STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	151561	A. BUILDING 00 B. WING	08/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HEART TO HEART HOSPICE OF EASTERN INDIANA LLC	1178 FREMONT COURT SUITE 2 ELKHART, IN 46516

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S 0000 Bldg. 00	This visit was for a State Complaint survey of a Deemed Hospice provider. Survey Dates: 08/30/2022-08/31/2022 Complaint Number: IN003888787- Substantiated; State deficiencies were cited. Census: 65 Facility Number: 010002 Provider Number: 151561 QR: Area 2, 9/8/22	S 0000		
S 0503 Bldg. 00	418.52(a)(2) NOTICE OF RIGHTS AND RESPONSIBILITIES (2) The hospice must comply with the requirements of subpart I of part 489 of this chapter regarding advance directives. The hospice must inform and distribute written information to the patient concerning its policies on advance directives, including a description of applicable State law. Based on record review and interview, the agency failed to ensure the patients' designated durable medical power of attorney received patient condition updates and was permitted to participate in decision making for the patient for 1 of 3 records reviewed of patients residing in skilled nursing facilities (Patient #3). Findings include:	S 0503	The Executive Director (ED), Patient Care Manager (PCM) and/or the Area Clinical Manager (ACM) will educate all staff responsible for admissions, Registered Nurse Case Manager (RNCM) and Social Workers (SW) on policy RI.2 titled Advanced Directives and policy RI.1 IN tilted Patient Rights and	09/30/2022

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

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	1. Review of an agency policy with revised date of 11/10/2015, titled "Advance Directives RI.2" stated on page 2, " Medical Power of Attorney A document that enables the patient to appoint someone they trust to make decisions about their medical care, if they cannot make those decisions themselves. ... may also be called ... appointment of a health care agent ... 2. ... Agency staff will inquire whether the patient has an advance directive at the time of the initial assessment. ... Agency staff will make every effort to obtain a copy of any patient's advance directive and file this copy in the medical record." 2. Review of an agency policy with revised date of 03/28/2022, titled "Patient Rights and Responsibilities RI.1 IN" Stated, "11. "In the event I, as the patient becomes incapacitated or deemed incompetent by a physician, have the right to have my health care decisions carried out by my family or legal representative." 3. The clinical record for Patient #3, included a scanned document titled "Indiana Health Care Representative Appointment," signed and dated by witness on 06/15/22, that relayed the individual Other A was appointed as patient's health care representative. A. Review of the nurse Visit Note Report, dated 06/27/22 signed by registered nurse [RN] #1, indicated individual Other D was updated after the visit and failed to evidence the hospice contacted patients' health care representative, Other A, regarding the update. B. Review of the nurse Visit Note Report, dated 06/28/22 signed by RN #3, indicated individual Other D was updated by phone and notified of		Responsibilities to ensure the patient's designated durable medical power of attorney receives patient condition updates and is able to participate in decision making. The Executive Director (ED) and Patient Care Manager (PCM) will be responsible to ensure a durable medical power of attorney is obtained when indicated as well as honoring the durable medical power of attorney when it is warranted regarding patients change in condition as well as participating in decision making. The Area Clinical Manager (ACM)/designee will audit 25% of active patient records with a known durable medical power of attorney to ensure the legal document is present as well as well as to ensure, when warranted, the durable medical power of attorney is being notified of patients change of condition and included in decision making when the patient can no longer make decisions on their own until 100% of compliance is met. If non-compliance is identified during the audits, the employee will be identified and one on one education will occur. After compliance has been met, ongoing audits of 10% of the records will occur through the QAPI process. Audit findings will	

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	new orders and failed to evidence the hospice contacted Other A, patients' health care representative, regarding the patient's new orders. C. Review of an agency document titled "Coordination Notes Report" signed and dated 06/29/22, noted to be a late entry for 06/28/2022 prn (as needed) visit by RN #3 indicated " ... phoned Other D with update on patient condition ... Other D verbalized ... wanted no further interventions such as surgery for the wound ...." The documentation failed to evidence the agency contacted patients' health care representative, Other A, regarding the patient update and failed to evidence the patients' health care representative made the decision regarding wound care. D. Review of an agency document titled "Coordination Notes Report" signed and dated 06/29/22 by RN #3, indicated " ... would contact Other D ... agency records indicated Other D is POA ... per Other F at facility POA is ... Other A ...." E. Review of an agency document titled "Coordination Notes Report" signed and dated 07/05/22 by RN #1, indicated " ... Other D ... updated after visit ...." The documentation failed to evidence the hospice contacted patients' health care representative, Other A, regarding the patient update. F. During an interview on 08/30/22 at 11:08 AM, Other A indicated at the time Patient #3 was admitted to the hospice, the hospice had a conference call that included Other A and Other B. Other B sent a copy of the patients' medical power of attorney paperwork to the hospice agency. Other A indicated this was the only time		be reported through QAPI quarterly and reviewed by the Governing Body.	

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	the hospice agency spoke with him / her on the phone about Patient #3. Other A indicated had made calls to hospice agency for patient updates and had been told by the hospice agency they would not speak with him / her because they did not have the medical power of attorney paperwork for Other A. G. During an interview on 08/30/2022 at 12:48 PM, Other A indicated Patient #3 and Other D resided together, were not legally married. H. During an interview on 08/31/2022 at 2:40 PM, when asked why the agency would not contact the healthcare representative with patient information, the clinical supervisor indicated the agency must verify the individual calling is included in the patients' contact list and the hospice initially did not have the durable medical power of attorney paperwork.			
S 0512 Bldg. 00	418.52(c)(1) RIGHTS OF THE PATIENT The patient has a right to the following: (1) Receive effective pain management and symptom control from the hospice for conditions related to the terminal illness; Based on record review and interview, the agency failed to ensure the patient received timely symptom control from the hospice for conditions related to the terminal illness in 1 of 3 records reviewed of patients residing in skilled nursing facilities (Patient #1). Findings include: Review of an agency policy with revised date of 03/28/2022, titled "Patient Rights and Responsibilities RI.1 IN" indicated " ... every	S 0512	The Executive Director (ED), Patient Care Manager (PCM) and/or the Area Clinical Manager (ACM) will educate all Registered Nurse Case Managers (RNCM) and on call staff on policy TX.2 titled On Call for Patient C and policy RI.1 Patients Rights and Responsibilities to ensure all patients will receive timely response after hours and timely symptom control from the hospice related to the terminal illness.	09/30/2022

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	patient and family has the right ... to receive ... symptom control from the hospice for the conditions related to the terminal illness ...." Review of an agency policy with revised date of 08/16/2007, titled "On Call for Patient Care" indicated " ... purpose ... to ensure that patient care needs will be met safely and appropriately after agency office hours ...." Review of an agency document with revised date of 05/11/2015, titled "Opportunity for Improvement", signed and dated 08/17/22 by the administrator indicated Other C called triage, at 3 PM on 8/13/22, regarding Patient #1 due to Patient was very lethargic (sleepy) and would not wake up. No phone calls for the estimated time of arrival of the nurse was made to Other C. The on call nurse arrived to the facility to see Patient 5 hrs after the phone call to triage. Record review for Patient #1, included an agency document dated 08/25/22 and titled "IDG (interdisciplinary group) Summary Report" that indicated "pt has had increased anxiety over benefit period and received new orders for routine Lorazepam (to decrease anxiety) 0.5 mg (milligrams) TID (three times a day) on 8/8/22 and then decreased to BID (twice a day) routine on 8/15/22 following a prn (as needed) visit for pt due to report of pt being lethargic ... pt also received new order for Keflex (antibiotic) for possible UTI (urinary tract infection) due to symptoms of increased confusion and increased drowsiness ...." Review of an agency document dated 08/13/2022, titled "Visit Note Report" signed and dated 08/15/22 by LPN #1, indicated " ... in-home time ... began ... 08/13/2022 ... 08:05 PM ... OCV (on call		The Executive Director (ED) and Patient Care Manager (PCM) will be responsible to ensure patients will receive timely after hours services, and symptom control from the hospice related to the terminal illness. The Area Clinical Manager (ACM)/designee will audit 25% of patient records to ensure patients are receiving timely response after hours and timely symptom management from the hospice related to the terminal illness until 100% of compliance is met. If noncompliance is identified, the responsible employee will be identified, and one on one education will occur. Ongoing, 10% of records will be reviewed through the QAPI process. Audit findings will be reported through QAPI quarterly and reviewed by the Governing Body.	

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	visit) r/t (related to) increase fatigue ... appears to be tired ...." During an interview on 08/31/22 at 2:40 PM, the administrator indiocated 5 hours was not an acceptable time period to wait for a nurse to call back regarding a Patient concern or to make a visit to a patient with symptoms.			
S 0555 Bldg. 00	418.56(e)(2) COORDINATION OF SERVICES [The hospice must develop and maintain a system of communication and integration, in accordance with the hospice's own policies and procedures, to-] (2) Ensure that the care and services are provided in accordance with the plan of care. Based on record review and interview, the agency failed to ensure hospice services were provided according to the plan of care for 1 of 2 records reviewed of patients receiving wound care (Patient #3). Findings include: 1. Review of an agency policy with revised date of 01/01/2020, titled "Plan of Care Process TX.06" indicated " ... purpose ... to ensure that the care provided is in accordance with the written plan of care ... the POC (plan of care) includes ... designation of discipline(s) responsible for providing specific services ...." 2. The clinical recoord for Patient #3, included an agency document titled "Order Number: 896635" dated 06/07/22 for the beneift period 6/14/22 to 08/12/22 with physician orders for a skilled nurse visit three times weekly that relayed 1) Hospice nurse to cleanse unstageable wound (wound bed	S 0555	The Executive Director (ED), Patient Care Manager (PCM) and/or the Area Clinical Manager (ACM) will educate all Registered Nurse Case Managers (RNCM) and admission nurses on policy TX.06 titled Plan of Care Process and on policy PE 1 "Patient Assessments" with a focus on identifying that the assessments will utilize standard assessment tools to include assessment of skin integrity, and to ensure hospice services are provided according to the plan of care. The Executive Director (ED) and Patient Care Manager (PCM) will be responsible to ensure patients will receive complete assessments and that services are provided according to the plan of care.	09/30/2022

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	that cannot be visualized in order to stage the wound, the depth of the wound) to the right ischial tuberosity (sit bone, the bone at the bottom of the pelvis that makes contact with a surface when a person is sitting down) with clean gauze and wound cleanser, apply medihoney (mixture of two honeys which act as an antibacterial) to wound bed, cover wound with border dressing, once weekly, and measure wound once weekly. Facility nurse to provide wound care, as ordered, every other day and prn (as needed) for soiled or dislodged dressing. 2)Hospice nurse to cleanse STII (stage 2 wound that looks like an open wound or a blister) wound to coccyx (tailbone) with clean gauze and wound cleanser, apply barrier cream (barrier against irritation from body fluids), cover wound with border dressing once weekly and measure wound once weekly and the facility nurse to provide wound care as ordered every other day and prn for soiled or dislodged dressing. A. Review of agency documents dated 06/14/2022, titled "Order 905258" indicated Right ischium pressure ulcer (damage to an area of the skin caused by pressure on the area): using clean technique, cleanse wound with normal saline, pat dry with gauze, apply medihoney and aquacell (moisture-retention dressing with antimicrobial properties), cover with gauze dressing. Right ischium dressing to be performed every other day by facility skilled nurse, hospice nurse to measure weekly. B. The Skilled Nurse Visit Note dated 06/14/22 and completed by licensed practical nurse (LPN) #2 documented no problems identified for the integumentary (skin) assessment, and that the facility nurse changed the coccyx dressing early in the day and the right ischium wound was		The Area Clinical Manager (ACM)/designee will audit 100% of patient records that have a wound to ensure patient's wounds are treated according to the plan of care until 100% of compliance is met. If noncompliance is identified during the audit, the responsible employee will be identified, and one on one education will occur. After compliance has been met, ongoing, 10% of records with wounds will be reviewed quarterly. Audit findings will be reported through QAPI quarterly and reviewed by the Governing Body.	

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	assessed. The documentation failed to evidence the hospice nurse assessed the ischium or coccyx wounds nor measurements, as per the plan of care. C. The Skilled Nurse Visit Note dated 06/15/22 and completed by LPN #2 relayed patient's coccyx wound dressing was changed by the facility nurse and measured. The documentation failed to evidence the hospice nurse assessed the ischium or coccyx wounds, with measurements and per the plan of care. D. The Skilled Nurse Visit Note dated 06/16/22 and completed by LPN #2 documented no problems were identified with the patient's integumentary assessment and the wound dressing to coccyx was changed this morning by facility nurse and measured. The documentation failed to evidence the hospice nurse assessed the ischium nor the coccyx wounds, with measurements and per the plan of care. E. The Skilled Nurse Visit Note dated 06/19/22 and completed by registered nurse #2 documented no problems were identified with Patient's integumentary assessment and failed to evidence the hospice nurse assessed the ischium nor the coccyx wounds, with measurements and according to the plan of care. F. The Skilled Nurse Visit Note dated 06/20/22 and completed by LPN #2, documented the wound dressing to patient's coccyx was changed that morning by facility nurse and was measured. The documentation relayed the nurse did not assess the patient's right ischium wound nor the coccyx wound because the caregiver completed the care. The documentation failed to evidence the hospice nurse assessed the ischium or coccyx wounds,			

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	including measurements, according to the plan of care. G. The Skilled Nurse Visit Note dated 06/23/22 and completed by LPN #2, documented they did not assess neither the coccyx nor the right ischium wounds during the visit, documented the caregiver provided the care. The documentation failed to evidence the hospice nurse assessed the ischium or coccyx wounds, with measurements according to the plan of care. H. The Skilled Nurse Visit Note dated 06/27/22 and completed by RN #1, and documented staff wound nurse performed wound care that morning, and report was received, patient's unstageable to right ischium wound remained unchanged and that wound care was provided by facility nurse. The documentation failed to evidence the hospice nurse assessed the ischium wound, with measurements, and according to the plan of care. I. The Skilled Nurse Visit Note dated 06/28/22 and completed by RN #3, documented the right ischium wound was not assessed nor was care provided due to the caregiver completed care. The documentation failed to evidence the hospice nurse assessed the ischium wound, including measurements, according to the plan of care. J. The Skilled Nurse Visit Note dated 06/29/22 and completed by RN #2 documented the right ischium wound was not assessed, nor was care provided because the caregiver completed the wound care. The documentation failed to evidence the hospice nurse assessed the ischium wound, including measurements, according to the plan of care. K. The Skilled Nurse Visit Note dated 7/05/22 and			

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	completed by RN #1 documented facility staff wound nurse performed wound care that morning, and report was received, patient with unstageable toright ischium wound, remained unchanged. The documentation failed to evidence the hospice nurse assessed the ischium wound, including measurements, according to the plan of care. L. During an interview on 08/31/22 at 2:40 PM, the clinical supervisor indicated the hospice nurse was to assess and measure the wounds weekly, as ordered.			
S 0762 Bldg. 00	418.112(b) PROFESSIONAL MANAGEMENT The hospice must assume responsibility for professional management of the resident's hospice services provided, in accordance with the hospice plan of care and the hospice conditions of participation, and make any arrangements necessary for hospice-related inpatient care in a participating Medicare/Medicaid facility according to §418.100 and §418.108. Based on record review and interview, the agency failed to maintain professional management of the patient's plan of care for 1 of 3 records reviewed of patients residing in skilled nursing facilities (Patient #3). Findings include: 1. Review of an agency document with revised date of 04/01/2016, titled "Hospice Services Agreement" between agency and facility B indicated " ... provision of services ... hospice ... maintain professional management responsibility/coordination of facility services and ensure services are furnished in a safe, timely, and	S 0762	The Executive Director (ED), Patient Care Manager (PCM) and/or the Area Clinical Manager (ACM) will educate all Registered Nurse Case Managers (RNCM) on policy Tx.06 titled Plan of Care Process, policy PE.01 titled Patient Assessments and the document Hospice Service Agreement to ensure professional management is maintained of the patients plan of care. The Executive Director (ED) and Patient Care Manager (PCM) will be responsible to ensure	09/30/2022

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	effective manner, according to the plan of care ...." 2. Review of an agency policy with revised date of 01/01/2020, titled "Plan of Care Process TX.06" indicated " ... purpose ... to ensure that the care provided is in accordance with the written plan of care ...." 2. The clinical record for Patient #3, included an agency document titled "Order Number: 896635" dated 06/07/22 for the benefit period 6/14/22 to 08/12/22 with physician orders for a skilled nurse visit three times weekly that relayed 1) Hospice nurse to cleanse unstageable wound (wound bed that cannot be visualized in order to stage the wound, the depth of the wound) to the right ischial tuberosity (sit bone, the bone at the bottom of the pelvis that makes contact with a surface when a person is sitting down) with clean gauze and wound cleanser, apply medihoney (mixture of two honeys which act as an antibacterial) to wound bed, cover wound with border dressing, once weekly, and measure wound once weekly. Facility nurse to provide wound care, as ordered, every other day and prn (as needed) for soiled or dislodged dressing. 2)Hospice nurse to cleanse STII (stage 2 wound that looks like an open wound or a blister) wound to coccyx (tailbone) with clean gauze and wound cleanser, apply barrier cream (barrier against irritation from body fluids), cover wound with border dressing once weekly and measure wound once weekly and the facility nurse to provide wound care as ordered every other day and prn for soiled or dislodged dressing. A. Review of agency documents dated 06/14/2022, titled "Order 905258" indicated Right ischium pressure ulcer (damage to an area of the skin		professional management is maintained related to wound care assessments completed at least every 7 days according to the plan of care. The Area Clinical Manager (ACM)/designee will audit 100% of patient records that have a wound to ensure all nurses are maintaining professional management of wounds by completing a wound assessment at least according to the plan of care until 100% of compliance is met. If noncompliance is identified during the audit, the responsible employee will be identified, and one on one education will occur. After compliance has been met, ongoing, 10% of records with wounds will be reviewed quarterly. Audit findings will be reported through QAPI quarterly and reviewed by the Governing Body.	

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HEART TO HEART HOSPICE OF EASTERN INDIANA LLC	1178 FREMONT COURT SUITE 2 ELKHART, IN 46516

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	caused by pressure on the area): using clean technique, cleanse wound with normal saline, pat dry with gauze, apply medihoney and aquacell (moisture-retention dressing with antimicrobial properties), cover with gauze dressing. Right ischium dressing to be performed every other day by facility skilled nurse, hospice nurse to measure weekly. B. The Skilled Nurse Visit Notes dated 06/14/22, 6/15/22, 6/16/22, 6/19/22, 6/20/22, 6/23/22, 6/27/22, 6/27/22, 6/28/22, 6/29/22, and 7/05/22 failed to evidence the hospice nurse assessed the patient's wounds and measurements per the pan of care. C. During an interview on 8/31/22 at 1 PM, RN #1 relayed they used the measurements of the facility nurse on the skilled nurse visit notes of 6/2/22 and 7/05/22, and did not did not assess, measure, nor provide the wound care for their patient. D. During an interview on 8/31/22 at 2:40 PM, the clinical manager relayed the hospice was responsible for the professional management of a hospice patients' wound care, when patient resides in a nursing facility, unless it is otherwise agreed upon with the nursing facility. The clinical manager relayed the hospice nurse was to assess and measure the hospice patient's wounds weekly as ordered.			