrophic Lateral Sclerosis]. The IDT care plan for the benefit period stated, " .... Pt [patient] now using oxygen at 2 liters via NC intermittently throughout the day for 1-2 hours at a time .... ". The care plan and current medication list failed to include oxygen. 6. Clinical record review of patient number 11, election date 3/1/18, for benefit period 3/1/18 to 5/29/18, included a diagnosis of COPD. The IDT care plan for benefit period stated, " ... he complains of shortness of breath and is on 2.5 liters NC .... " The care plan and current medication list failed to include oxygen. 7. Clinical record review of patient number 18, election date 3/1/18, for benefit period 3/1/18 to 5/29/18, included diagnoses COPD, Obstructive sleep apnea, and chronic respiratory failure with hypoxia [lack of oxygen]. Skilled nurse visits on 3/1, 3/8, and 3/29/18 stated, " .... Respiratory treatments: Oxygen, C-pap, 4 L/Min [liters per minute] by nasal cannula .... ". Review of the IDT care plan for the benefit period of 3/1/18 to 5/29/18 stated, " ... [patient]'s biox		is responsible for compliance of the education plan. The EMR revised entry for oxygen therapy will be incorporated into new employee orientation.	

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	[bioximeter, measures pulse and oxygen saturation] has been dropping into the 80s when he is not wearing the O2 [oxygen]. ... does not wear it when he smokes .... " The care plan and current medication list failed to include oxygen. 8. Clinical record review of patient number 20, election date 3/30/18, for benefit period 3/30/18 to 6/27/18, included diagnoses Idiopathic pulmonary fibrosis, COPD, Obstructive sleep apnea, and Pulmonary hypertension. The IDT care plan for the benefit period of 3/30/18 to 6/27/18 stated, " ... [pt] has been oxygen dependent for the past year using 4 L at rest, 6 L with activity .... " The care plan and current medication list failed to include oxygen. 9. During the exit conference on 6/20/18, the medical director indicated the agency was not aware that oxygen should be included on the medication list.			
L 0591 Bldg. 00	418.64(b)(1) NURSING SERVICES (1) The hospice must provide nursing care and services by or under the supervision of a registered nurse. Nursing services must ensure that the nursing needs of the patient are met as identified in the patient's initial assessment, comprehensive assessment, and updated assessments. Based on record review and interview, the Registered Nurse failed to ensure all wounds were identified, assessed, and measured per policy in 1 of 5 wound patients reviewed in a sample of 20. (#6) Findings include:	L 0591	L591 The policy and procedure and formulary were reviewed to assure the protocols met the current standards of care related to skin and wound care. This was completed with the DON, Assistant DON, Quality	07/17/2018

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	1. An agency policy, revised 3/17, titled, "Skin and Wound Care", stated, " ... Purpose: To ensure a uniform and consistent process for: integumentary assessment, documentation, skin care, related comfort measures, and wound care. ... 4. Wounds will be assessed at a minimum of every seven days by an RN [registered nurse] and measurement documented in EMR [electronic medical record] .... " 2. Record review of patient number 6, election date, 3/3/18, contained a plan of care for benefit period 3/3/18 to 5/31/18 and 6/1/18 to 8/29/18 with diagnoses of cerebral atherosclerosis, adult failure to thrive, and major depression. 2. Record review of patient number 6, election date, 3/3/18, contained an IDT care plan with comprehensive assessment updates for benefit periods 3/3/18 to 5/31/18 and 6/1/18 to 8/29/18 with diagnoses of Cerebral atherosclerosis, adult failure to thrive, and major depression. An RN entry on 4/18/18 stated, " ... IDT for Hospitalization for Hip Fracture 4/15/18 and A-fib [Atrial fibrillation] 4/17/18. ... The patient fell on 4/15/18 while being assisted out of a car, as a result of the fall she broke her hip. The team determined that the fall and fracture were not related to the patient's terminal diagnosis and the ambulance transport and hospital treatment for the fracture would not be covered by [agency]. On 4/17/18 it was found that the patient had gone into A-fib and had a low HGB/ HCT [hemoglobin/ hematocrit] she had been transferred to the HV [sic] floor and also received 2 units of PRBC [packed red blood cells] .... " The patient returned home on 4/24/18.		Assurance/Medical Records Coordinator, and the Clinical Staff Educator. Education program initiated for all nurses on Skin and Wound Care on 07/09/18. All nurses are to complete: ·Self-learning packet on wound and skin care. ·Review PowerPoint on wound and skin care as a reference. ·Update all care plans for patients with either an actual or potential skin problem. ·Complete Braden Risk Assessment in accordance with Agency policy and protocols and document accordingly. Responsibility of Patient Care Coordinators that the nurses complete the validation by 07/17/18. The Interdisciplinary Team (IDT) at the 14 day reviews will address wound measurements to increase the team members' involvement of the outcomes related to wound and skin care. The Patient Care Coordinators will be responsible in collaboration with the medical staff. All nursing care plans with potential or actual skin problems to be monitored concurrently for documentation and wound measurements every seven (7) days. This is to occur at the	

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	In an updated comprehensive assessment by a skilled nurse, dated 4/30/18, stated in the integumentary assessment, " ... right hip, surgical wound open to air, no s/s of infection. call placed to attending to get order to remove staples .... " The visit note failed to evidence a description or measurement of the surgical wound. In an updated comprehensive assessment, dated 5/4/18, the RN [registered nurse] stated, " .... since last review patient has returned home from hospital. Staples removed from right hip without difficulty, surgical wound healing without s/s [signs/symptoms] of infection ... no other significant changes .... " The visit note failed to evidence a description or measurement of the surgical wound. A focused SNV visit on 5/7/18, stated in the integumentary assessment, " ... Rt hip surgical site. drsg clean, dry and intact, pink with slight redness at incision line .... " The visit note failed to evidence measurements or further descriptions of the wound. A focused SNV on 5/9/18, stated in the assessment, " ... changed dressing to R hip, incision line well approximated, no redness or drainage .... " The visit note failed to evidence a description or measurement of the wound. A SNV on 5/11/18, stated in the integumentary assessment, " ... Rt hip surgical site drsg clean, dry and intact. ... Notes: Dressing D & I [dry and intact], loose along distal edge, reinforced with tape after viewing incision. Healing without sign of infection .... " The visit note failed to evidence a wound description or measurement. A SNV note on 5/14/18, stated in the		Interdisciplinary Team (IDT) meetings beginning 07/16/18. The Patient Care Coordinators will be responsible for monitoring their nurses' compliance with this standard. The Patient Care Coordinators will monitor the number of medical records in compliance with the standards at each 14-day review during the Interdisciplinary Team meeting. This will be submitted to the Quality Assurance Department and a weekly report will be published to the Nursing Leadership Team to identify trends and areas of improvement. The Quality Assurance/ Medical Records Coordinator will be responsible for monitoring compliance and ensure the deficiency is corrected. The evidence of compliance with wound and skin care will be reported to the Quality Improvement Committee. This will be evidence of improvements with documentation of wound measurements. The DON is responsible for ensuring the documentation is present and individual nurses' performance is reviewed. Wound and skin care indicators will be an ongoing criterion to be reported to the Quality Improvement Committee on a	

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	integumentary assessment, " ... Rt hip wound, incision healing, appears intact, without s/s of infection .... " The visit note failed to evidence a wound description or measurement. A SNV note on 5/15/18, stated in the assessment, " ... Narrative note: focused visit - bowels, and overall condition .... " The visit note failed to evidence an integumentary assessment/ wound description or measurement. A SNV note on 5/16/18, failed to evidence an integumentary assessment/ wound description or measurement. A SNV note on 5/18/18, failed to evidence an integumentary assessment/ wound description or measurement. A SNV note on 5/21/18, stated in the integumentary assessment, " ... incision to right hip healing without sign of infection. 2 small gap areas along incision. Dressing removed with scant pink drainage Area cleaned with normal saline, clean dressing applied .... " A narrative note stated, " ... Plan for next visit: Physical assessment, assess right hip incision, assess need for refills of meds or supplies. Take normal saline and gauzed [sic] 4x4 gauze to next visit for wound cleaning .... " The visit note failed to evidence a wound description or measurement. A SNV note on 5/23/18, stated in a wound assessment, " ... new wound, Coccyx wound, pressure ulcer .... ". The visit note failed to evidence descriptions or measurements of the "new" wound or the previous surgical wound. A SNV note on 5/25/18, stated in a wound		continual basis. The DON and Quality Assurance/ Medical Records Coordinator will be responsible to report findings quarterly until the Quality Improvement Committee deems the issues resolved.	

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	assessment, " ... coccyx wound, pressure ulcer Stage 2: partial thickness skin loss involving epidermis and/or dermis. The ulcer is superficial and presents clinically as an abrasion, blister or shallow crater, surrounding area normal, drainage purulent green with stains ... note: order Flagyl [antibiotic].... " The visit note failed to evidence measurements of the wound. A SNV note on 5/30/18 stated in the integumentary assessment, " ... wounds/ decubitus, coccyx wound pressure ulcer Stage 2 ... color pink/red, sero-sanguineous drainage stains ... [agency] will change dressing daily/ PRN [as needed]. Cleanse wound with NS, apply calcium alginate, and cover with mepilex. Notes: wound free from s/s of infection, crushed flagyl applied to wound .... " The visit note failed to evidence measurements of this wound or previous surgical wound. In an updated comprehensive assessment dated 5/31/18, the RN stated " ... since last review patient has developed a stage II wound to his/ her coccyx. Patient was semi-comatose at SNV [skilled nurse visit] yesterday ... no other significant changes .... " There was no documentation regarding the right hip wound from the previous update. A SNV note on 6/1/18, stated in a wound assessment " .... coccyx ulcer stage 2, pink/ red, sero-sanguineous, stains, wound cleansed with NS, crushed flagyl applied, covered with mepiliex .... " The visit note failed to evidence measurements of the wound. In an undated comprehensive assessment dated 6/4/18, stated in a wound assessment " ... coccyx ulcer stage 2, pink/ red, sero-sanguineous, stains,			

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	wound cleansed with NS, crushed flagyl applied, covered with mepiliex .... " The visit note failed to evidence measurements of the wound. A SNV note on 6/6/18 stated in a wound assessment, " ... coccyx ulcer stage 2, pink/ red, sero-sanguineous, stains, wound cleansed with NS, crushed flagyl applied, covered with mepiliex .... " The visit note failed to evidence measurements of the wound. In an updated comprehensive assessment on 6/11/18 stated in the integumentary assessment " ... coccyx wound stage 2, pink/ red, sero-sanguineous, drainage dampens, perform pressure ulcer/ wound care per physician orders. The visit note failed to evidence measurement of the wound. A SNV note on 6/13/18 stated in the wound assessment " ... coccyx wound, pressure ulcer, Stage 4: full thickness skin loss with extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures, pink/ red, 2 inch by 2 inch area of necrosis .... ". In an updated comprehensive assessment, dated 6/14/18, the RN stated, " .... no significant changes since last review .... " There was no documentation updating the patient's coccyx wound or surgical wound. In an updated comprehensive assessment dated 6/14/18, the RN stated " ... no significant changes since last review .... " There was no documentation updating the patient's coccyx wound or surgical wound. 4. A "Nursing Skill Validations 2017" form indicated employee M, a registered nurse, had been educated on decubitus wounds and staging of wounds. A "Nursing Orientation" form, dated			

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	4/15/15, indicated employee M had been oriented on skin and wound care. 5. During an interview on 6/19/18 at 3:40 PM, employee N stated he/ she would not "necessarily expect descriptions or measurements for surgical wounds". 6. During the exit conference on 6/20/18, the director of nursing and patient care coordinator acknowledged lack of wound descriptions.			