

|  |   |  |   |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>151555 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____ | X3) DATE SURVEY COMPLETED<br><br>06/25/2014 |
|--|---|--|---|

|   |  |
|---|--|
| NAME OF PROVIDER OR SUPPLIER<br><br>KOSCIUSKO HOME CARE & HOSPICE INC | STREET ADDRESS, CITY, STATE, ZIP CODE<br>1515 PROVIDENT DR STE 250<br>WARSAW, IN 46580 |
|---|--|

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)   | (X5) COMPLETION DATE |
|--------------------|--|---------------|---|----------------------|
| L000000            | <p>This was a Hospice Federal recertification and State relicensure survey.</p> <p>Survey Dates: June 23, 24, and 25, 2014</p> <p>Facility Number: IN009511</p> <p>Medicaid Number: 200297120</p> <p>Surveyor:: Tonya Tucker, RN, PHNS</p> <p>Quality review: Joyce Elder, MSN, BSN, RN<br/>June 27, 2014</p>  | L000000       |   |                      |
| L000625            | <p>418.76(g)(1)<br/>HOSPICE AIDE ASSIGNMENTS AND DUTIES<br/>(1) Hospice aides are assigned to a specific patient by a registered nurse that is a member of the interdisciplinary group. Written patient care instructions for a hospice aide must be prepared by a registered nurse who is responsible for the supervision of a hospice aide as specified under paragraph (h) of this section.</p> <p>Based on clinical record review, policy review, and interview, the agency failed to ensure written patient care instructions for a hospice aide were updated by the registered nurse in 1 of 3 active patient records reviewed of patients receiving</p> | L000625       | The Home Health Aide Plan of Care for the patient could not be corrected due to her death the night before the situation was brought to the attention of the Hospice Director. An in-service for the Registered Nurses to include re-instruction of the requirement | 07/08/2014           |

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

TITLE

(X6) DATE

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.

|   |  |   |   |  |  |   |  |
|---|--|---|---|--|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                      |  | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>151555 |   | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____                           |  | X3) DATE SURVEY COMPLETED<br><br>06/25/2014 |  |
| NAME OF PROVIDER OR SUPPLIER<br><br>KOSCIUSKO HOME CARE & HOSPICE INC |  |   |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>1515 PROVIDENT DR STE 250<br>WARSAW, IN 46580 |  |   |  |
| (X4) ID PREFIX TAG  | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   | ID PREFIX TAG   | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)   | (X5) COMPLETION DATE   |  |   |  |
|   | <p>hospice aide services creating the potential to affect all patients of the hospice receiving hospice aide services. (#3)</p> <p>Findings include:</p> <p>1. Clinical record #3, election date and start of care 1/31/14, contained a document dated 4/29/14 signed by all members of the interdisciplinary group titled "Team Care Plan as of 04-29-2014" stating, "AID 2-2-2014 1 x [times] week x 12 weeks." The record evidenced a document dated 5/22/14 stating, "The Hospice Plan of Care was reviewed and/or revised at our Interdisciplinary Group Meeting on: 5/22/14. ... Unless noted below, your patient's symptoms are being managed with the current plan of care and, he or she is making progress toward their desired goals. Significant changes or new problems related to condition, caregiver, environment or services provided since the last update: 'Large wounds on backside, 5 cm [centimeter] round x 2' Barriers to meeting desired goals: 'PCG [patient caregiver] not attentive to skin care. Dressings will not stay in place' Plan to address Barriers: Aides to assess and clean area, nurse to assess and dress wound as appropriate."</p> |   | <p>of updating the Home Health Aide/Homemaker Plan of Care whenever there are changes to the patient's condition will be completed by 7/8/14. This in-service will be conducted by Teresa Payne, RN BSN. Hospice Home Health Aide and Homemaker policy and procedure will be reviewed at this time.</p> |  |  |   |  |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                      |  | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>151555 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____  |                      | X3) DATE SURVEY COMPLETED<br><br>06/25/2014 |
|---|--|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER<br><br>KOSCIUSKO HOME CARE & HOSPICE INC |  |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>1515 PROVIDENT DR STE 250<br>WARSAW, IN 46580                          |                      |   |
| (X4) ID PREFIX TAG  | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   | ID PREFIX TAG   | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |   |
| L000627   | <p>A. The document titled "Aide Plan of Care" was initiated by the registered nurse on 1/31/14 and reviewed / revised on 3/21/14. The registered nurse failed to update the Aide Plan of Care with the information from the 5/22/14 meeting.</p> <p>B. On 6/25/14 at 1:10 PM, employee P (clinical director/registered nurse) indicated the registered nurse should have updated the aide care plan to include the information discussed in the 5/22/14 meeting.</p> <p>2. The policy with a reviewed date of 11/7/08 titled "Hospice Aide and Homemaker Services" states, "Procedure: ... G. Hospice aide assignments and duties. 1. Hospice aides are assigned to a specific patient by a registered nurse that is a member of the interdisciplinary group. Written patient care instructions for a hospice aide will be prepared by a registered nurse who is responsible for the supervision of a hospice aide ... 2. A hospice aide provides services that are: (i) ordered by the interdisciplinary group. ... ."</p> <p>418.76(g)(3)<br/>HOSPICE AIDE ASSIGNMENTS AND</p> |   |   |                      |   |

|   |   |   |   |  |  |   |  |
|---|---|---|---|--|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                      |   | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>151555 |   | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____                           |  | X3) DATE SURVEY COMPLETED<br>06/25/2014 |  |
| NAME OF PROVIDER OR SUPPLIER<br><br>KOSCIUSKO HOME CARE & HOSPICE INC |   |   |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>1515 PROVIDENT DR STE 250<br>WARSAW, IN 46580 |  |   |  |
| (X4) ID PREFIX TAG  | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  | ID PREFIX TAG   | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)   | (X5) COMPLETION DATE   |  |   |  |
|   | <p><b>DUTIES</b></p> <p>(3) The duties of a hospice aide include the following:</p> <p>(i) The provision of hands-on personal care.</p> <p>(ii) The performance of simple procedures as an extension of therapy or nursing services.</p> <p>(iii) Assistance in ambulation or exercises.</p> <p>(iv) Assistance in administering medications that are ordinarily self-administered.</p> <p>Based on clinical record review, policy and document review, and interview, the hospice failed to ensure the hospice aide assisted rather than administered medications in 1 of 3 active patient records reviewed of patients receiving hospice aide services creating the potential to affect all patients of the agency receiving aide services. (#3)</p> <p>Findings include:</p> <p>1. Clinical record #3, election date and start of care 1/31/14, contained a document dated 4/29/14 signed by all members of the interdisciplinary group titled "Team Care Plan as of 04-29-2014" stating, " AID 2-2-2014 1 x [times] week x 12 weeks." The record contained a document titled "Aide Plan of Care" initiated by the registered nurse on 1/31/14 and reviewed / revised on 3/21/14 stating, "BATH: Bed: Complete Partial As pt [patient] tolerates HAIR: Shampoo: 1 x wk [week] Style per pt request DRESS: Hospital Gowns</p> | L000627   | The Plan of Care for Patient #3 included patient flow sheets A-G. The Registered Nurses and Home Health Aides were instructed verbally on 6/25/14 that the aides will no longer apply or administer medications to patients. The Home Health Aide Plan of Care for the patient could not be corrected due to her death the night before the situation was brought to the attention of the Hospice Director. The written policy and procedure for medication assistance by the Home Health Aides will be reviewed and revised by 7/18/14. All current patient plans of care will be reviewed and corrected if necessary by 7/18/14 and a copy of policy and procedure will be given to staff. Teresa Payne, RN BSN, Clinical Director of Hospice will be responsible for completing all education and policy and procedure changes and care plan review. | 07/18/2014   |  |   |  |

|  |   |  |   |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>151555 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____ | X3) DATE SURVEY COMPLETED<br><br>06/25/2014 |
|--|---|--|---|

|   |  |
|---|--|
| NAME OF PROVIDER OR SUPPLIER<br><br>KOSCIUSKO HOME CARE & HOSPICE INC | STREET ADDRESS, CITY, STATE, ZIP CODE<br>1515 PROVIDENT DR STE 250<br>WARSAW, IN 46580 |
|---|--|

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|--------------------|--|---------------|---|----------------------|
|--------------------|--|---------------|---|----------------------|

|  |   |  |  |  |
|--|---|--|--|--|
|  | <p>SKIN: Check for pressure areas q.s. [every shift] Lotion: All over See below ... Other: 'Shampoo caps for washing hair. Triple antibiotic ointment on legs. Nystatin under folds of skin.'</p> <p>A. The document dated 5/1/14 and signed by employee W (hospice aide) titled "Home Health Aide Flowsheet" states, "SKIN: Pressure areas 'Yes No new areas' ...Bottom cream-bottom Nystatin-all skin folds ... Triple Atb [antibiotic] - legs ... ."</p> <p>B. The document dated 5/8/14 and signed by employee L (hospice aide) titled "Home Health Aide Flowsheet" states, "SKIN: Pressure areas 'Yes Ongoing Nurse aware' ... Nystatin to folds &amp; red spots antibiotic to legs ... ."</p> <p>C. The document dated 5/12/14 and signed by employee L titled "Home Health Aide Flowsheet" states, "SKIN: Pressure areas 'Yes Ongoing Nurse aware' ... Nystatin under folds of skin ... Triple antibiotic oint. [ointment] on legs ... ."</p> <p>D. The document dated 5/15/14 and signed by employee L titled "Home Health Aide Flowsheet" states, "SKIN: Pressure areas 'Yes Nurse aware' ... Ongoing Bottom cream ... Nystatin on all</p> |  |  |  |
|--|---|--|--|--|

|   |   |   |   |  |  |   |  |
|---|---|---|---|--|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                      |   | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>151555 |   | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____                           |  | X3) DATE SURVEY COMPLETED<br><br>06/25/2014 |  |
| NAME OF PROVIDER OR SUPPLIER<br><br>KOSCIUSKO HOME CARE & HOSPICE INC |   |   |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>1515 PROVIDENT DR STE 250<br>WARSAW, IN 46580 |  |   |  |
| (X4) ID PREFIX TAG  | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  | ID PREFIX TAG   | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE   |  |   |  |
|   | <p>red areas &amp; under folds ... Triple antibiotic oint. on legs ... "</p> <p>E. The document dated 5/22/14 and signed by employee L titled "Home Health Aide Flowsheet" states, "SKIN: Pressure areas 'Yes Ongoing Nurse aware' ... Bottom cream ... Nystatin on red areas &amp; under folds ... Triple antibiotic ointment on legs ... ."</p> <p>F. The document dated 5/29/14 and signed by employee L titled "Home Health Aide Flowsheet" states, "SKIN: Pressure areas 'Yes Ongoing Nurse aware' ... Triple antibiotic ointment on legs - Nystatin under folds of skin ... ."</p> <p>G. The document dated 6/2/14 and signed by employee L titled "Home Health Aide Flowsheet" states, "SKIN: Pressure areas 'Yes Ongoing Nurse aware' ... Triple antibiotic on red areas ... ."</p> <p>2. On 6/25/14 at 1:08 PM, employee P (clinical director/registered nurse) indicated the aides should not have been applying the medications.</p> <p>3. The policy with a review date of 11/7/08 titled "Hospice Aide and Homemaker Services" states, "Procedure: ... G. Hospice aide assignments and</p> |   |   |  |  |   |  |

|   |   |   |   |                      |   |
|---|---|---|---|----------------------|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                      |   | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>151555 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____  |                      | X3) DATE SURVEY COMPLETED<br><br>06/25/2014 |
| NAME OF PROVIDER OR SUPPLIER<br><br>KOSCIUSKO HOME CARE & HOSPICE INC |   |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>1515 PROVIDENT DR STE 250<br>WARSAW, IN 46580                          |                      |   |
| (X4) ID PREFIX TAG  | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)                    | ID PREFIX TAG   | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |   |
|   | duties. ... 2. A hospice aide provides services that are: ... (iii) Permitted to be performed under State law by such hospice aide ... ." |   |   |                      |   |