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	161580	A. BUILDING _____ B. WING _____	04/08/2021

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(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
E 000	Initial Comments A Recertification Survey in conjunction with a COVID-19 Focused Infection Control Survey was conducted by the Department of Inspections and Appeals completed on 4/5/21 through 4/8/21. The hospice was found to be operating in compliance with the requirements of the Establishment of Emergency Preparedness and CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19.	E 000	POC accepted on 4/20/21 with date of correction 5/19/21. See attached word document — B. Rasmussen	
L 000	INITIAL COMMENTS The Department of Inspections and Appeals conducted a Recertification Survey in conjunction with a COVID-19 Focused Infection Control Survey 4/5/21 through 4/8/21. The hospice was found to be in substantial compliance in relation to CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. The recertification survey found the hospice operating out of compliance with the following standard level hospice regulations.	L 000		
L 531	CONTENT OF COMPREHENSIVE ASSESSMENT CFR(s): 418.54(c)(7) [The comprehensive assessment must take into consideration the following factors:] (7) Bereavement. An initial bereavement assessment of the needs of the patient's family and other individuals focusing on the social, spiritual, and cultural factors that may impact their	L 531		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 4/19/2021

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.

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L 531	Continued From page 1 ability to cope with the patient's death. Information gathered from the initial bereavement assessment must be incorporated into the plan of care and considered in the bereavement plan of care. This STANDARD is not met as evidenced by: Based on hospice policy review, clinical record review and staff interview, the hospice failed to perform an initial bereavement assessment, within 5 days of the patient's election to the hospice benefit and as part of the initial comprehensive assessment, to determine patient and/or family bereavement needs and risk factors in a timely manner for 4 of 13 sampled patients (Patients #1, #5, #7 and #8). The hospice reported 34 current patients at the time of the survey. Failure to complete an initial bereavement assessment increased the risk that patient or family/caregiver grieving and bereavement needs would not be addressed appropriately, leading to prolonged or dysfunctional grieving and potentially increased the risk of self harm for hospice patients or survivors. Findings include: According to the policy and procedure titled Patient Assessment, dated 7/2020, based on the patient' needs and findings from the initial assessment, the Patient Care Coordinator/RN coordinates and designates disciplines that must participate in the comprehensive assessment of the patient within 5 days of his or her election of hospice.	L 531		

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L 531	Continued From page 2 1. Patient #5 had an admission to hospice on 9/30/2020 and received services in a nursing home. The clinical record review revealed: The social worker visit completed by the social worker, dated 2/22/2021, locked as completed on 3/1/2021 (7 days passed the visit date). 2. Patient #8 had an admission to hospice on 12/1/2020 and received services in a private home setting. The clinical record review revealed: The initial skilled nurse visit, dated 12/1/2020, identified the patient bereavement risk minimal. The document failed to include a complete bereavement assessment. 3. Patient #1 had an admission to hospice on 2/12/21 and received services in a private home residence. Clinical record review revealed: a. The initial comprehensive assessment completed by the skilled nurse, dated 3/12/21, failed to include assessment of the patient's bereavement risk. b. The social worker note, dated 3/18/21, documented a bereavement risk assessment. The initial bereavement risk assessment completed by the social worker exceeded the 5 day requirement per regulation by 2 days.	L 531		

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L 531	Continued From page 3 4. Patient #7 had an admission to hospice on 3/14/21 and received services in a nursing home. Clinical record review revealed: a. The initial comprehensive assessment completed by the skilled nurse, dated 3/14/21, failed to include assessment of the patient's bereavement risk. b. The social worker note, dated 3/17/21, documented the family refused the social work visit. The clinical record lacked evidence of completion of an initial bereavement risk assessment by the social worker or any other discipline. The above findings for Patients #1, #5, #7, and #8 were reviewed with the Hospice Administrator and Clinical Manager. Hospice staff provided no further information prior to the end of the survey.	L 531		
L 543	PLAN OF CARE CFR(s): 418.56(b) All hospice care and services furnished to patients and their families must follow an individualized written plan of care established by the hospice interdisciplinary group in collaboration with the attending physician (if any), the patient or representative, and the primary caregiver in accordance with the patient's needs if any of them so desire. This STANDARD is not met as evidenced by: Based on clinical record review, hospice policy review and staff interview, the hospice failed to	L 543		

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L 543	Continued From page 4	L 543		

ensure the provision of care in accordance with the patient's plan of care for 3 of 3 sampled patients (Patient #1, #7 and #9).

The hospice reported a current census of 34 patients.

Failure to follow the patient's Plan of Care as directed by the Interdisciplinary Group (IDG) put the patient at risk for inconsistent care that may not meet the needs of the patient.

Findings include:

1. Patient #9 had a hospice admission date of 10/15/2020 and received hospice services while residing in a private home residence.

a. The clinical record included a verbal physician order, dated 3/11/21, and signed by the physician. The order included an order for kerafoam dressing to the coccyx, change every 3 days and as needed for skin breakdown.

The Skilled Nurse visit dated 3/9/21 documented the patient had an area on his/her coccyx that has an superficial open area, area with no drainage and shows no signs or symptoms of infection. Kerrafoam dressing applied to the area. The hospice failed to document physician notification or order at the time the area first observed or document the wound measurements.

The nurse failed to get an order from the physician in a timely manner for treatment to the open area on the patient's coccyx.

2. Patient #1 had a hospice admission date of 2/12/21 and received hospice services while

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L 543	Continued From page 5 residing in a private home residence. Clinical record review revealed: a. The Plan of Care (POC) dated, 2/12/21 to 5/12/21, included Interdisciplinary group (IDG) orders for wound care to the left heel and instructions to clean the wound with normal saline, apply Santyl ointment, cover with Dakin's solution soaked gauze, and wrap with gauze twice daily. b. The skilled nurse visit note, dated 3/26/21, documented the nurse changed the dressing on the patient's heel and applied gauze saturated with Vaseline to wound, wrapped with kerlix netting, and secured with sock. c. A physician's order, dated 3/30/21, ordered to cleanse the wound with normal saline, cover with Vaseline gauze, cover with dressing, and secure with tape. The clinical record lacked documentation of a physician order for the use of Vaseline gauze for the dressing change prior to 3/30/21. d. The POC, dated, 2/12/21 to 5/12/21, included IDG orders for assessment of lung sounds. e. The skilled nurse visit notes, dated 2/26, 3/11, and 3/26/21, lacked documentation of assessment of lung sounds. The nurse failed to follow the POC. 3. Patient #7 had a hospice admission date of 3/14/21 and received hospice services while residing in a nursing home.	L 543		

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L 543	Continued From page 6 Clinical record review revealed: a. The POC dated, 3/14/21 to 6/11/21, included IDG orders for assessment of oxygen saturation, lung sounds, bowel pattern, pain, and sleep pattern. b. The skilled nurse visit note, dated 3/15/21, lacked documentation of assessment of oxygen saturation, bowel pattern, and sleep pattern. c. The skilled nurse visit note, dated 3/17/21, lacked documentation of assessment of sleep pattern. d. The skilled nurse visit note, dated 3/22/21, lacked documentation of assessment of oxygen saturation, lung sounds, and bowel pattern. e. The skilled nurse visit note, dated 3/25/21, lacked documentation of assessment of oxygen saturation and pain. f. The skilled nurse visit note, dated 3/29/21, lacked documentation of assessment of sleep pattern. The nurse failed to follow the POC. The above findings for Patients #1, #7, and #9 were reviewed with the Hospice Administrator and Clinical Manager. Hospice staff provided no further information prior to the end of the survey.	L 543		
L 547	CONTENT OF PLAN OF CARE CFR(s): 418.56(c)(2) [The plan of care must include all services	L 547		

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L 547	Continued From page 7 necessary for the palliation and management of the terminal illness and related conditions, including the following:] (2) A detailed statement of the scope and frequency of services necessary to meet the specific patient and family needs. This STANDARD is not met as evidenced by: Based on clinical record review and hospice policy review, the hospice failed to ensure the hospice Interdisciplinary Group developed patient plans of care which specified the scope and frequency for all services required by and provided to patients for 12 of 13 sampled patients (Patients #1, #2, #3, #4, #5, #6, #7, #9, #10, #11, #12 and #13). The hospice reported a current census of 34 patients. Failure to identify a scope and frequencies for all ordered services increased the potential for hospice services to not adequately meet the needs of hospice patients and families. Findings include: Review of the hospice's policy, titled Plan of Care, dated 10/2017, identified the patient's plan of care (POC) specifies the care and services necessary to meet the needs of the patient/caregiver as identified in the initial, comprehensive and updated assessments of the patient. The POC is reviewed and updated by the interdisciplinary group (IDG) every 15 days or more frequently if needed.	L 547		

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L 547	Continued From page 8 Review of the hospice's policy, titled Plan of Care - Content, dated 7/2020, identified the plan of care includes a detailed statement of the scope and frequency of services necessary to meet the specific patient and family needs. 1. Patient #3 was admitted to hospice on 12/8/2020 and received services while residing in a nursing home. Clinical record review revealed the following: a. The initial plan of care, dated 12/8/2020, included documentation of physician orders for skilled nursing services 1-2 times a week and PRN (as needed). b. An IDG update to the plan of care meeting note, dated 2/12/21 and 3/26/21, included documentation of skilled nursing services 1-2 times a week and PRN and social work 1-3 times a month and PRN. c. An IDG update to the plan of care meeting notes, dated 2/26/21 and 3/12/21, included documentation of skilled nursing services 1-2 times a week and PRN and social work PRN. d. The plan of care failed to identify a frequency and reason for the PRN visits. 2. Patient #4 was admitted to hospice on 12/3/2020 and received services while residing in a nursing home. Clinical record review revealed the following: a. The initial plan of care, dated 12/4/2020, included documentation of physician orders for skilled nursing services 1-2 times a week and PRN.	L 547		

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b. An IDG update to the plan of care meeting note, dated 2/12 and 2/26/21, included documentation of skilled nursing services 1-2 times a week and PRN, social work 2-4 times a month and PRN, spiritual 1-3 times a month and PRN, music therapy 2-4 times a month and PRN, massage therapy 2-4 times a month and PRN, and volunteer calls 2-4 times a month and PRN.

c. An IDG update to the plan of care meeting notes, dated 3/12 and 3/26/21, included documentation of social work 2-4 times a month and PRN.

d. The plan of care failed to identify a frequency and reason for the PRN visits.

3. Patient #11 was admitted to hospice on 2/5/21, received services while residing in a private home and had a death date of 2/12/21. Clinical record review revealed the following:

a. The initial plan of care, dated 2/5/21, included documentation of physician orders for skilled nursing services 1-2 times a week and PRN.

b. An IDG update to the plan of care meeting note, dated 2/12/21, included documentation of skilled nursing services 1-2 times a week for one week, 2 times a week and PRN and social work 2-4 times a month and PRN.

c. The plan of care failed to identify a frequency and reason for the PRN visits.

4. Patient #12 was admitted to hospice on 2/19/21, received services while residing in a private home and had a discharge date of

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L 547	Continued From page 10 3/27/21. Clinical record review revealed the following: a. The initial plan of care, dated 2/26/21, included documentation of physician orders for skilled nursing services 1-2 times a week and PRN and social work 1-3 times a month and PRN. b. An IDG update to the plan of care meeting note, dated 3/12 and 3/26/21, included documentation of skilled nursing services 1-2 times a week and PRN, social work 1-3 times a month and PRN and volunteer calls 2-4 times a month and PRN. c. The plan of care failed to identify a frequency and reason for the PRN visits. 5. Patient #13 was admitted to hospice on 12/15/2020, received services while residing in a private home and had a discharge date of 2/17/21. Clinical record review revealed the following: a. The initial plan of care, dated 12/18/2020, included documentation of physician orders for skilled nursing services 1-2 times a week and PRN. b. An IDG update to the plan of care meeting note, dated 12/31/2020, 1/15 and 1/29/21, included documentation of skilled nursing services 1-2 times a week and PRN and social work 1-3 times a month and PRN. c. An IDG update to the plan of care meeting notes, dated 2/12 and 2/26/21, included documentation of skilled nursing services 1 time	L 547		

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L 547	Continued From page 11 a week and PRN and social work PRN. d. The plan of care failed to identify a frequency and reason for the PRN visits. 6. Patient #5 had a hospice admission date of 9/39/2020 and received services while residing in a nursing home. The clinical record review revealed the following: The POC, dated 10/6/2020 to 1/3/2021 and 1/4/2021 to 4/3/2021, included orders for skilled nursing, social worker music therapy and home health aide services. The IDG meeting note, dated 2/12/21, 2/26/21, 3/12/21 and 3/26/21, included an order for skilled nurse 1 to 2 times a month and prn, social worker 1 to 3 times a month and as needed (prn) and music therapy 2 to 4 times and month and prn. The IDG failed to identify the amount of visits ordered. 7. Patient #9 had a hospice admission date of 10/15/2020 and received services while residing in a private home residence. The clinical record review revealed the following: The POC, dated 10/6/2020 to 1/3/2021 and 1/4/2021 to 4/3/2021, included orders for skilled nursing, social worker, massage therapy and home health aide services. The IDG meeting note, dated 2/12/21, 2/26?21, 3/12/21 and 3/26/21, included an order for skilled nurse 1 to 2 times a month and prn, massage therapy 2 to 4 times a month and prn and social worker 1 to 3 times a month and as needed. The	L 547		

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L 547	Continued From page 12 IDG failed to identify the amount of visits ordered. 8. Patient #2 had an admission to hospice on 9/16/2020 and received services while residing in a nursing home. a. The IDT update, dated 2/12/2021 included an order for skilled nurse: 1-2 times per week and PRN, social worker: 0 times 1 month, then 1-3 times per month and PRN, massage therapy 0 times 1 month, then 2-4 times per month and PRN and spiritual care: 0 times 1 month, then 1-3 times per month and PRN. The Plan of Care failed to identify a specific number of PRN visits. b. The IDT update, dated 2/26/2021 included an order for skilled nurse: 1-2 times per week and PRN, social worker: 0 times 1 month, then 1-3 times per month and PRN, massage therapy: 0 times 1 month, then 2-4 times per month and PRN and spiritual care: 0 times 1 month, then 1-3 times per month and PRN. The Plan of Care failed to specify a specific number of PRN visits. c. The IDT update, dated 3/12/2021 included an order for skilled nurse: 1-2 times per week and PRN, social worker: 0 times 1 month, then 1-3 times per month and PRN, massage therapy: 0 times 1 month, then 2-4 times per month and PRN and spiritual care: 0 times 1 month, then 1-3 times per month and PRN. The Plan of Care failed to identify a specific number of PRN visits. d. The IDT update, dated 3/26/2021 included an order for nursing: 0-1 time per week for one week, then 1 time per week and PRN and social worker visits PRN. The Plan of Care failed to specify a specific number of PRN visits. 9. Patient #1 had a hospice admission date of	L 547		

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L 547	Continued From page 13 2/12/21 and received hospice services while residing in a private home residence. The POC, dated 2/12/21 to 5/12/21, included IDG orders for skilled nursing visits 1-2 times per week and as needed. a. The IDG meeting to update the POC, dated 2/17, included IDG orders for nursing visits 1-2 times per week and as needed and spiritual care visits 1-3 times per month and as needed. The IDG failed to identify a specific frequency and reason for the delivery of the as needed nursing and spiritual care services for the patient. b. The IDG meeting to update the POC, dated 2/26, included IDG orders for massage therapy visits 1-2 times per month for one month and then 2-4 times per month and as needed for comfort and relaxation with use of essential oils. The update also included IDG orders for social work visits 2-4 times per month and as needed. The IDG failed to identify a specific frequency and reason for the delivery of the as needed massage therapy and social work services for the patient. c. The IDG meeting to update the POC, dated 3/26, included IDG orders for volunteer services 1-3 times per month and as needed. The IDG failed to identify a specific frequency and reason for the delivery of the as needed volunteer services for the patient. 10. Patient #6 had a hospice admission date of 3/12/21 and received hospice services while residing in a nursing home. The POC, dated 3/12/21 to 6/10/21, included IDG orders for skilled	L 547		

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nursing visits 1-2 times per week and as needed.

The IDG meeting to update the POC, dated 3/17, included IDG orders for nursing visits 1-2 times per week and as needed and social work visits 1-3 times per month as as needed.

The IDG failed to identify a specific frequency and reason for the delivery of the as needed nursing and social work services for the patient.

11. Patient #7 had a hospice admission date of 3/14/21 and received hospice services while residing in a nursing home. The POC, dated 3/14/21 to 6/11/21, included IDG orders for skilled nursing visits 1-2 times per week and as needed.

The IDG meeting to update the POC, dated 3/19/21, included IDG orders for nursing visits 1-2 times per week and as needed and social work visits as needed.

The IDG failed to identify a specific frequency and reason for the delivery of the as needed nursing and social work services for the patient.

12. Patient #10 had a hospice admission date of 2/8/21 and received hospice services while residing in a private home residence. The POC, dated 2/8/21 to 5/8/21, included IDG orders for skilled nursing visits 1-2 times per week and as needed.

a. The IDG meeting to update the POC, dated 2/12/21, included IDG orders for nursing visits 1-2 times per week and as needed and social work visits 2-4 times per month and as needed.

The IDG failed to identify a specific frequency and

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L 547	Continued From page 15 reason for the delivery of the as needed nursing and social work services for the patient. b. The IDG meeting to update the POC, dated 2/26/21, included IDG orders for music therapy visits 2-4 times per month and as needed. The IDG failed to identify a specific frequency and reason for the delivery of the as needed music therapy services for the patient. The above findings for Patient #1, #2, #3, #4, #5, #6, #7, #9, #10, #11, #12 and #13 were reviewed with Hospice Administrator and Clinical Manager. Hospice staff provided no further information prior to the end of the survey.	L 547		
L 579	PREVENTION CFR(s): 418.60(a) The hospice must follow accepted standards of practice to prevent the transmission of infections and communicable diseases, including the use of standard precautions. This STANDARD is not met as evidenced by: Based on hospice policy review and home visit observation, the hospice failed to ensure staff performed tasks during home visits in a manner to prevent contamination and/ or the spread of infection. The survey identified concerns with 1 of 3 home visit observations (Patient #2). The hospice reported a current census of 34 patients. Failure to ensure services during home visits follow accepted standards of practice for infection control increased the risk of contamination during	L 579		

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the home visit, the development of an infection and/or transmission of organisms from home to home.

Findings include:

According to hospice policy, titled Infection Control - Respiratory Illness and Covid-19, dated 5/2020, identified to wash hands between tasks and procedures on the same patient to prevent cross-contamination of different body sites and remove gloves promptly after use, before touching noncontaminated items and environmental surfaces, and before going to another patient, and wash hands immediately to avoid transfer of microorganisms to other patients or environments.

Patient #2 had an admission to hospice on 9/16/2020 and received services while residing in a nursing home.

On 4/6/21 beginning at 10:30 AM, during a home visit observation with Staff C, Registered Nurse (RN). Staff C placed nurse bag on bedside table on barrier, placed a second barrier on overbed table and entered the bag. She placed the blood pressure cuff, thermometer and pulse oximeter on second barrier. She sanitized her hands, put on gloves and assessed patient's temperature, pulse oximetry, made notes with paper pad and pen then assessed blood pressure. She placed the equipment back on the barrier. Staff C. removed the urinary drainage bag from the cloth cover, assessed urine and replaced urinary drainage bag back inside cloth cover. She failed to complete hand hygiene and removed the stethoscope from her neck and assessed patient's lung sounds, heart tones bowel sounds

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L 579	Continued From page 17 and replaced stethoscope around her neck. She removed gloves and performed hand hygiene, then used alcohol wipes to clean stethoscope and placed it in bag. RN sanitized thermometer, blood pressure cuff and pulse oximeter and placed equipment back on dirty barrier and then returned the equipment to her nursing bag. The nurse failed to remove gloves, sanitize hands and reapply gloves before touching the urinary drainage bag and failed to place noncontaminated equipment in her nursing bag. The above findings for Patient #2 were reviewed with Hospice Administrator and Clinical Manager. Hospice staff provided no further information prior to the end of the survey.	L 579		
L 647	LEVEL OF ACTIVITY CFR(s): 418.78(e) Volunteers must provide day-to-day administrative and/or direct patient care services in an amount that, at a minimum, equals 5 percent of the total patient care hours of all paid hospice employees and contract staff. The hospice must maintain records on the use of volunteers for patient care and administrative services, including the type of services and time worked. This STANDARD is not met as evidenced by: Based on hospice staff interview, the hospice failed to provide volunteer services that, at a minimum, equals 5 percent of the total patient care hours of all paid hospice employees and contract staff. The hospice reported a current census of 34 patients.	L 647		

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L 647	Continued From page 18 Failure to maintain volunteer hours for hospice patients puts the patients and families at risk of not receiving the services necessary to meet the needs of the patients and puts the hospice at risk of not providing all regulatory requirements for a hospice program. Findings include: During an interview on 4/8/21 at 12:10 PM, the Hospice Administrator reported the percentage of volunteer hours for 2019 was 4.3 %. The hospice failed to meet the volunteer hours of 5 percent of the total patient care hours of all paid hospice employees and contracted staff. The Administrator received the above findings and the hospice provided no further information prior to the end of the survey.	L 647		
L 655	PROFESSIONAL MANAGEMENT RESPONSIBILITY CFR(s): 418.100(e) A hospice that has a written agreement with another agency, individual, or organization to furnish any services under arrangement must retain administrative and financial management, and oversight of staff and services for all arranged services, to ensure the provision of quality care. Arranged services must be supported by written agreements that require that all services be-- (1) Authorized by the hospice; (2) Furnished in a safe and effective manner by qualified personnel; and (3) Delivered in accordance with the patient's plan	L 655		

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L 655	Continued From page 19 of care. This STANDARD is not met as evidenced by: Based on review of written contractual agreements and hospice staff interview, the hospice failed to ensure the written agreement between the hospice and 2 of 3 sampled services under arrangement included all of the required contract components. The hospice reported a total of 26 written agreements for services under arrangement with companies at the time of the survey. Failure to include the required contract components within the contractual agreement increased the potential that hospice management and oversight failed to occur and the patient would not receive services as specified on the plan of care. Findings include: 1. A medical equipment and supply contract, dated 3/15/13, failed to include the following contractual language: the hospice retains administrative management, the hospice maintains oversight of staff and services, all services are authorized by the hospice, and all services are delivered in accordance with the patient's plan of care. 2. A pharmacy contract, dated 3/24/21, failed to include the following: the hospice retains administrative management, the hospice maintains oversight of staff and services, and all services are delivered in accordance with the patient's plan of care.	L 655		

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L 655	Continued From page 20 The surveyor reviewed the above findings with the Administrator and hospice staff provided no further information prior to the end of the survey.	L 655		
L 679	AUTHENTICATION CFR(s): 418.104(b) All entries must be legible, clear, complete, and appropriately authenticated and dated in accordance with hospice policy and currently accepted standards of practice. This STANDARD is not met as evidenced by: Based on clinical record review, hospice policy review and hospice staff interview, the hospice failed to ensure all entries completed in the patient electronic clinical records were signed, locked within the required time frame, and included accurate discipline credentials for 9 of 13 sampled patients (Patients #1, #3, #4, #5, #6, #8, #10, #12 and #13). The hospice reported a current census of 34 patients. Failure to ensure all clinical record documentation included accurate information and were completed timely may result in ineffectively coordinated patient care. Findings include: Review of the hospice's policy, titled Data Collection and Review, dated 7/2020, identified documentation is completed within two business days after the day of the visit, regular business days defined as Monday through Friday not including holidays.	L 679		

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L 679	Continued From page 21 During an interview on 4/6/21 at 10:04 AM, the Hospice Administrator reported all documentation is to be completed by two business days after the day of the visit. 1. Patient #4 was admitted to hospice on 12/3/2020 and received services while residing in a nursing home. Clinical record review revealed the following: a. The music therapy visit notes, dated 2/1, 2/8, 2/15, 2/24, 3/3, 3/12, 3/19 and 3/22/21, included an electronic signature with staff name but failed to identify the staff credentials. b. The handwritten paper massage therapy visit note, dated 2/18/21, included a handwritten signature with the staff name but failed to identify the staff credentials. c. The volunteer visit notes, dated 2/7 and 2/21/21, was marked as completed on 3/6/21 and 3/19/21 and 9 days late per hospice policy. 2. Patient #13 was admitted to hospice on 12/15/2020, received services while residing in a private home and had a discharge date of 2/17/21. Clinical record review revealed the following: a. The music therapy visit notes, dated 12/23, 12/29/21 and 1/6/21, included an electronic signature with staff name but failed to identify the staff credentials. b. The hospice aide visit notes, dated 1/11 and 1/14/21, was marked as completed on 1/19/21, 4 and 1 days late per hospice policy.	L 679		

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L 679	Continued From page 22 c. The hospice aide visit note, dated 1/29/21, was marked as completed on 2/4/21, 2 days late per hospice policy. 3. Patient #3 was admitted to hospice on 12/8/2020 and received services while residing in a nursing home. Clinical record review revealed the skilled nursing visit note, dated 2/1/21, was marked as completed on 2/4/21, 1 day late per hospice policy. 4. Patient #12 was admitted to hospice on 2/19/21, received services while residing in a private home and had a discharge date of 3/27/21. Clinical record review revealed the social work visit note, dated 2/24/21, was marked as completed on 3/1/21, 1 day late per hospice policy. 5. Patient #5 had a hospice admission date of 9/30/2020, and received hospice services while residing in a nursing home. Clinical record review revealed the following: a. The massage therapy visit note, dated 2/10/2021 and 3/10/2021, was electronically signed as completed but failed to include a title. b. The IDG notes failed to identify the date of staff meeting for coordination of services. 6. Patient #8 had a hospice admission date of 12/1/2020, and received hospice services while residing in a private home residence.	L 679		

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L 679	Continued From page 23 Clinical record review revealed the following: a. The volunteer visit note, dated 2/4/21 and 2/18/21, failed to include a signature and title. 7. Patient #1 had a hospice admission date of 2/12/21 and received hospice services while residing in a private home residence. Clinical record review revealed the skilled nurse narrative note, dated 2/10/21, included a electronic signature of completion of 2/15/21, 1 day late according to hospice policy. 8. Patient #6 had a hospice admission date of 3/12/21 and received hospice services while residing in a nursing home. Clinical record review revealed music therapy visit notes, dated 3/17, 3/24, 3/30, and 4/6/21, included a handwritten signature and date of completion. The signature lacked inclusion of the credentials or title of the music therapist. 9. Patient #10 had a hospice admission date of 2/8/21 and received hospice services while residing in a private home residence. Clinical record review revealed: a. The massage therapy visit note, dated 2/18/21, included a handwritten signature and date of completion. The signature lacked inclusion of the credentials or title of the massage therapist. b. The music therapy visit notes, dated 2/15, 2/24, 3/3, 3/10, 3/17, 3/23, and 3/30/21, included a handwritten signature and date of completion.	L 679		

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L 679	Continued From page 24 The signature failed to include the credentials or title of the music therapist. The above findings for Patients #1, #3, #4, #5, #6, #8, #10, #12 and #13 were reviewed with Hospice Administrator and Clinical Manager. Hospice staff provided no further information prior to the end of the survey.	L 679		
L 683	DISCHARGE OR TRANSFER OF CARE CFR(s): 418.104(e)(2) (2) If a patient revokes the election of hospice care, or is discharged from hospice in accordance with §418.26, the hospice must forward to the patient's attending physician, a copy of- (i) The hospice discharge summary; and (ii) The patient's clinical record, if requested. This STANDARD is not met as evidenced by: Based on clinical record review and staff interview, the hospice failed to ensure the hospice staff sent a copy of a discharge summary to the attending physician for 1 of 2 sampled (live) discharged patients (Patient #12). The hospice reported a total of 7 live discharge in the past 3 months. Failure to ensure the hospice staff included the attending physician in the process for imminent discharge placed the patient at risk for not receiving ongoing medical care and services to meet the needs of the patients. Findings: During an interview on 4/8/21 at 9:00 AM, the	L 683		

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L 683	Continued From page 25 Clinical Manager reported the discharge order, summary and medication list are faxed to the hospice medical director and attending physician. Patient #12 was admitted to hospice on 2/19/21, received services while residing in a private home and had a discharge date of 3/27/21. The discharge summary, dated 3/26/21, lacked documentation the discharge summary was forwarded to the patient's attending physician. During an interview on 4/8/21 at 10:10 AM, the Administrator reviewed the discharge summary and confirmed the sheets lacked proof of being faxed to the attending physician. The medical director would have received a paper copy of the discharge summary at the interdisciplinary group meeting after the discharged. The Administrator received the above findings and hospice staff provided no further information prior to the end of the survey.	L 683		
L 795	CRIMINAL BACKGROUND CHECKS CFR(s): 418.114(d)(1) The hospice must obtain a criminal background check on all hospice employees who have direct patient contact or access to patient records. Hospice contracts must require that all contracted entities obtain criminal background checks on contracted employees who have direct patient contact or access to patient records. This STANDARD is not met as evidenced by: The Iowa Code, Chapter 135C.33 requires hospice agencies to complete a criminal history, a	L 795		

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dependent adult abuse, and child abuse record check on all prospective direct or contracted employees with the potential for direct patient contact, within 30 days prior to the date of hire, using either the Iowa Single Information Repository (SING), or using both the Iowa Department of Criminal Investigation (DCI) to conduct the criminal background check, and using the Iowa Department of Human Services to conduct the dependent adult abuse and child abuse background checks.

The Iowa Administrative Code, Chapter 119, requires the hospice agency to obtain authorized clearance from the Department of Human Services (DHS) prior to hiring any prospective employee who DCI has reported has a criminal record for any conviction more severe than a simple misdemeanor.

Based on review of employee personnel files and staff interview, the hospice failed to ensure completion of a criminal background check for 4 of 7 sampled employees and volunteers who began serving hospice patients since their last survey, dated 7/16/18.

The hospice reported a current census of 34 patients.

Failure to complete criminal background checks as required by Federal regulation, increased the potential risk of harm to agency patients from hospice staff and volunteers who had direct patient contact.

Findings include:

1. Staff E, Licensed Practical Nurse, had a hire

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ESSENCE OF LIFE HOSPICE	3207 220TH TRAIL AMANA, IA 52203

(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
L 795	Continued From page 27 date of 11/12/18. Staff E's personnel file contained a criminal background check, dated 10/9/18, 34 days prior to the hire date. 2. Staff F, Massage Therapist, had a hire date of 12/19/19. Staff F's personnel file contained a criminal background check, dated 8/26/19, 115 days prior to the hire date. During an interview on 4/8/21 at 11:25 AM, the Administrator reported Staff F was offered an as needed job position in August so the background check was completed prior to the job offer being extended but she was unable to complete the orientation until December. 3. Staff G, Volunteer, had a hire date of 7/25/19. Staff G's personnel file contained a criminal background check, dated 6/6/19, 49 days prior to the hire date. 4. Staff H, Volunteer, had a hire date of 7/27/2020. Staff H's personnel file contained a criminal background check, dated 5/28/2020, 60 days prior to the hire date. The Administrator was notified of the above findings. No further information was provided prior to the end of the survey.	L 795		

POC accepted on 4/20/21 with date of correction 5/19/21. See 2567 – B. Rasmussen

Jacquela Aanestad
Administrator
4/19/2021

Essence of Life Hospice Amana, IA #16-1580 Survey ending 4/8/2021

Document written 4/19/2021

Jacqueline Aanestad, Administrator signing document

L 531 CONTENT OF COMPREHENSIVE ASSESSMENT 418.54(c)(7)

An initial bereavement assessment of the needs of the patient's family and other individuals focusing on the social, spiritual, and cultural factors that may impact their ability to cope with the patient's death. Information gathered from the initial bereavement assessment must be incorporated into the plan of care and considered in the bereavement plan of care.

Failure to complete an initial bereavement assessment increased the risk that patient or family caregiver grieving, and bereavement needs would not be addressed appropriate, leading to prolong or dysfunctional grieving and potentially increased the risk of self-harm for hospice patients or survivors.

This concern was reviewed on 4/8 and 4/9 with Social workers, 4/12, and 4/13 with nursing and social workers to review procedures for collecting the initial bereavement assessment and then reviewed what to do if SW was unable to meet patient/family or answer assessment questions in 5 days. Social Work will perform the assessment in 5 days, if unable then they will contact the nurse to complete the assessment before the end of 5 days for the comprehensive plan of care.

Additional Review will take place at QAPI meeting on 4/21/2021

Clinical charts will be reviewed at 25% of active charts monthly to ensure these items are met by social work and or nursing. Charts will be reviewed for 6 months to ensure compliance. This information will be reported to the QAPI report team monthly and to the managing member. After 6 months, ongoing monitoring will continue quarterly using a PIP tool with a minimum of 10% of charts audited by Patient Care coordinator or designee.

Overall responsibility of this item falls to the Administrator and designee. It will be completed by 5/19/2021.

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L 543 PLAN OF CARE CFR S: 418.56(b)

All hospice care and services furnished to patient and families must follow an individualized written plan of care established by the hospice interdisciplinary group in collaboration with the attending physician (if any), the patient or representative, and the primary caregiver in accordance with the patient's needs if any of them so desire

Failure to follow the patients plan of care as directed by the interdisciplinary group put the patient at risk for inconsistent care that may not meet the needs of the patient.

Specifically, the delay in physician orders for wound care and nurses not following plan of care for assessment of patient.

Met with nursing staff on 4/8,4/9, 4/12, 4/14 to review interventions and how to obtain orders for wounds. Reviewed care plan interventions and added specifications for the Interventions to meet needs of patient assessment. Updated interventions were put in place on 4/19/2021

Reviewed policy on plan of care

Additional Review will take place at QAPI meeting on 4/21/2021

Clinical charts will be reviewed at 25% of active charts monthly to ensure orders are written and sent at time of implementation and interventions frequencies are met by nursing. Charts will be reviewed for 6 months to ensure compliance. This information will be reported to the QAPI report team monthly and to the managing member. After 6 months, ongoing monitoring will continue quarterly using a PIP tool with a minimum of 10% of charts audited by Patient Care coordinator or designee.

Overall responsibility of this item falls to the Administrator and designee. It will be completed by 5/19/2021.

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L547 Content of plan of care418.56© (2)

Plan of care necessary for the palliation and management of the terminal illness and related conditions including the following: 2) A detailed statement of the scope and frequency of services necessary to meet the specific patient and family needs.

Failure to identify a scope and frequencies for all ordered services increased the potential for hospice services to not adequately meet the needs of hospice patients and families.

Met with each department Nursing, Social Work, Spiritual, Music, and Massage to review orders for scope and frequency of PRN orders. Meeting on 4/8,4/9/4/12,4/14. Each patient's orders were reviewed and re written to create a more specific plan of care to meet their needs.

Additional Review will take place at QAPI meeting on 4/21/2021

Clinical charts will be reviewed at 25% of active charts monthly to ensure these items are met by all disciplines. Charts will be reviewed for 6 months to ensure compliance. This information will be reported to the QAPI report team monthly and to the managing member. After 6 months, ongoing monitoring will continue quarterly using a PIP tool with a minimum of 10% of charts audited by Patient Care coordinator or designee.

Overall responsibility of this item falls to the Administrator and designee. It will be completed by 5/19/2021.

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L579 PREVENTION CFR 418.60(a)

Hospice must follow the accepted standard of practice to prevent the transmission of infections and communicable diseases including the use of standard precautions.

Failure to ensure services during home visits follow accepted standard of practice for infection control increased the risk of contamination during the home visit, the development of an infection and or transmission of organisms from home to home.

Specifically, infection issues with bag technique and between tasks of contamination.

Met with all staff on 4/9/2021, and each department to review infection control policy. All staff viewed video on proper bag technique and completed infection control training course. Each staff will perform demonstration of bag technique and had staff supervisory visit. This training is done at hire and annually during our meeting yearly review and competency training.

Additional Review will take place at QAPI meeting on 4/21/2021

Overall responsibility of this item falls to the Administrator and designee. It will be completed by 5/19/2021.

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L 647 Level of Activity 418.78 (e) Volunteers must provide day to day administrative and or direct patient care services in an amount that at minimum equals 5 % of the total patient care hours of all paid hospice employees and contract staff. The hospice must maintain records on the use of volunteers for patient care and administrative services including the type of services and time worked.

Failure to maintain volunteer hours for hospice patients put the patients and families at risk of not receiving the services necessary to meet the needs of the patients and puts the hospice at risk of not providing all regulatory requirements for the hospice program.

Specifically, that our volunteers only provided 4/3% for 2019

During this time we had 2 significant volunteers move away and leave during winter months. We also had a new coordinator start. Administration met with Volunteer Coordinator on 4/13 and 4/16 to review when and how to utilize volunteers and recruitment. A plan to develop new volunteers and utilize the current ones more often.

Each month volunteer hours will be calculated to determine status and create additional opportunities for volunteers. Creating additional recruitment events will also be developed once the pandemic is over and allowing more interaction. Monitoring this monthly and report to QAPI and managing member.

Additional Review will take place at QAPI meeting on 4/21/2021

Overall responsibility of this item falls to the Administrator and designee. It will be completed by 5/19/2021.

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L 655 Professional Management Responsibility 418.100(e)

A hospice that has a written agreement with another agency, individual or organization to furnish any services under arrangement must retain administrative and financial management, and oversight of staff and services for all arranged services, to ensure the provision of quality care Arranged services must be supported by written agreements that require all services be

1. **Authorized by the hospice**
2. **Furnished in a safe and effective manner by qualified personnel and**
3. **Delivered in accordance with the patients plan of care**

Failure to include the required contract components within the contractual agreement increased the potential that hospice management and oversight failure to occur and the patient would not receive services specified on the plan of care.

Specifically DME and Pharmacy contracts did not include every required provision to furnish their services:

4/14 emailed with DME, reviewed items missing in the current contract (hospice retains administrative management, oversite of staff and services, all services are authorized by the hospice, and all services are delivered in accordance with the hospice plan of care); a revised contract was written also discussed

4/14 contacted pharmacy administrator about items missing in the current contract (hospice retains administrative management, oversight of staff and services and all services are authorized by the hospice); a revised contract was written and signed on 4/16/2021.

Annual Review of all contracts will be performed to ensure all items are in compliance. Overall responsibility of this item falls to the Administrator and designee. To be completed by 5/19/2021

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L 679 Authentication 418.104 (b)

All entries must be legible, clear, complete, and appropriately authenticated and dated in accordance with hospice policy and currently accepted standards of practice.

Failure to ensure all clinical record documentation included accurate information and were completed timely may result in ineffectively coordinated patient care.

Specifically missing credentials on signatures and late documented visit notes.

4/8/2021 email to Music and Massage staff to instruct on making sure credentials were with all signature and designation of title. The electronic signature was corrected on 4/9/2021. 4/9/2021 all staff were re instructed in documentation policy of 2 business days. Staff signed off on policy review

Additional Review will take place at QAPI meeting on 4/21/2021

Clinical charts will be reviewed at 25% of active charts monthly to ensure credential are on documentation and timely items are met by staff. Charts will be reviewed for 6 months to ensure compliance. This information will be reported to the QAPI report team monthly and to the managing member. After 6 months, ongoing monitoring will continue quarterly using a PIP tool with a minimum of 10% of charts audited by Patient Care coordinator or designee.

Overall responsibility of this item falls to the Administrator and designee. It will be completed by 5/19/2021.

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L 683 DISCHARGE OR TRANSFER OF CARE 418.104 (e)(2)

2 If a patient revokes the election of hospice care or is discharged form hospice in accordance with 418.26 the hospice must forward to the patient attending physician a copy of the hospice discharge summary and the patient clinical record if requested

Failure to ensure the hospice staff included the attending physician in the process for imminent discharge placed the patient at risk for not receiving ongoing medical care and services to meet the needs of the patient.

Specifically, that the complete discharge summary was not sent to physicians and returned.

Met with nursing staff on 4/9 and 4/12,4/14 and office staff. Reviewed regulation and modified discharge summary to include a physician verification of receiving all information. By returning this form it verifies the receiving of the information.

Additional Review will take place at QAPI meeting on 4/21/2021

Clinical charts will be reviewed at 25% of discharged charts monthly to ensure these items are met by staff. Charts will be reviewed for 6 months to ensure compliance. This information will be reported to the QAPI report team monthly and to the managing member. After 6 months, ongoing monitoring will continue quarterly using a PIP tool with a minimum of 10% of charts audited by Patient Care coordinator or designee.

Overall responsibility of this item falls to the Administrator and designee. It will be completed by 5/19/2021.

Essence of Life Hospice Amana, IA #16-1580 Survey ending 4/8/2021

L 795 CRIMINAL BACKGROUND CHECKS 418.114 (d) (1)

The hospice must obtain a criminal background check on all hospice employees who have direct patient contact or access to patient records. Hospice contracts must require that all contracted entities obtain criminal background checks on contracted employees who have direct patient contact or access to patient records.

Failure to complete criminal background checks as required by Federal regulation, increased the potential risk of harm to agency patients from hospice staff and volunteers who had direct patient contact.

Specifically, background checks were done beyond 30 days before employee or volunteer starts dates. On 4/8 met with staff in charge of performing background check and orientation on boarding. Reviewed state regulations and how to implement this in the onboarding check list.

Quarterly starting May 2021, all new hire HR files will be reviewed to ensure these requirements are met by hospice and volunteer staff. This information will be reported to the QAPI report team quarterly and to the managing member.

Overall responsibility of this item falls to the Administrator and designee. It will be completed by 5/19/2021.