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<tbody>
<tr>
<td>E 000</td>
<td>Initial Comments</td>
<td>A survey for Medicare certification was completed for Harrison County Hospice on 10/31/19. The agency had nine current patients. The Emergency Preparedness regulations were also reviewed as part of the Medicare certification survey completed on 10/31/19. One standard level deficiency was identified related to Emergency Preparedness. EP Training Program CFR(s): 418.113(d)(1) (1) Training program. The [facility, except CAHs, ASCs, PACE organizations, PRTFs, Hospices, and dialysis facilities] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. *For Hospitals at §482.15(d) and RHCs/FQHCs at §491.12:] (1) Training program. The [Hospital or RHC/FQHC] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training.</td>
<td>E 037</td>
<td>Please see attached.</td>
<td>12/31/19</td>
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E 037 Continued From page 1

(iv) Demonstrate staff knowledge of emergency procedures.

*[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following:
(i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles.
(ii) Demonstrate staff knowledge of emergency procedures.
(iii) Provide emergency preparedness training at least annually.
(iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others.

*[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following:
(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.
(ii) After initial training, provide emergency preparedness training at least annually.
(iii) Demonstrate staff knowledge of emergency procedures.
(iv) Maintain documentation of all emergency preparedness training.

*[For PACE at §460.84(d):] (1) The PACE organization must do all of the following:
(i) Initial training in emergency preparedness
E 037 | Continued From page 2

Policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles.

(ii) Provide emergency preparedness training at least annually.

(iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency.

(iv) Maintain documentation of all training.

*For CORFs at §485.68(d): (1) Training. The CORF must do all of the following:

(i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.

(ii) Provide emergency preparedness training at least annually.

(iii) Maintain documentation of the training.

(iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF’s emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment.

*For CAHs at §485.625(d): (1) Training program. The CAH must do all of the following:

(i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and
Continued From page 3
cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.
(ii) Provide emergency preparedness training at least annually.
(iii) Maintain documentation of the training.
(iv) Demonstrate staff knowledge of emergency procedures.

*For CMHCs at §485.920(d): (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least annually.

This STANDARD is not met as evidenced by:
Review of the agency's policy titled, "Volunteer Requirements/Documentation," showed that volunteers attend an orientation program specific to hospice services and the job/tasks to be performed and then listed what the orientation included. The list failed to include emergency preparedness.

Review of V-1's employee file showed:
- Date of hire was 04/30/19 for volunteer services; and
- Failed to show documentation of emergency preparedness training.

During an interview on 10/30/19 at 11:50 AM, the
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<tr>
<td>E 037</td>
<td>Continued From page 4 nursing supervisor stated that emergency preparedness training is not being done for volunteers on hire and annually.</td>
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<tr>
<td>L 531</td>
<td>CONTENT OF COMPREHENSIVE ASSESSMENT CFR(s): 418.54(c)(7)</td>
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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 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 policy review, record review, and interview, the social worker failed to identify the potential bereaved person when completing the admission bereavement assessment and only completed one bereavement assessment when the patient had more than one caregiver/family member involved in the direct care of the patient in, but not limited to, two (Records/Patients #2 and #3) out of five full record reviews completed. This deficient practice has the potential to affect the bereavement follow-up after the patient expires of all the patients served by the agency.

Findings included:

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<td>L 531</td>
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<td>Continued From page 5 showed:</td>
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<td>- The hospice bereavement plan of care will be developed based on an initial assessment of the patient and family/caregivers needs;</td>
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<td>- During the admission process, the social worker will complete a bereavement risk assessment; and</td>
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<td>- The bereavement social worker will review the bereavement risk assessment to determine potential needs of the survivors.</td>
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<td>RECORD/PATIENT #2: Review of the clinical record showed admittance of the patient on 09/24/19 with diagnoses of depression and failure to thrive. The patient lives in a long term care facility (LTCF).</td>
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<td>Review of the clinical record showed a hospice social worker assessment dated 09/25/19. The assessment:</td>
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<td>- Failed to identify the name of the caregiver giving information and staying with the patient that day; and</td>
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<td>- Showed the patient had two daughters and a son that were listed as caregivers.</td>
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<td>Review of the bereavement assessment and the social worker assessment dated 09/25/19 failed to show the name or identify the caregiver being evaluated for bereavement issues.</td>
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<td>RECORD/PATIENT #3: Review of the clinical record showed admittance of the patient on 09/13/19 with a primary diagnosis of chronic kidney disease, stage 4 (the kidneys are not working well) and other diagnoses of anemia (low red blood cell count), cardiovascular disease (heart and vein disease), diabetes mellitus II (an adult onset endocrine</td>
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</table>
| L 531 | Please see attached. | 12/31/19 | Continued From page 6 disease that causes high blood sugars) and right heel pressure ulcer (a wound caused by continuous pressure to a body part). The patient is cared for by adult children in the home setting. Review of the clinical record showed a hospice social worker assessment dated 09/16/19. The assessment: - Failed to identify the name of the caregiver giving information and staying with the patient that day: and - Showed the patient had two daughters that were listed as caregivers. Review of the bereavement assessment and the social worker assessment dated 09/16/19 failed to show the name or identify the caregiver being evaluated for bereavement issues. During an interview on 10/30/19 at 12:00 PM, the social worker stated that he/she had reviewed the documentation of the initial bereavement assessments and agreed the documentation failed to include the name/relationship of the person assessed for potential bereavement risk. During an interview on 10/31/19 at 10:10 AM, the nursing supervisor stated that he/she would expect to see documentation of the identity of the person being assessed for bereavement. L 545 | CONTENT OF PLAN OF CARE CFR(s): 418.56(c) The hospice must develop an individualized written plan of care for each patient. The plan of care must reflect patient and family goals and interventions based on the problems identified in the initial, comprehensive, and updated.
L 545

Continued From page 7
comprehensive assessments. The plan of care must include all services necessary for the palliation and management of the terminal illness and related conditions, including the following:

This STANDARD is not met as evidenced by:
Based on policy review, record review, and interview, the agency failed to update the plan of care when there were problems identified and changes made based on the updated comprehensive assessment in one (Record/Patient #2) out of five full record reviews completed.
This deficient practice has the potential to affect the care provided to all the agency's patients.

Findings included:

Review of the agency's policy titled, "The Plan of Care," dated 04/2019, showed the following:
- The plan of care will be based on the ongoing comprehensive assessments performed by members of the interdisciplinary group (IDG); and
- Any changes in the patient's condition must result in a change in the plan of care.

RECORD/PATIENT #2:
Review of the clinical record showed admittance of the patient on 09/24/19 with diagnoses of depression and failure to thrive. The patient lived in a long term care facility (LTCF).

Review of the nursing visit note dated 09/27/19 showed:
- The LTCF nurse reported that he/she had to give as needed acetaminophen (mild pain reliever) due to the patient complaining of pain all
HARRISON COUNTY HOSPICE

Continued From page 8

- The patient has notable, scattered bruising mostly on both arms; and
- Documentation failed to show education or training completed on safe transfer techniques with the LTDCF staff or hospice aide.

Review of the 10/01/19 hospice interdisciplinary care plan failed to show an up-date to the plan of care (POC) to include:
- Interventions for education to LTDCF staff and hospice aide regarding transfer techniques or any equipment or supplies needed for safe transfers; and
- Updated goals and outcomes regarding safe transfers.

During an interview on 10/31/19 at 1:40 PM, the case manager (CM-1) stated that he/she:
- Addressed the issue about safe transfers with the LTDCF staff;
- Provided education to the LTDCF nurse and aides about safe transfers and the use of a gait belt;
- Provided a gait belt for patient use;
- Failed to document the education; and
- Failed to up-date the plan of care interventions, goals, and outcomes.

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:
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**(X1) PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER:** 261541

**(X2) MULTIPLE CONSTRUCTION**

A. BUILDING __________
B. WING __________

**(X3) DATE SURVEY COMPLETED** 10/31/2019

**NAME OF PROVIDER OR SUPPLIER**

**HARRISON COUNTY HOSPICE**

**STREET ADDRESS, CITY, STATE, ZIP CODE**

PO BOX 425
BETHANY, MO 64424

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| L 579         | Continued From page 9  
Based on Drugs.Com medication review, policy review, clinical record review, home visit observation, and interview, the agency failed to ensure basic standards of practice for infection control were maintained during a home visit for bag technique and in the use of non-bacteriostatic normal saline for wound cleansing in, but not limited to, one (Record/Patient #3) of three home visits observed. This deficient practice has the potential to increase the infection risk for all agency patients.  
Findings included:  
Review of the Drugs.Com insert for sodium chloride for irrigation (normal saline) showed that if the irrigation solution contains no bacteriostat, antimicrobial agent or added buffer, it is intended only for use as a single-dose, short procedure irrigation, or cell washing fluid. When smaller volumes are required the unused portion should be discarded.  
Review of the agency's policy titled, "Infection Control Policy," dated 04/2019, showed hands must be washed and dried before and after any direct client contact and/or the removal of gloves, removal of PPE (personal protective equipment), and before entering nursing bag.  
RECORD/PATIENT #3:  
Review of the clinical record showed admittance of the patient on 09/13/19 with a primary diagnosis of chronic kidney disease, stage 4 (the kidneys are not working well) and other diagnoses of anemia (low red blood cell count), cardiovascular disease (heart and vein disease), diabetes mellitus II (an adult onset endocrine disease that causes high blood sugars) and right | L 579 | Please see attached. | 12/31/19 |
### Statement of Deficiencies and Plan of Correction

<table>
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<tr>
<th>Statement of Deficiencies</th>
<th>Provider/Supplier/CLIA Identification Number:</th>
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#### Harrison County Hospice

**Name of Provider or Supplier:** Harrison County Hospice  
**Street Address, City, State, Zip Code:** PO Box 425, Bethany, MO 64424

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<tr>
<th>ID</th>
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<th>Summary Statement of Deficiencies (Each Deficiency Must Be Preceded by Full Regulatory or LSC Identifying Information)</th>
<th>ID Prefix Tag</th>
<th>Provider's Plan of Correction (Each Corrective Action Should Be Cross-Referenced to the Appropriate Deficiency)</th>
<th>Completion Date</th>
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</table>
| L 579 | Continued From page 10  
Heel pressure ulcer (a wound caused by continuous pressure to a body part). The patient is cared for by children in the home setting.  
During a home visit observation on 10/30/19 at 9:50 AM, the following was observed:  
- The case manager (CM2) reached into the bag to remove supplies at least two times and did not use hand hygiene prior to entering the nursing bag; and  
- While performing wound care, CM2 was observed using a bottle of previously opened normal saline (sodium chloride solution used to cleanse the wound). The bottle label showed the normal saline was non-bacteriostatic.  
During an interview on 10/30/19 at 1:50 PM, CM2 stated that he/she:  
- Was nervous and probably missed using the (hand sanitizer) gel several times;  
- Should have removed all the supplies needed at one time; and  
- Did not know that the normal saline bottle could only be used one time.  
During an interview on 10/31/19 at 10:00 AM, the nursing supervisor stated that he/she:  
- Was not aware the normal saline bottles were single use;  
- Would try to find smaller bottles for use on wounds; and  
- The staff should use hand hygiene each time before entering bag.  
Counseling Services  
CFR(s): 418.64(d)(3)  
(3) Spiritual counseling The hospice must:  
(i) Provide an assessment of the patient's and... | L 579 | Please see attached. | 12/31/19 |
| L 598 | Counseling Services  
Counseling Services  
CFR(s): 418.64(d)(3)  
(3) Spiritual counseling The hospice must:  
(i) Provide an assessment of the patient's and... | L 598 | Please see attached. | 12/31/19 |
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<td>L 598</td>
<td>Continued From page 11 family's spiritual needs. (ii) Provide spiritual counseling to meet these needs in accordance with the patient's and family's acceptance of this service, and in a manner consistent with patient and family beliefs and desires. (iii) Make all reasonable efforts to facilitate visits by local clergy, pastoral counselors, or other individuals who can support the patient's spiritual needs to the best of its ability. (iv) Advise the patient and family of this service.</td>
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This STANDARD is not met as evidenced by: Based on policy review, record review, home visit observation, and interview, the agency failed to provide spiritual counseling to meet the spiritual needs of the patients and families and in a manner consistent with the patient and family beliefs and desires, but not limited to, two (Records/Patients #2 and #4) out of five complete record reviews completed. This deficient practice has the potential to affect the spiritual care provided to all the agency's patients.

Findings included:

Review of the agency's policy titled, "Spiritual Care Counseling Services," dated 04/2019, showed the following:
- The agency will provide spiritual care counseling in keeping with the patient's/family's belief system and practice;
- The spiritual care counselor will provide direct support and coordinate services;
- The spiritual care counselor will visit based on the patient's needs and acceptance of these services; and
- Spiritual care assessments and counseling will
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**X1 PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER:**

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**NAME OF PROVIDER OR SUPPLIER:**

**HARRISON COUNTY HOSPICE**

**STREET ADDRESS, CITY, STATE, ZIP CODE:**

**PO BOX 425**

**BETHANY, MO 64424**

**DATE SURVEY COMPLETED:**

10/31/2019

**SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION):**

**L 598** Continued From page 12

be documented in the patient’s clinical record.

**RECORD/PATIENT #2:**

Review of the clinical record showed admittance of the patient to hospice on 09/24/19 with diagnoses of depression and failure to thrive. The patient lived in a long term care facility (LTCF).

During a home visit observation on 10/29/19 at 9:10 AM, the spiritual counselor was observed interacting with the patient. He/she provided a brief conversation with the patient and then provided prayer. The visit lasted between 10-15 minutes.

During a home visit observation interview on 10/29/19 at 9:30 AM, the patient stated that he/she:

- Enjoyed the spiritual visits and talking; and
- Would enjoy having scripture readings and liked old hymns and music.

During an interview on 10/29/19 At 10:10 AM, the spiritual counselor:

- Was asked about the short length of the visits to the patient (10-15 minutes). He/she stated that the length of the visit depended on the expressed needs of the patient. Some visits are short, about 15 minutes, and others can be 45 minutes or longer;
- Stated that the patient had no strong spiritual connection with any faith group and had recently been baptized by the Methodist church;
- He/she had known the patient for many years by a personal connection to the patient’s family;
- When asked about the patient’s interest in scripture and music, the spiritual counselor stated that he/she had not considered doing scriptures or hymns with the patient.

**X2 MULTIPLE CONSTRUCTION**

A. BUILDING

B. WING

**X3 DATE SURVEY COMPLETED**

**L 598**

Please see attached.

12/31/19
L 598 Continued From page 13

RECORD/PATIENT #4:
Review of the clinical record showed admittance to hospice of the patient on 09/20/19 with diagnoses of Alzheimer's Disease (a progressive disease of the brain that causes increasing loss of memory and physical function) and heart disease. He/she lived in the home with the spouse. The daughter comes frequently and does most of the physical care of the patient. Other family members come in to help with meals and cleaning.

Review of the clinical record showed:
- The nursing visit note dated 09/30/19, documented that daughter was concerned about the patient's spouse. He/she was having difficulty dealing with all the changes in the patient, new people coming to the home, and changes in the schedule. The daughter requested the spiritual counselor come and visit with the patient's spouse that day;
- A spiritual care clinical note dated 09/30/19 showed the visit lasted 1.5 hours. The documentation failed to show that concerns expressed by the daughter were addressed with the spouse. The documentation failed to show exactly what issues were addressed during the visit. The documentation showed that:
  * The patient and family denied any spiritual issues at this time;
  * Reading and prayer was provided to the patient;
  * The plan was to make regular visits to offer support; and
  * The spouse and daughter were open and appreciative of the spiritual counselor visits, support and prayer.
- The next spiritual care visit was dated 10/28/19

L 598 Please see attached. 12/31/19
L 598 Continued From page 14
(a month later) and was 15 minutes long. The documentation failed to show any specific issues discussed and the documentation was very vague. The documentation failed to show how the spouse was dealing with the changes in schedule and the decline of the patient.

During an interview on 10/31/19 at 9:55 AM, the administrator:
- Agreed that the spiritual counselor's visits are generally very short (15-20 minutes long) and they have addressed this with him/her in the past;
- Agreed that the spiritual counselor's documentation is lacking specific content; and
- Stated that the agency has provided in-services for spiritual counseling services but apparently need to find additional resources.

L 628 HOSPICE AIDE ASSIGNMENTS AND DUTIES

Hospice aides must report changes in the patient's medical, nursing, rehabilitative, and social needs to a registered nurse, as the changes relate to the plan of care and quality assessment and improvement activities. Hospice aides must also complete appropriate records in compliance with the hospice's policies and procedures.

This STANDARD is not met as evidenced by:
Based on policy review, record review, home visit observation, and interview, the agency failed to ensure the hospice aide reported changes in the patient's medical, nursing, rehabilitative, and social needs to a registered nurse (RN) in, but not limited to, two (Records/Patients #1 and #5) out of five full records reviewed. This deficient
**HARRISON COUNTY HOSPICE**

**STREET ADDRESS, CITY, STATE, ZIP CODE**
PO BOX 425
BETHANY, MO 64424

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<td>L 628</td>
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<td>Continued From page 15 practice has the potential to affect the care of all patients that receive hospice aide services.</td>
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Findings included:

Review of the agency's policy titled, "Hospice Aide Services," dated 04/2019, showed:
- The hospice aide duties include reporting changes in the patient's condition and needs; and
- Hospice aides will document care provided in accordance with the hospice aide assignment.

**RECORD/PATIENT #1:**
Review of the clinical record showed admittance of the patient to hospice on 09/17/19 for diagnoses of lung, liver and bone cancer. The patient lived in his/her home where a son also resided. The family plan to provide care.

Review of the hospice aide visit notes showed that:
- The hospice aide provided only homemaker services until the aide care plan was changed on 10/11/19 to include a shower and personal care one time per week;
- On the 10/18/19 hospice aide visit note, the aide documented the patient refused all personal care. (This was the first visit that personal care was to be provided,) The hospice aide failed to document that the RN was notified;
- On the 10/25/19 hospice aide visit note, the aide documented a complete bed bath was given. The aide failed to document communication with the RN regarding the need to give a bed bath rather than the assigned shower due to the patient being too weak and worn out to tolerate the shower.

During a home visit observation on 10/29/19 at...
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<tr>
<td>L 628</td>
<td>Continued From page 16</td>
<td>L 628</td>
<td>Please see attached.</td>
<td>12/31/19</td>
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</table>

10:50 AM, the patient stated he/she was getting chair baths because he/she was too weak and tired to get in the shower. The son also agreed that patient was getting chair baths.

During an interview on 10/30/19 at 2:40 PM, the aide stated that he/she:
- Did not document contacting the RN on 10/19/19 to communicate that the patient had declined the personal care as ordered; and
- Provided a bed bath to the patient while in the recliner on 10/25/19 instead of the shower and did not call the RN to have the care plan changed to a bed bath.

RECORD/PATIENT #5:
Review of the clinical record showed admittance of the patient to hospice on 07/15/19 with diagnoses of leukemia (cancer in the blood of the white blood cells) and congestive heart failure (CHF-the heart no longer functions correctly and causes increased fluid to build up in tissues). The patient resides in a long term care facility (LTCF).

Review of a hospice aide missed visit note dated 09/20/19 showed that the aide went to the LTCF and the patient refused a shower. Documentation showed:
- The patient was very sleepy;
- The LTCF aide said the patient's oxygen saturation (a measure of the amount of oxygen in the blood, measured with a pulse oximeter-normal is greater than 90%) was ranging between 70 and 80;
- The LTCF aide placed the oxygen on the patient and oxygen saturation went up to 98%:
- The hospice aide failed to document that the RN was notified of the change in the patient's condition and the missed visit.
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<tr>
<th>ID</th>
<th>PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
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<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETION DATE</th>
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<tr>
<td>L 628</td>
<td>Continued From page 17</td>
<td>During an interview on 10/31/19 at 9:10 AM, the nursing supervisor stated that he/she would expect the hospice aide to report changes in the patient condition and missed visits to the RN.</td>
<td>L 628</td>
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<td>Please see attached.</td>
<td>12/31/19</td>
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<tr>
<td>L 678</td>
<td>Please see attached.</td>
<td>[Each patient's record must include the following:] (7) Physician orders.</td>
<td>L 678</td>
<td>Please see attached.</td>
<td>12/31/19</td>
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</table>

This STANDARD is not met as evidenced by: Based on policy review, record review, and interview, the agency failed to ensure physician orders were obtained in, but not limited to, one (Record/Patient #1) of five full records reviewed. This deficient practice has the potential to affect the quality of care for all patients receiving services.

Findings included:

Review of the agency's policy titled, "Verification of Physician Orders," dated 04/2019, showed:
- Orders will be obtained from a licensed physician (or other authorized practitioner) for care and services to be provided to hospice patients; and
- A copy of the physician's or licensed independent practitioner's order will be kept in the clinical record.

RECORD/PATIENT #1:
Review of the clinical record showed admittance of the patient to hospice on 09/17/19 for diagnoses of lung, liver and bone cancer. The patient lived in his/her home where a son also
L 678  Continued From page 18
resided. The family plan to provide care.

Review of the clinical record failed to show the following physician orders:
- 09/25/19- Tubigrips compression hose;
- 10/01/19- DME- seat cushion;
- 10/07/19- Abrasion and skin tear wound treatment;
- 10/11/19- Right forearm skin tear wound treatment;
- 10/15/19- Frequency of Foley catheter changes (tube inserted in the bladder to drain urine continuously into a drainage bag); and
- 10/26/19- Frequency of Foley catheter flushes and the amount of normal saline (a mild salt water solution) to use when flushing.

During an interview on 10/30/19 at 2:25 PM, CM1 provided orders for some of the missing orders in the record. He/she was unable to provide orders for the above missing orders.

An interview on 10/31/19 at 9:30 AM with CM1 showed he/she:
- Reviewed the electronic medical record and verified the verbal orders were not written when the order was obtained from the physician; and
- Created late orders dated 10/30/19 and sent them to the physician.

L 707  INPATIENT CARE PAIN & SYMPTOM CONTROL CFR(s): 418.108(a)(2)

[Inpatient care for pain control and symptom management must be provided in one of the following:]

(2) A Medicare-certified hospital or a skilled nursing facility that also meets the standards specified in §418.110(b) and (e) regarding

L 707  Please see attached

21/31/19

12/31/19
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<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
<th>COMPLETION DATE</th>
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<tr>
<td>L 707</td>
<td>Continued From page 19 24-hour nursing services and patient areas.</td>
<td>L 707</td>
<td>Please see attached.</td>
<td>12/31/19</td>
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This STANDARD is not met as evidenced by: Based on policy review, contract review, and interview, the agency failed to include in the contract for respite care with the nursing facility, under the standards specified in 418.110(e), patient areas, the requirement for the facility to provide space for private patient and family visiting, accommodations for family members to remain with the patient throughout the night, and visitors at any hour, including infants and small children. This deficient practice has the potential to affect the emotional well being for all hospice patients that use respite care.

Findings included:

Review of the agency's policy titled, "Coordination of Care with Contracts/Agreements," dated 04/2019, showed the hospice will have written agreements to provide general and respite in-patient services.

Review of the agency's undated contract titled, "Harrison County Hospice Collaborative Care Agreement," with Crestview Home, showed:
- No mention of the requirement for the facility to provide space for private patient and family visiting;
- Accommodations for family members to remain with the patient throughout the night was only allowed as determined by the facility, and
- Visitors at any hour, including infants and small children only included the hospice patient's children.

During a review of the contracts for respite with
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<td>L 707</td>
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<td>12/31/19</td>
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<td>L 713</td>
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<td>12/31/19</td>
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Continued From page 20

the nursing supervisor on 10/31/19 at 9:45 AM, the nursing supervisor agreed with the findings. At 10:50 AM, the nursing supervisor stated that he/she had given the surveyors the wrong contract. A blank copy of the agreement with Crestview Home was provided for review. This contract was reviewed and some of the missing and misstated items were found corrected. The nursing supervisor stated that they were still missing some things.

INPATIENT CARE PROVIDED UNDER ARRANGEMENTS

 CFR(s): 418.108(c)(3)

[If the hospice has an arrangement with a facility to provide for short-term inpatient care, the arrangement is described in a written agreement, coordinated by the hospice and at a minimum specifies-]

(3) That the hospice patient's inpatient clinical record includes a record of all inpatient services furnished and events regarding care that occurred at the facility; that a copy of the discharge summary be provided to the hospice at the time of discharge; and that a copy of the inpatient clinical record is available to the hospice at the time of discharge;

This STANDARD is not met as evidenced by: Based on policy review, contract review, and interview, the agency failed to include in the contract for general in-patient (GIP) and respite care with the facilities, the requirement for the facility to provide a discharge summary to the hospice at the patient's discharge from the facility. This deficient practice has the potential to affect the post discharge care from the in-patient...
L 713 Continued From page 21
facility of all hospice patients that use respite or GIP care.

Findings included:

Review of the agency's policy titled, "Coordination of Care with Contracts/Agreements," dated 04/2019, showed the hospice will have written agreements to provide general and respite in-patient services.

Review of the agency's contract titled, "Agreement for Provision of General Inpatient Hospital/Respite Care/Outpatient Services Between Harrison County Hospice and Harrison County Community Hospital," dated 10/15/19, showed that a copy of the discharge summary would be provided "If requested" by the hospice. The regulation states that a discharge summary will be provided to the hospice at the time of discharge.

Review of the agency's undated contract titled, "Harrison County Hospice Collaborative Care Agreement," with Crestview Home, failed to show any mention of a discharge summary from the facility to be provided to the hospice.

During a review of the contracts for respite and general in-patient with the nursing supervisor on 10/31/19 at 9:45 AM, the nursing supervisor agreed with the findings. At 10:50 AM, the nursing supervisor stated that he/she had given the surveyors the wrong contract. A contract with the hospital was up-dated with new information and was signed by the hospital administrator on 10/15/19 and was the current contract. A blank copy of the agreement with Crestview Home was provided for review. These contracts were
<table>
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<th>L 713</th>
<th>Continued From page 22 reviewed and some of the missing and misstated items were found corrected. The nursing supervisor stated that they were still missing some things.</th>
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<tbody>
<tr>
<td>L 714</td>
<td>INPATIENT CARE PROVIDED UNDER ARRANGEMENTS CFR(s): 418.108(c)(4)</td>
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</table>

[If the hospice has an arrangement with a facility to provide for short-term inpatient care, the arrangement is described in a written agreement, coordinated by the hospice and at a minimum specifies-]  
(4) That the inpatient facility has identified an individual within the facility who is responsible for the implementation of the provisions of the agreement;  

This STANDARD is not met as evidenced by: Based on policy review, contract review, and interview, the agency failed to include in the contract for respite care with the nursing facility and general in-patient (GIP) care/respite care with the hospital, the requirement for the facility to provide an identified individual within the inpatient facility who is responsible for the implementation of the provisions of the agreement. This deficient practice has the potential to affect the ease of communication and implementation of the contract for all hospice patients that use respite care.  

Findings included:  
Review of the agency's policy titled, "Coordination of Care with Contracts/Agreements," dated 04/2019, showed the hospice will have written
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<tr>
<td>L 714</td>
<td>Continued From page 23 agreements to provide general and respite in-patient services.</td>
<td>L 714</td>
<td>Please see attached.</td>
<td>12/31/19</td>
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Review of the agency's contract titled, "Agreement for Provision of General Inpatient Hospital/Respite Care/Outpatient Services Between Harrison County Hospice and Harrison County Community Hospital," dated 10/15/19, failed to show any mention of an identified individual who is responsible for the implementation of the provisions of the agreement.

Review of the agency's undated contract titled, "Harrison County Hospice Collaborative Care Agreement," with Crestview Home, failed to show any mention of an identified individual who is responsible for the implementation of the provisions of the agreement.

During a review of the contracts for respite and general in-patient with the nursing supervisor on 10/31/19 at 9:45 AM, the nursing supervisor agreed with the findings. At 10:50 AM, the nursing supervisor stated that he/she had given the surveyors the wrong contract. A contract with the hospital was up-dated with new information and was signed by the hospital administrator on 10/15/19 and was the current contract. A blank copy of the agreement with Crestview Home was provided for review. These contracts were reviewed and some of the missing and misstated items were found corrected. The nursing supervisor stated that they were still missing some things.
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<th>(X4) ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
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<th>(X5) COMPLETE DATE</th>
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| L 000             | Initial Comments  
A survey for state certification was completed for Harrison County Hospice on 10/31/19. The agency had nine current patients. | L 000         |                                                                                                  |                  |
| L 157             | 30-35.010(2)(D)(4) Plan of Care  
The plan shall include:  
A. Identification of the patient's/family's problems and needs;  
B. The scope and frequency of services needed to meet the patient's and family's needs and by whom the services will be provided, prescribed and required medical equipment, supplies, medications, treatments and the level of care;  
C. Realistic and achievable goals; and  
D. All physician orders.  
This regulation is not met as evidenced by:  
Refer to Federal tag L545 | L 157     | Please see attached                                                                 | 12/31/19        |
| L 160             | 30-35.010(2)(E)(1) Authorized Prescriber's Orders  
Authorized Prescriber's Orders. Medications, treatments and procedures shall be administered only with an order by an authorized prescriber.  
This regulation is not met as evidenced by:  
Refer to Federal tag L678 | L 160     | Please see attached                                                                 | 12/31/19        |
| L 192             | 30-35.010(2)(G)(4)(C) Spiritual care services  
The spiritual assessment shall include, at a minimum:  
(I) The identification of any religious affiliation the patient and family may have; and  
(II) The nature and scope of any spiritual | L 192     | Please see attached.                                                                | 12/31/19        |
**SUMMARY STATEMENT OF DEFICIENCIES**

<table>
<thead>
<tr>
<th>ID TAG</th>
<th>DESCRIPTION</th>
<th>ACTION</th>
<th>COMPLETE DATE</th>
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<tbody>
<tr>
<td>L 192</td>
<td>Continued From page 1 concerns or needs identified.</td>
<td>Please see attached.</td>
<td>12/31/19</td>
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<td>This regulation is not met as evidenced by:</td>
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<td></td>
<td>Refer to Federal tag L598</td>
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<td>L 233</td>
<td>30-35.010(2)(J)(3) Volunteers</td>
<td>Please see attached.</td>
<td>12/31/19</td>
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<td>The hospice shall document initial screening and active and ongoing efforts to recruit and retain volunteers.</td>
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<td>This regulation is not met as evidenced by:</td>
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<tr>
<td></td>
<td>Based on policy review, personnel record review, and interview, the agency failed to show documentation of the volunteer intial screening for hire in, but not limited to, one out of one volunteer personnel file reviewed. This deficient practice has the potential to affect the services provided to all the agency patients receiving volunteer services.</td>
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<td>Findings included:</td>
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<td></td>
<td>Review of the agency's policy titled, &quot;Volunteer Requirements/Documentation,&quot; dated 04/2019, failed to show mention of using volunteer screening and documentation in the hiring process.</td>
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<td></td>
<td>Review of Volunteer #1 (V 1) employee file failed to show documentation of a volunteer screening during the hiring process. V 1 was hired 04/30/18 to provide volunteer assistance at the agency.</td>
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<td>During an interview on 10/30/19 at 11:50 AM, the volunteer coordinator stated that he/she:</td>
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<td>- Did not know a formal volunteer screening was required;</td>
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<td>- Does talk to the potential volunteer to make</td>
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<td>L 233</td>
<td>Continued From page 2</td>
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<td>sure they are interested and explains the volunteer's duties;</td>
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<td>- Does not document that conversation or any screening: and</td>
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<td>- Did not document this for any of the potential volunteers.</td>
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<tr>
<td>L 244</td>
<td>30-35.010(2)(K)(5)(B) Central Clinical Records</td>
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<td>Complete documentation of all assessments, services and events including:</td>
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<td>(I) The physical condition of the patient;</td>
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<td>(II) The psychosocial status of the patient/family;</td>
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<td>(III) The spiritual status of the patient/family; and</td>
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<td>(IV) Potential bereavement complications;</td>
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<td>This regulation is not met as evidenced by:</td>
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<td></td>
<td>Refer to Federal tag L531</td>
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<tr>
<td>L 257</td>
<td>30-35.010(2)(L)(3) Facility Resident</td>
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<td>The hospice shall document education provided and/or education offered and declined by the nursing home.</td>
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<td>This regulation is not met as evidenced by:</td>
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<tr>
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<td>Based on policy review and interview, the agency failed to document education provided and/or education offered and declined by the long term care facilities (LTCFs).</td>
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<td>This deficient practice has the potential to affect the hospice care of all the agency's patients residing in a facility.</td>
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<td>Findings included:</td>
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|       | Review of the agency's policy titled, "Provision of care to Residents of Skilled Nurse Facilities/Nursing Facilities (SNF/NF) or
L 257 Continued From page 3

Intermediate Care Facility for Individuals with Mental Retardation (ICF/MR)," dated 04/2019, showed the organization must assure orientation of SNF/NF or ICF/MR staff furnishing care to hospice patients.

During an interview on 10/30/19 at 3:10 PM, the nursing supervisor stated that he/she:
- Was not aware of this requirement;
- Only offers training on Alzheimer’s Disease (degeneration of the brain that results in memory loss and loss of function) and infection control;
- Does not keep a record of what training is offered to the LTCF; and
- The agency mainly has hospice patient's in one nursing facility in town.

L 257 Please see attached. 12/31/19