	EPARTMENT OF HEALTH AND HUMAN SERVICES ENTERS FOR MEDICARE & MEDICAID SERVICES						DRM APPROVED MB NO. 0938-039
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 151501		UILDING	DNSTRUCTION 00	COMP	e survey leted)/2018
	PROVIDER OR SUPPLIE	R ND PALLIATIVE CARE INC, THE	<u>:</u>	STREET ADDRESS, CITY, STATE, ZIP COE 111 SUNNYBROOK CT SOUTH BEND, IN 46637			
(X4) ID PREFIX TAG E 0000	SUMMARY (EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD D CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE	(X5) COMPLETION DATE
Bidg. 00	conducted by the In Health in accordan Survey dates: 6/12 Facility number: 5 Provider number: Census: 405 At this Emergency Community Home with Emergency Pr	151501 Preparedness survey, Health was found in compliance reparedness Requirements for icaid Participating Providers	EO	000			
Bldg. 00			L 0	000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

PRINTED: 07/17/2018

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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.

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 151501	A. BUILDING B. WING	<u>00</u>	(X3) DATE SURVEY COMPLETED 06/20/2018	
	PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP PROVIDER OR SUPPLIER 111 SUNNYBROOK CT R FOR HOSPICE AND PALLIATIVE CARE INC, THE SOUTH BEND, IN 46637			DC		
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION 2 20	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIC DATE	
L 0530 Bldg. 00	ASSESSMENT [The comprehending into consideratio (6) Drug profile. prescription and herbal remedies treatments that of This includes, build (i) Effectiveness (ii) Drug side effect (iii) Actual or pote (iv) Duplicate dru (v) Drug therapy laboratory monited Based on observation interview, the agent medications were profile in 7 of 7 participation (ist accuracy, rother relevant cont medication therapt individualized need all prescription an	of drug therapy ects ential drug interactions ig therapy currently associated with	L 0530	L530 (A) The order sheet for the hosy inpatient unit (IPU) and hospice home care patients have been updated to include oxygen, liter 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.	s, ,	

CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED:	07/17/2018
FORM AP	PROVED
OMB NO.	0938-039

	VT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 151501	(X2) MULTIPLE C A. BUILDING B. WING	0NSTRUCTION 00	X3) DATE SURVEY COMPLETED 06/20/2018
	PROVIDER OR SUPPLIE	R ND PALLIATIVE CARE INC, THE	111 SU	ADDRESS, CITY, STATE, ZIP COD JNNYBROOK CT H BEND, IN 46637	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	(X5) COMPLETIO
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
				(C) Cerner electronic medical	
	2. During a home	visit at the hospice inpatient		record Medication Profile updat	ted
	-	8:45 AM, the patient was		to include oxygen therapy. The	
		ng oxygen per nasal cannula.		Assistant DON will be responsi	
		8 98 F		for implementation.	
	Clinical record rev	iew of patient number one,			
		6, for benefit period $3/31/18$ to		(D) Patients presently in the IP	u l
		t period 5/30/18 to 7/28/18,		or hospice home care with oxy	
		s of essential hypertension,		therapy to have order added to	•
	•	isorder, peripheral vascular		Medication Profile, and physicia	
		rotic heart disease, and atrial		signature obtained. The	
	fibrillation.			Medication Profile, reconciliation	n
				and the oxygen therapy initiate	
	Review of an IDT	(interdisciplinary team) care		on the nursing care plan to me	
		B, stated the patient was		patient's individualized needs v	
		spice inpatient unit on 6/11/18		occur the week of	****
		ide, " Oxygen for comfort per		07/16/18-07/20/18 at the	
		f 2-4 L [liters], nasal cannula		Interdisciplinary Team (IDT)	
		ication list failed to include		meetings. All of the Patient Car	~
	oxygen.	leation list lance to include		Coordinators will be responsible	
	oxygen.			for monitoring their nurses'	C
	3 During a home	visit on 6/13/18 at 1:15 PM, the		compliance with this requireme	nt
	-	ed using oxygen per nasal			iii.
		ome short of breath when		(E) Admission nurses will begir	、
	speaking at length.			ordering and profiling oxygen o	
	speaking at length.			the medication order sheet at the	
	Clinical record rev	iew of patient number two,		time of admission. The Assista	
		17, for benefit period 3/7/18 to		DON will be responsible for	
		diagnosis of COPD [chronic		monitoring this corrective action	
		hary disease]. The IDT care			
		t period stated, " [patient] is		(F) Reviewed policies and	
		ters [L] per n/c [nasal cannula]			- I
		nedication list failed to include		procedures related to managin drugs and biologicals for the IP	-
		realization list raned to include		u	
	oxygen.			and hospice home care patient	5
	1 Dumin a - hanne	visit on 6/12/19 at 12:00 DM 44		on 07/09/18. Policies and	
		visit on 6/13/18 at 12:00 PM, the		procedures were updated to	
	-	ed using oxygen and was		incorporate oxygen therapy. To	
	anxious when it wa	as removed for his bath.		implemented in "draft" format u	ntii
		in the structure of the		final approval by the Board of	
	Clinical record rev	iew of patient number three,	1	Directors.	

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 151501	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION <u>00</u>	CON	(X3) DATE SURVEY COMPLETED 06/20/2018	
	PROVIDER OR SUPPLIE	R ND PALLIATIVE CARE INC, THE	111 SU	ADDRESS, CITY, STATE, ZIP C JNNYBROOK CT H BEND, IN 46637	OD		
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S) CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE	
	 5/29/18, included chronic bronchitis fibrosis. The IDT stated, " has ha March 2017, he redependent on oxyg with activity " medication list fai 5. Clinical record election date 1/7/1 6/23/18, included [Amyotrophic Lat plan for the benefin now using oxygen throughout the day The current medic oxygen. 6. Clinical record election date 3/1/1 5/29/18, included care plan for benefic complains of short liters NC ". The include oxygen. 7. Clinical record election date 3/1/1 5/29/18, included care plan for benefic omplains of short liters NC ". The include oxygen. 7. Clinical record election date 3/1/1 5/29/18, included sleep apnea, and chypoxia [lack of o Skilled nurse visit: " Respiratory the L/Min [liters per mathematication care plan for the short filters per mathematication for the plan for the short filters per mathematication for the short filters per mathematication for the plan for t	 17, for benefit period 3/1/18 to diagnoses Mucopurulent and Idiopathic pulmonary care plan for the benefit period ad a significant decline by quired 24/7 oxygen is gen at 2-3 liters at rest and 6-7 The care plan and current led to include oxygen. review of patient number 10, 7, for benefit period 4/25/18 to a diagnosis of ALS eral Sclerosis]. The IDT care t period stated, " Pt [patient] at 2 liters via NC intermittently / for 1-2 hours at a time ". ation list failed to include review of patient number 11, 8, for benefit period 3/1/18 to a diagnosis of COPD. The IDT fit period stated, " he tness of breath and is on 2.5 the current medication list failed to review of patient number 18, 8, for benefit period 3/1/18 to diagnoses COPD, Obstructive hronic respiratory failure with xygen]. s on 3/1, 3/8, and 3/29/18 stated, reatments: Oxygen, C-pap, 4 ninute] by nasal cannula " 					

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 151501	A. BUILDING B. WING	B. WING		
	PROVIDER OR SUPPLIE	ER AND PALLIATIVE CARE INC, THE	111 SU	ADDRESS, CITY, STATE, ZIP COD INNYBROOK CT I BEND, IN 46637		
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
L 0533 Bldg. 00	 dropping into the O2 [oxygen] d ". The current oxygen. 8. Clinical record election date 3/30, 6/27/18, included fibrosis, COPD, CP ulmonary hypert this benefit period dependent for the with activity ". failed to include o 9. During the exit medical director in aware that oxygen medication list. 418.54(d) UPDATE OF CC ASSESSMENT The update of th assessment must hospice interdisc collaboration with physician, if any) that have taken pasessment. It r the patient's respons update must be a sthe condition no less frequent! 	d oxygen saturation] has been 80s when he is not wearing the loes not wear it when he smokes medication list failed to include review of patient number 20, /18, for benefit period 3/30/18 to diagnoses Idiopathic pulmonary 0bstructive sleep apnea, and ension. The IDT care plan for 1 stated, "[pt] has been oxygen past year using 4 L at rest, 6 L The current medication list xygen. t conference on 6/20/18, the ndicated the agency was not a should be included on the DMPREHENSIVE e comprehensive st be accomplished by the ciplinary group (in h the individual's attending) and must consider changes place since the initial must include information on gress toward desired ell as a reassessment of the se to care. The assessment accomplished as frequently of the patient requires, but y than every 15 days.	L 0533	L533 (A) The policy and procedure an	d	

	R MEDICARE & MEDIC				OMB NO. 0938-039
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO		(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED
		151501	B. WING		06/20/2018
			STREET .	ADDRESS, CITY, STATE, ZIP COD	•
NAME OF F	PROVIDER OR SUPPLIE	R	111 SU	INNYBROOK CT	
CENTER	R FOR HOSPICE A	ND PALLIATIVE CARE INC, TH	E SOUTH	HBEND, IN 46637	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	-	assessments in 1 of 5 patients		formulary were reviewed to a	ssure
	with wounds in a s	ample of 20 records reviewed.		the protocols met the current	
	(#6)			standards of care related to s	skin
				and wound care. This was	
	Finding includes:			completed with the DON,	
				Assistant DON, Quality	
	1. An agency polic	ey, revised 5/16, titled,		Assurance/Medical Records	
		assessment of the Patient",		Coordinator, and the Clinical	Staff
	-	prehensive assessment		Educator.	
		nducted by the IDT			
	· ·	eam] in collaboration/		(B) Education program initiat	ed for
		he patient's attending		all nurses on Skin and Woun	
		ractitioner (if any). Updates to		Care on 07/09/18. All nurses	
		assessment will consider all		to complete:	arc
	-	occurred since the initial		 Self-learning packet on w 	round
	-	ess toward desired outcomes,		and skin care.	Journa
		re provided by the IDT "		• Review PowerPoint on w	aund
	and response to car	te provided by the 1D1		and skin care as a reference	
	2 An aganay poli	cy, revised 3/17, titled, "Skin		· Update all care plans for	
		stated, " Purpose: To			
		nd consistent process for:		patients with either an actual	0
		essment, documentation, skin		potential skin problem.	
				Complete Braden Risk	.:41-
		ort measures, and wound care		Assessment in accordance w	
		e assessed at a minimum of		Agency policy and protocols	anu
		by an RN [registered nurse]		document accordingly.	_
		documented in EMR [electronic		Responsibility of Patient Care	
	medical record]			Coordinators that the nurses	
	2 1	Construction of the Construction		complete the validation by	
		of patient number 6, election		07/17/18.	
		ined an IDT care plan with			
	<u>^</u>	essment updates for benefit		(C) The Interdisciplinary Tea	
~	· ·	//31/18 and 6/1/18 to 8/29/18		(IDT) at the 14 day reviews w	
	with diagnoses of Cerebral atherosclerosis, adult failure to thrive, and major depression.		address wound measuremen	its to	
		nd major depression.		increase the team members'	
				involvement of the outcomes	
		18/18 stated, " IDT for		related to wound and skin ca	
	-	Hip Fracture 4/15/18 and A-fib		The Patient Care Coordinato	rs will
	[Atrial fibrillation]	4/17/18 The patient fell on		be responsible in collaboration	n
	4/15/18 while bein	g assisted out of a car, as a		with the medical staff.	
	result of the fall sh	e broke her hip. The team			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 30BI11

Facility ID: 005934

If continuation sheet

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	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 151501	(X2) MULTIPLE CO A. BUILDING B. WING	DNSTRUCTION 00	COME	e survey pleted D/2018
	PROVIDER OR SUPPLIE	ND PALLIATIVE CARE INC, TH	111 SU	ADDRESS, CITY, STATE, ZIP CO INNYBROOK CT I BEND, IN 46637	D	
CENTEI (X4) ID PREFIX TAG	SUMMARY (EACH DEFICIE REGULATORY C determined that th related to the patie ambulance transpo- the fracture would On 4/17/18 it was into A-fib and had hematocrit] she ha [sic] floor and also [packed red blood home on 4/24/18. In an updated com skilled nurse, date integumentary ass wound open to air to attending to get The visit note faild measurement of th In an updated com 5/4/18, the RN [re last review patient hospital. Staples r difficulty, surgical [signs/symptoms] significant change A focused SNV vi integumentary ass site. drsg clean, d redness at incision to evidence measu of the wound.	A STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION e fall and fracture were not ent's terminal diagnosis and the ort and hospital treatment for not be covered by [agency]. found that the patient had gone a low HGB/ HCT [hemoglobin/ d been transferred to the HV o received 2 units of PRBC cells] " The patient returned prehensive assessment by a d 4/30/18, stated in the essment, " right hip, surgical , no s/s of infection. call placed order to remove staples " ed to evidence a description or the surgical wound. prehensive assessment, dated gistered nurse] stated, " since has returned home from removed from right hip without wound healing without s/s of infection no other s " sit on 5/7/18, stated in the essment, " Rt hip surgical ry and intact, pink with slight line " The visit note failed rements or further descriptions	E SOUTH ID PREFIX TAG	BEND, IN 46637 PROVIDER'S PLAN OF CORRECTIVE ACTION SHO (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY) (D) All nursing care plan potential or actual skin p to be monitored concurr documentation and wou measurements every se days. This is to occur at Interdisciplinary Team (I meetings beginning 07// Patient Care Coordinator responsible for monitorin nurses' compliance with standard.	NULD BE PROPRIATE	(X5) COMPLETIO DATE
	assessment, " ch incision line well a drainage " The	n 5/9/18, stated in the nanged dressing to R hip, approximated, no redness or e visit note failed to evidence a usurement of the wound.				

					OM			
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 151501	(X2) MULTIPI A. BUILDIN B. WING		od 00	CO	(X3) DATE SURVEY COMPLETED 06/20/2018	
NAME OF	PROVIDER OR SUPPLIEF	2			DRESS, CITY, STATE, ZIP CO	D		
CENTE	R FOR HOSPICE AN	ND PALLIATIVE CARE INC, TH			NYBROOK CT END, IN 46637			
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE	ID PREFI		PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	ULD BE	(X5) COMPLET	
TAG	A SNV on 5/11/18, assessment, " Rt dry and intact N intact], loose along tape after viewing i of infection " TT a wound description A SNV note on 5/1 integumentary asse incision healing, ap infection " The wound description of A SNV note on 5/1 " Narrative note: overall condition evidence an integur description or meas A SNV note on 5/1 integumentary asse measurement. A SNV note on 5/1 integumentary asse measurement. A SNV note on 5/2 integumentary asse hip healing without areas along incisior pink drainage Area clean dressing appli stated, " Plan for assessment, assess a for refills of meds c and gauzed [sic] 4x	 4/18, stated in the ssment, " Rt hip wound, pears intact, without s/s of visit note failed to evidence a or measurement. 5/18, stated in the assessment, focused visit - bowels, and . " The visit note failed to nentary assessment/ wound surement. 6/18, failed to evidence an ssment/ wound description or 8/18, failed to evidence an ssment/ wound description or 1/18, stated in the ssment, " incision to right sign of infection. 2 small gap h. Dressing removed with scant a cleaned with normal saline, ied " A narrative note next visit: Physical right hip incision, assess need or supplies. Take normal saline 4 gauze to next visit for wound visit note failed to evidence a 					DATE	

	NT OF DEFICIENCIES	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 151501	(X2) MULTIPLE CO A. BUILDING B. WING	DNSTRUCTION 00	СОМ	(X3) DATE SURVEY COMPLETED 06/20/2018	
	PROVIDER OR SUPPLIE	R ND PALLIATIVE CARE INC, THE	111 SU	ADDRESS, CITY, STATE, ZIP (NNYBROOK CT I BEND, IN 46637	P COD		
(X4) ID PREFIX TAG	(EACH DEFICIE	7 STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF		(X5) COMPLETIC DATE	
	assessment, " no pressure ulcer ' evidence descriptii "new" wound or th A SNV note on 5/, assessment, " co Stage 2: partial th epidermis and/or c and presents clinic shallow crater, sur purulent green wit [antibiotic] " TT measurements of t A SNV note on 5/, integumentary ass decubitus, coccyx color pink/red, ser [agency] will ch needed]. Cleanse alginate, and cove free from s/s of in wound " The v measurements of t wound. In an updated com 5/31/18, the RN st patient has develop	 23/18, stated in a wound ew wound, Coccyx wound, The visit note failed to ons or measurements of the ne previous surgical wound. 25/18, stated in a wound occyx wound, pressure ulcer ickness skin loss involving termis. The ulcer is superficial eally as an abrasion, blister or rounding area normal, drainage h stains note: order Flagyl he visit note failed to evidence he wound. 30/18 stated in the essment, " wounds/ wound pressure ulcer Stage 2 o-sanguineous drainage stains nange dressing daily/ PRN [as wound with NS, apply calcium r with mepilex. Notes: wound fection, crushed flagyl applied to risit note failed to evidence his wound or previous surgical 					
	[skilled nurse visit significant change documentation reg from the previous A SNV note on 6/] yesterday no other s " There was no garding the right hip wound					

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	PROVIDER OR SUPPLIE	R ND PALLIATIVE CARE INC, THE		111 SU	ADDRESS, CITY, STATE, ZIP (NNYBROOK CT I BEND, IN 46637			
(X4) ID PREFIX		Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(2 COMPI	X5) Leti
	NS, crushed flagy " The visit not measurements of t In an undated com 6/4/18, stated in a ulcer stage 2, pink wound cleansed w covered with mepi evidence measurem A SNV note on 6// assessment, " co sero-sanguineous, NS, crushed flagy " The visit not measurements of t In an updated com 6/11/18 stated in t coccyx wound s sero-sanguineous, pressure ulcer/ wo The visit note failed the wound. A SNV note on 6// assessment " co Stage 4: full thick destruction, tissue bone, or supportin by 2 inch area of r comprehensive ass stated, " no sign review " There the patient's coccy	prehensive assessment dated wound assessment " coccyx / red, sero-sanguineous, stains, ith NS, crushed flagyl applied, diex " The visit note failed to nents of the wound. 6/18 stated in a wound occyx ulcer stage 2, pink/ red, stains, wound cleansed with applied, covered with mepiliex e failed to evidence he wound. prehensive assessment on he integumentary assessment "						
		ated " no significant changes						

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 151501	A. BU	BUILDING <u>00</u> CC WING 06		COMPL) DATE SURVEY COMPLETED 06/20/2018	
	PROVIDER OR SUPPLIE	R ND PALLIATIVE CARE INC, THE	E	111 SU	ADDRESS, CITY, STATE, ZIP COD INNYBROOK CT 1 BEND, IN 46637			
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L 0548 Bidg. 00	 wound or surgical 3. A "Nursing Skii indicated employed been educated on a of wounds. A "Nu 4/15/15, indicated on skin and wound 4. During an inter employee N stated expect description wounds". 5. During the exit director of nursing acknowledged lack 418.56(c)(3) CONTENT OF P [The plan of care necessary for the of the terminal illuincluding the folk (3) Measurable of implementing and care. Based on record re ensure the plan of measurable outcor patients with woun reviewed. (#6) Finding included: 1. An agency political 	dating the patient's coccyx wound. Il Validations 2017" form e M, a registered nurse, had decubitus wounds and staging trsing Orientation" form, dated employee M had been oriented d care. view on 6/19/18 at 3:40 PM, he/ she would not "necessarily s or measurements for surgical conference on 6/20/18, the and patient care coordinator c of wound descriptions. LAN OF CARE must include all services e palliation and management ness and related conditions,	L 05	548	L548 1.The Interdisciplinary Team (IDT) at the 14 day reviews wil address wound measurements increase the team members' involvement of the outcomes related to wound and skin care The Patient Care Coordinators be responsible in collaboration with the medical staff.	l s to e. s will	07/16/201	

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 151501	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE COMPL 06/20 /	ETED
	PROVIDER OR SUPPLIE	^R ND PALLIATIVE CARE INC, TH	111 SU	ADDRESS, CITY, STATE, ZIP COD JNNYBROOK CT H BEND, IN 46637		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTIO	N	(X5)
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF	BE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE
	are based on inform	nation from the patient's		All nursing care plans with		
		nsive assessment and the		potential or actual skin prob	lems	
		oward outcomes specified in		to be monitored concurrent	y for	
		es to the plan of care are		documentation and wound		
		plan and communicated to		measurements every sever	ı (7)	
	members of the ID	Т "		days. This is to occur at the		
				Interdisciplinary Team (IDT)	
		of patient number 6, election		meetings beginning 07/16/1	8. The	
		ined a plan of care for benefit		Patient Care Coordinators	vill be	
	· ·	/31/18 and 6/1/18 to 8/29/18		responsible for monitoring t	heir	
	with diagnoses of o	cerebral atherosclerosis, adult		nurses' compliance with this	S	
		nd major depression. The		standard.		
	· ·	/22/18 to 6/23/18, contained			of medical	
		ted the patient fell and		The Patient Care Coordinat		
	fractured his/ her h	ip on 4/15/18, requiring surgery		monitor the number of med		
	for repair. The pati	ent returned home on $4/24/18$.		records in compliance with		
				standards at each 14-day re	eview	
	In an updated IDT	care plan, dated 5/4/18, the RN		during the Interdisciplinary	Team	
		stated, " since last review		meeting. This will be submi	tted to	
	patient has returned	d home from hospital. Staples		the Quality Assurance Depa	artment	
	removed from righ	t hip without difficulty, surgical		and a weekly report will be		
	-	hout s/s [signs/symptoms] of		published to the Nursing		
	infection no othe	er significant changes." The		Leadership Team to identify	/ trends	
	· ·	to be updated to include		and areas of improvement.	The	
	measurable outcon	nes of the surgical wound.		Quality Assurance/ Medical		
				Records Coordinator will be	;	
	-	care plan, dated 5/31/18, the		responsible for monitoring		
		ce last review patient has		compliance and ensure the		
		II wound to his/ her coccyx.		deficiency is corrected.		
		omatose at SNV [skilled nurse				
		no other significant changes.		The evidence of compliance	e with	
		mentation regarding the right		wound and skin care will be	;	
		e previous update. The plan of		reported to the Quality		
		dated to include measurable		Improvement Committee. T	his will	
	outcomes of the su	rgical wound.		be evidence of improvement	nts with	
				documentation of wound		
	In an updated IDT	care plan, dated 6/14/18, the		measurements. The DON is	5	
	RN stated, " no	significant changes since last		responsible for ensuring the	9	
	review ". A SN	V on $6/13/18$ stated in the		documentation is present a	nd	
	wound assessment	, " coccyx wound, pressure		individual nurses' performa	nce is	

	NT OF DEFICIENCIES OF CORRECTION	x1) provider/supplier/clia identification number 151501	(X2) MULTIPL A. BUILDING B. WING	e construction G <u>00</u>	(X3) DATE SURVEY COMPLETED 06/20/2018
	PROVIDER OR SUPPLIE	R ND PALLIATIVE CARE INC, THE	111	EET ADDRESS, CITY, STATE, ZIP COD SUNNYBROOK CT JTH BEND, IN 46637	
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	CROSS-REFERENCED TO THE APPROPI	N (X5) EE COMPLETIO DATE
	extensive destructi to muscle, bone, or pink/red, 2 inch by The plan of care fa measurable outcom wound.	I thickness skin loss with on, tissue necrosis, or damage r supporting structures, 2 inch area of necrosis " iled to be updated to include nes of the surgical and coccyx conference on 6/20/18, the staff rmation.		reviewed. Wounds and skin care indica will be an ongoing criterion to reported to the Quality Improvement Committee on continual basis. The DON an Quality Assurance/Medical Records Coordinator will be responsible to report finding quarterly until the Quality Improvement Committee de the issues resolved.	a nd s
Bldg. 00	necessary for the of the terminal illr including the follo (4) Drugs and tre the needs of the Based on record re observation, the ag ordered medication medication profile pulmonary diagnos 2, 3, 10, 11, 18, 20 Findings include: 1. An agency poli "Medication Revie stated, " 2. The this list for accurate other relevant cons medication therapy	must include all services e palliation and management ness and related conditions, owing:] atment necessary to meet patient. view, interview, and gency failed to ensure all ns were included on the in 7 of 7 patients with ses of 20 records reviewed. (#1,	L 0549	L549 The Quality Assurance (QA) will review all new admission concurrently to assure order oxygen have been ordered a have been signed by the atte physician. Any variances in practice will be reported to th Assistant DON on a daily ba follow-up and intervention. T Quality Assurance/ Medical Records Coordinator will mo compliance with this require This will occur daily until it is reported to the Quality Improvement Committee.	ns rs for and ending he asis for The pnitor ment.

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 151501	(X2) MULTIPLE C A. BUILDING B. WING	00 00	X3) DATE SURVEY COMPLETED 06/20/2018
NAME OF	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP COD JNNYBROOK CT	
CENTER	R FOR HOSPICE A	ND PALLIATIVE CARE INC, THE		H BEND, IN 46637	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETIC
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	dose, frequency, a	nd route of administration "		ongoing criterion to be reported the Quality Improvement	to
	2 During a home	visit at the hospice inpatient		Committee on a continual basis	
	-	8:45 AM, the patient was		going forward. The DON and	,
		ng oxygen per nasal cannula.		Quality Assurance/Medical	
		ig on ygon por nusur cumunu.		Records Coordinator will be	
	Clinical record rev	iew of patient number one,		responsible to report findings	
		6, for benefit period 3/31/18 to		quarterly until the Quality	
		t period 5/30/18 to , included		Improvement Committee deems	e
		l hypertension, major		the issue resolved and in	5
	U U	r, peripheral vascular disease,		compliance.	
	<u>^</u>	art disease, and atrial fibrillation.			
				The results of concurrent	
	An IDT (interdisci	plinary team) care plan, dated		monitoring to be reported at the	•
	6/12/18, stated the	patient was admitted to the		Quality Improvement Committe	e at
	hospice inpatient u	init on $6/11/18$ with orders to		its quarterly meetings.	
	include, " Oxyg	en for comfort per physicians			
	order of 2-4 L [lite	rs], nasal cannula " The care		During Interdisciplinary Team	
	plan and a current	medication list failed to include		(IDT) meetings beginning	
	oxygen.			07/15/18, all new admissions a	nd
				14 day reviews will be reviewed	1
	-	visit on 6/13/18 at 1:15 PM, the		and monitored of Medication	
	•	ed using oxygen per nasal		Profile and appropriately initiati	•
		ne short of breath when		the nursing care plan based on	
	speaking at length.			patient and family goals related	to
				respiratory status. The Patient	
		iew of patient number two,		Care Coordinators will submit a	
		17, for benefit period $3/7/18$ to		report to Quality Assurance. Th	e
	-	diagnosis of COPD [chronic		Assistant DON will monitor for	
	-	hary disease]. The IDT care		compliance to ensure this	
	-	t period stated, " [patient] is		deficiency is corrected and will	not
		ters [L] per n/c [nasal cannula]		recur.	
	_	and current medication list			
	failed to include or	kygen.		Education to all Case Manager	Ś,
	4 During the			triage nurses, visit nurses, and	
		visit on 6/13/18 at 12:00 PM, the		admission nurses on the revise	
	-	ed using oxygen and was		Cerner electronic medical recor	
	anxious when it wa	as removed for his bath.		(EMR) entry for oxygen therapy	'.
	Clinical record rev	iew of patient number three,		The DON will assure 100% participation in the education ar	nd
		r	1		

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CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 06/20/2018 151501 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 111 SUNNYBROOK CT CENTER FOR HOSPICE AND PALLIATIVE CARE INC, THE SOUTH BEND, IN 46637 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE election date 12/1/17, for benefit period 3/1/18 to is responsible for compliance of 5/29/18, included diagnoses Mucopurulent the education plan. chronic bronchitis and Idiopathic pulmonary fibrosis. The IDT care plan for the benefit period The EMR revised entry for oxygen stated, " ... has had a significant decline by therapy will be incorporated into March 2017, he required 24/7 oxygen ... is new employee orientation. 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

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Event ID: 30BI11

Facility ID: 005934

005934

If continuation sheet Pa

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FORM APPROVED

07/17/2018

	VT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 151501	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION	x3) date survey completed 06/20/2018
	PROVIDER OR SUPPLIE	R ND PALLIATIVE CARE INC, THE	111 SU	ADDRESS, CITY, STATE, ZIP COD JNNYBROOK CT H BEND, IN 46637	
(X4) ID PREFIX TAG	(EACH DEFICIE REGULATORY C	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION ires pulse and oxygen	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E (X5) COMPLETIO DATE
_ 0591	he is not wearing to wear it when he sr current medication 8. Clinical record election date 3/30/ 6/27/18, included of fibrosis, COPD, O Pulmonary hyperto The IDT care plan to 6/27/18 stated, ' dependent for the j with activity " medication list fail 9. During the exit medical director in aware that oxygen medication list. 418.64(b)(1)	for the benefit period of 3/30/18 [pt] has been oxygen bast year using 4 L at rest, 6 L The care plan and current ed to include oxygen. conference on 6/20/18, the dicated the agency was not should be included on the			
Bldg. 00	and services by or registered nurse. ensure that the n are met as identi	nust provide nursing care or under the supervision of a Nursing services must ursing needs of the patient ied in the patient's initial oprehensive assessment,	L 0591	L591	07/17/201
	Registered Nurse fidentified, assessed	view and interview, the ailed to ensure all wounds were d, and measured per policy in 1 s reviewed in a sample of 20.	L 0391	The policy and procedure and formulary were reviewed to ass the protocols met the current standards of care related to ski and wound care. This was completed with the DON, Assistant DON, Quality	sure

CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED:	07/17/2018
FORM API	PROVED
OMB NO. ()938-039
(X3) DATE SURVE	Y

AND PLAN	D PLAN OF CORRECTION IDENTIFICATION NUMBER 151501		A. BUILDING B. WING	<u>00</u>	COMPLETED 06/20/2018	
	ROVIDER OR SUPPLIE	R ND PALLIATIVE CARE INC, THE	111 SU	ADDRESS, CITY, STATE, ZIP COD JNNYBROOK CT H BEND, IN 46637		
(X4) ID PREFIX TAG	(EACH DEFICIE	' STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIC DATE	
	 An agency poli and Wound Care", ensure a uniform a integumentary ass care, related comformed and the second care, related comformed and the second care care care care care care care care	cy, revised 3/17, titled, "Skin stated, " Purpose: To nd consistent process for: essment, documentation, skin ort measures, and wound care e assessed at a minimum of		Assurance/Medical Records Coordinator, and the Clinical Sta Educator. Education program initiated for a nurses on Skin and Wound Care on 07/09/18. All nurses are to	aff	
	every seven days b and measurement medical record]	by an RN [registered nurse] documented in EMR [electronic ."		complete: ·Self-learning packet on woun and skin care. ·Review PowerPoint on wound		
	date, 3/3/18, conta period 3/3/18 to 5/	of patient number 6, election ined a plan of care for benefit 31/18 and 6/1/18 to 8/29/18 with ral atherosclerosis, adult failure or depression.		and skin care as a reference. ·Update all care plans for patients with either an actual or potential skin problem. ·Complete Braden Risk		
	date, 3/3/18, conta comprehensive ass periods 3/3/18 to 5 with diagnoses of	of patient number 6, election ined an IDT care plan with sessment updates for benefit i/31/18 and 6/1/18 to 8/29/18 Cerebral atherosclerosis, adult nd major depression.		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.	1	
	Hospitalization for [Atrial fibrillation 4/15/18 while beir result of the fall sh determined that th related to the patie ambulance transpo the fracture would	(18/18 stated, " IDT for Hip Fracture 4/15/18 and A-fib 4/17/18 The patient fell on g assisted out of a car, as a le broke her hip. The team e fall and fracture were not nt's terminal diagnosis and the ort and hospital treatment for not be covered by [agency]. found that the patient had gone		The Interdisciplinary Team (IDT the 14 day reviews will address wound measurements to increas the team members' involvement the outcomes related to wound and skin care. The Patient Care Coordinators will be responsible collaboration with the medical staff.	se of	
	into A-fib and had hematocrit] she ha [sic] floor and also	a low HGB/ HCT [hemoglobin/ d been transferred to the HV o received 2 units of PRBC cells] " The patient returned		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		

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 151501	X2) MULTIPLE CONSTRUCTION A. BUILDING O B. WING		(X3) DATE SURVEY COMPLETED 06/20/2018	
	PROVIDER OR SUPPLIE	^R ND PALLIATIVE CARE INC, TH	111 SU	ADDRESS, CITY, STATE, ZIP COD JNNYBROOK CT H BEND, IN 46637		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETIC	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
	In an updated com	prehensive assessment by a		Interdisciplinary Team (IDT)		
	skilled nurse, date	d 4/30/18, stated in the		meetings beginning 07/16/18. T	he	
	integumentary asso	essment, " right hip, surgical		Patient Care Coordinators will b	e	
	wound open to air,	no s/s of infection. call placed		responsible for monitoring their		
	to attending to get	order to remove staples "		nurses' compliance with this		
	The visit note faile	d to evidence a description or		standard.		
	measurement of th	-				
		-		The Patient Care Coordinators	will	
	In an updated com	prehensive assessment, dated		monitor the number of medical		
	5/4/18, the RN [re	gistered nurse] stated, " since		records in compliance with the		
	last review patient	has returned home from		standards at each 14-day review	N	
	hospital. Staples r	emoved from right hip without		during the Interdisciplinary Tear	n	
	difficulty, surgical	wound healing without s/s		meeting. This will be submitted		
	[signs/symptoms]	of infection no other		the Quality Assurance Departm		
		s " The visit note failed to		and a weekly report will be		
		tion or measurement of the		published to the Nursing		
	surgical wound.			Leadership Team to identify tre	nds	
				and areas of improvement. The		
	A focused SNV vi	sit on $5/7/18$, stated in the		Quality Assurance/ Medical		
		essment, " Rt hip surgical		Records Coordinator will be		
		y and intact, pink with slight		responsible for monitoring		
		line " The visit note failed		compliance and ensure the		
		rements or further descriptions		deficiency is corrected.		
	of the wound.	, t				
		5/0/10 / 11 /		The evidence of compliance with	h	
		1 5/9/18, stated in the		wound and skin care will be		
		anged dressing to R hip,		reported to the Quality		
		approximated, no redness or		Improvement Committee. This		
		visit note failed to evidence a		be evidence of improvements w	litn	
	description or mea	surement of the wound.		documentation of wound		
	A CD IV. 5/11/10			measurements. The DON is		
		, stated in the integumentary		responsible for ensuring the		
		hip surgical site drsg clean,		documentation is present and	.	
	-	Notes: Dressing D & I [dry and		individual nurses' performance	IS	
		g distal edge, reinforced with		reviewed.		
		incision. Healing without sign				
		The visit note failed to evidence		Wound and skin care indicators		
	a wound description	on or measurement.		will be an ongoing criterion to b	e	
				reported to the Quality		
	A SNV note on 5/	14/18, stated in the		Improvement Committee on a		

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 151501	(X2) MULTIPLE CO A. BUILDING B. WING	DNSTRUCTION 00	COMP	: SURVEY LETED) /2018
	PROVIDER OR SUPPLIE	R R ND PALLIATIVE CARE INC, THE	111 SU	ADDRESS, CITY, STATE, ZIP COF INNYBROOK CT I BEND, IN 46637)	
CENTER (X4) ID PREFIX TAG	SUMMARY (EACH DEFICIE REGULATORY C integumentary assi- incision healing, a infection " The wound description A SNV note on 5/ " Narrative note overall condition . evidence an integu description or mea A SNV note on 5/ integumentary assi- measurement. A SNV note on 5/ integumentary assi- measurement. A SNV note on 5/ integumentary assi- measurement. A SNV note on 5/ integumentary assi- measurement.	 X STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION essment, " Rt hip wound, ppears intact, without s/s of e visit note failed to evidence a or measurement. 15/18, stated in the assessment, e: focused visit - bowels, and " The visit note failed to umentary assessment/ wound usurement. 16/18, failed to evidence an essment/ wound description or 18/18, failed to evidence an essment/ wound description or 21/18, stated in the essment, " incision to right tt sign of infection. 2 small gap 	E SOUTH ID PREFIX TAG	BEND, IN 46637 PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APP DEFICIENCY) continual basis. The DOI Quality Assurance/ Medi Records Coordinator will responsible to report find quarterly until the Quality Improvement Committee the issues resolved.	ILD BE ROPRIATE V and cal be lings	(X5) COMPLETION DATE
	pink drainage Are clean dressing app stated, " Plan fo assessment, assess for refills of meds and gauzed [sic] 4 cleaning " The wound description A SNV note on 5/2 assessment, " no pressure ulcer" evidence description	 on. Dressing removed with scant ca cleaned with normal saline, lied " A narrative note r next visit: Physical r right hip incision, assess need or supplies. Take normal saline x4 gauze to next visit for wound visit note failed to evidence a or measurement. 23/18, stated in a wound ew wound, Coccyx wound, The visit note failed to ons or measurements of the ne previous surgical wound. 25/18, stated in a wound 			ntinuation sheet	

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 151501	A. B	AULTIPLE CO BUILDING VING	ONSTRUCTION 00	C(DATE SURVEY DMPLETED 6/20/2018
	PROVIDER OR SUPPLIE R FOR HOSPICE A	R ND PALLIATIVE CARE INC, THE		111 SU	ADDRESS, CITY, STATE, ZIP (INNYBROOK CT I BEND, IN 46637	COD	
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	HOULD BE	(X5) COMPLETIC DATE
	 Stage 2: partial the epidermis and/or of and presents clinic shallow crater, surpurulent green witt [antibiotic] " The measurements of the A SNV note on 5/2 integumentary assistic decubitus, coccyx color pink/red, ser [agency] will cheeded]. Cleanse alginate, and cove free from s/s of intwound " The visit measurements of the wound. In an updated composition of the previous A SNV note on 6/2 assessment " cosero-sanguineous, NS, crushed flagy] " The visit not measurements of the previous A SNV note on 6/2 assessment of the previous A SNV note on 6/2 assessment and composition of the previous A SNV note on 6/2 assessment of the previous A SNV note on 6/2 assessment and composition of the previous A SNV note on 6/2 assessment and composition of the previous A SNV note on 6/2 assessment and the previous A SNV note on 6/2 assessment and the previous A SNV note on 6/2 assessment and the previous A SNV note on 6/2 assessment and the previous A SNV note on 6/2 assessment and the previous A SNV note on 6/2 assessment and the previous A SNV note on 6/2 assessment and the previous A SNV note on 6/2 assessment and the previous A SNV note on 6/2 assessment and the previous A SNV note on 6/2 assessment and the previous A SNV note on 6/2 assessment and the previous A SNV note on 6/2 assessment and the previous A SNV note on 6/2 assessment and the previous A SNV note on 6/2 assessment and the previous A SNV note on 6/2 assessment and the previous A SNV note on 6/2 assessment and the previous A SNV note on 6/2 Assessment A SNV note A SNV here and A SNV here A SNV her	30/18 stated in the essment, " wounds/ wound pressure ulcer Stage 2 o-sanguineous drainage stains nange dressing daily/ PRN [as wound with NS, apply calcium r with mepilex. Notes: wound fection, crushed flagyl applied to risit note failed to evidence his wound or previous surgical prehensive assessment dated ated " since last review ped a stage II wound to his/ her as semi-comatose at SNV El yesterday no other s " There was no garding the right hip wound update. 1/18, stated in a wound occyx ulcer stage 2, pink/ red, stains, wound cleansed with l applied, covered with mepiliex e failed to evidence					

AND PLAN OF CORRECTION IDENTIF		x1) provider/supplier/clia identification number 151501	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		X3) DATE SURVEY COMPLETED 06/20/2018	
NAME OF PROVIDER OR SUPPLIER CENTER FOR HOSPICE AND PALLIATIVE CARE INC, THE		111 SU	ADDRESS, CITY, STATE, ZIP JNNYBROOK CT H BEND, IN 46637	COD		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THI	SHOULD BE	(X5) COMPLETIC
	 covered with mepi evidence measurer A SNV note on 6/a assessment, " co sero-sanguineous, NS, crushed flagyl " The visit nota measurements of t In an updated com 6/11/18 stated in tl coccyx wound s sero-sanguineous, pressure ulcer/ wo The visit note faile the wound. A SNV note on 6/ assessment " coo Stage 4: full thick destruction, tissue bone, or supporting by 2 inch area of m comprehensive ass stated, " no sign review " There the patient's coccy In an updated com 6/14/18, the RN st since last review documentation updated 	prehensive assessment on he integumentary assessment " tage 2, pink/ red, drainage dampens, perform and care per physician orders. d to evidence measurement of 13/18 stated in the wound ccyx wound, pressure ulcer, ness skin loss with extensive necrosis, or damage to muscle, g structures, pink/ red, 2 inch ecrosis ". In an updated essment, dated 6/14/18, the RN hificant changes since last was no documentation updating x wound or surgical wound. prehensive assessment dated ated " no significant changes " There was no lating the patient's coccyx				
	indicated employe been educated on o	wound. Il Validations 2017" form e M, a registered nurse, had lecubitus wounds and staging rsing Orientation" form, dated				

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR	ENTERS FOR MEDICARE & MEDICAID SERVICES					ОМ	B NO. 0938-039
STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA				INSTRUCTION	(X3) DATE SURVEY	
AND PLAN	AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BU	ILDING	00	COMPL	ETED
		151501	B. WI	NG		06/20/	/2018
	NAME OF PROVIDER OR SUPPLIER			111 SU	ADDRESS, CITY, STATE, ZIP COD NNYBROOK CT		
CENTER	R FOR HOSPICE AN	ID PALLIATIVE CARE INC, THE		SOUTH	I BEND, IN 46637		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	4/15/15, indicated e	mployee M had been oriented					
	on skin and wound	care.					
	employee N stated h	iew on 6/19/18 at 3:40 PM, ne/ she would not "necessarily or measurements for surgical					
	director of nursing a	onference on 6/20/18, the and patient care coordinator of wound descriptions.					

30BI11 Facility ID: 005934