Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered via Email

August 31, 2022

Administrator
Accentcare Fairview Hospice - West, LLC
767 Eustis Street #150
Saint Paul, MN 55114

Re: Event ID: 10TV11

Dear Administrator:

A survey was completed at your agency on August 24, 2022 for the purpose of assessing compliance with Federal certification regulations. At the time of survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more deficiencies. The findings from this survey are documented on the electronically delivered form CMS 2567.

Certification deficiencies are listed on the left side of the form. The right side of the form is to be completed with your written plan for corrective action. The plan must be specific, realistic, include the date certain for correction of each deficiency and be signed and dated by the administrator or other authorized official of the agency.

An acceptable plan of correction must contain the following elements:

- The plan of correcting the specific deficiency. The plan should address the processes that led to the deficiency cited;
- The procedure for implementing the acceptable plan of correction for the specific deficiency cited;
- The monitoring procedure to ensure that the plan of correction is effective and that the specific deficiency cited remains corrected and/or in compliance with the regulatory requirements;
- The title of the person responsible for implementing the acceptable plan of correction; and,
- The date by which the correction will be completed.

Ordinarily, a provider will be expected to take the steps necessary to achieve compliance within 60 days of the exit interview. If possible, please type your plan of correction to ensure legibility.

Please return the original plan of correction to the following address within ten calendar days of your receipt of this notice. Questions regarding your plan of correction should also be directed to the below contact.

Jen Bahr, RN, Unit Supervisor
Bemidji District Office
Licensing and Certification Program

An equal opportunity employer.

Health Regulation Division
Minnesota Department of Health
705 5th Street NW, Suite A
Bemidji, Minnesota 56601-2933
Email: Jennifer.bahr@state.mn.us
Office: (218) 308-2104 Mobile: (218) 368-3683

Please make a copy of your plan of correction for your records. Failure to submit an acceptable written plan of correction of Federal deficiencies within ten calendar days may result in decertification and a loss of Federal reimbursement.

Please feel free to call me with any questions related to this letter.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

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Administrator
Accentcare Fairview Hospice - West, LLC
767 Eustis Street #150
Saint Paul, MN 55114

Re: Event ID: 10TV11

Dear Administrator:

On August 24, 2022, a survey was completed at your agency by a survey team from the Minnesota Department of Health, Health Regulation Division for the purpose of assessing compliance with State licensing regulations. At the time of the survey a complaint was found to be substantiated, however no licensing orders were issued.

Attached is the Minnesota Department of Health order form. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	241514	A. BUILDING _____ B. WING _____	C 08/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCENTCARE FAIRVIEW HOSPICE - WEST, LLC	767 EUSTIS STREET #150 SAINT PAUL, MN 55114

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L 000	INITIAL COMMENTS On 8/22/22 through 8/24/22, an abbreviated survey was completed at your facility to conduct a complaint investigation to determine compliance with the regulations at 42 CFR Part §418, Conditions of Participation for Hospice Services. The agency was not found to be in full compliance. The following complaint was found to be SUBSTANTIATED: H15143910C (MN85811), with a deficiency issued at L533 As a result of the investigation additional deficiencies were issued at L509 and L533.	L 000		
L 509	EXERCISE OF RIGHTS/RESPECT FOR PROPRTY/PERSON CFR(s): 418.52(b)(4)(ii) [The hospice must:] (ii) Immediately investigate all alleged violations involving anyone furnishing services on behalf of the hospice and immediately take action to prevent further potential violations while the alleged violation is being verified. Investigations and/or documentation of all alleged violations must be conducted in accordance with established procedures; This STANDARD is not met as evidenced by: Based on interview and document review, the agency failed to ensure allegations of potential abuse were thoroughly investigated for 1 of 3 patients (P4) reviewed for grievances. Findings include:	L 509	Action: All leaders will complete training in the learning management system on policy 102 Adverse Events, Policy 225 Suspected Abuse or Neglect, Protocol 5002 Adverse Events and Course: Quality106 Adverse Events Reporting to reinforce knowledge on how to investigate and document and adverse event by 9/23/22. P4 was discharged from service by death. Monitoring: The leadership team will review 100% of adverse events weekly to ensure effective and efficient management per policy and protocol. The Senior leadership team will review 100% of Adverse Event reports and will guide team directors in missing investigative steps weekly. This will be an ongoing process. Reporting: The leadership team will review all adverse event trends with the QAPI committee quarterly. Responsible Person: Executive Director	9/23/22

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

Heather E Belton — Interim Executive Director — 9/16/2022

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.

Accepted on 9/20/22

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L 509	Continued From page 1 P4's plan of care (POC) for benefit period 7/14/22 through 10/11/22, indicated a start of care (SOC) date 7/14/22. Diagnoses included malignant neoplasm of pancreas, liver and bile duct, pulmonary embolism, diabetes, hypertension cerebral palsy, pressure ulcers and neuromuscular dysfunction of bladder. Home health aide (HHA) visits were ordered two visits a week for one week then one visit a week for twelve weeks. The HHA was to assist with personal care, hygiene and activities of daily living (ADLs). P4 was identified as orientated and goals included for a nursing POC to be established to meet P4's needs. The agency's Quality Improvement Summary identified the agencies complaints received 3/21/22 through 8/23/22. P4's family member (FM)-B reported to the agency on 7/29/22, HHA-B was rough during cares. Interventions listed on the complaint identified the agency had spoken with the staff involved and had reassigned the staff member to other patients. The grievance investigation did not include observations of HHA-B performing patient cares, interviews with other patients HHA-B was assigned or other staff to ensure abuse did not occur. P4's visits from 7/14/22 through 8/1/22, identfied HHA-B had assisted P4 with a bed bath, shampoo, skin care, perineal care and turning and repositioning on 7/22/22, 7/25/22 and 7/27/22. P4's interdisciplinary summary report dated 8/1/22, indicated P4 had passed away peacefully at her home. There was no documentation of a grievance received.	L 509		

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L 509	Continued From page 2 P4's communication notes from 7/14/22 through 8/1/22, identified the record lacked any documentation regarding P4's grievance of rough treatment with cares. When interviewed on 8/24/22, at 8:45 a.m. the hospice director (HD) stated the team director followed up with HHA-B and found he had no history of accusations of rough treatment and stated he did not feel he had been rough when providing care to P4. The agency thought it was best just to reassign HHA-B to other patients. The report in the agency's Quality Improvement Summary documented the entire investigation, interventions and prevention of each complaint. The director stated P4's FM-B complaint investigation consisted entirely of speaking with HHA-B regarding the accusation and to reassign him to a different patient. During a conference call interview on 8/24/22, at 10:45 a.m. the vice president of operations (VP) stated quality incidents were reported to the supervisor. Follow up activities were managed outside of the electronic record and they tracked who was spoken to with in a word document and develop the corrective plan. One of things the agency planned to implement was to have an adverse event meeting to ensure investigations were more robust. The VP could not idenify if FM-B's concern was thoroughly investigated. The agency's Adverse Events revised 1/24/20, indicated the responsible supervisor must initiate an investigation within two working days of receipt of a complaint. If the adverse event was related to abuse or neglect of a vulnerable person, employees should also consult policy 222	L 509		

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L 509	Continued From page 3 Suspected Abuse, Neglect or Exploitation. All components of the investigation must be documented and retained for seven years. The agency's Suspected Abuse, Neglect or Exploitation policy revised 3/20/20, indicated all cases of suspected abuse, neglect, exploitation would be reported to the appropriate protection agency. The executive director or designee would immediately initiate an investigation of all alleged violations. If allegations of abuse or neglect involved employees or volunteers, the executive director or designee would remove the accused employee or volunteer from involvement with care to protect the patient. The decision to allow the employee to return to work would be made by the executive director, administrator, along with members of the national leadership team, once a thorough investigation was completed and the allegations were determined to be unfounded.	L 509		
L 530	CONTENT OF COMPREHENSIVE ASSESSMENT CFR(s): 418.54(c)(6) [The comprehensive assessment must take into consideration the following factors:] (6) Drug profile. A review of all of the patient's prescription and over-the-counter drugs, herbal remedies and other alternative treatments that could affect drug therapy. This includes, but is not limited to, identification of the following: (i) Effectiveness of drug therapy (ii) Drug side effects (iii) Actual or potential drug interactions (iv) Duplicate drug therapy (v) Drug therapy currently associated with	L 530	Action: All leaders and nurses will complete training learning management on protocol 3019 Medication Reconciliation in the system to reinforce knowledge that a medication review is to be completed with every visit by 9/23/22. P2 will have a comprehensive Medication Reconciliation completed with the facility nurse by 9/16/22. Monitoring: The leadership team will complete 3 RN supervisory visits per week to oversee medication reconciliation process and provide instruction in real time until a threshold of 80% compliance with medication reconciliation is met for 4 consecutive weeks. After the threshold is met, this will be monitored with routine supervisory visits.	9/23/22

		Reporting: The leadership team will review trends weekly until the threshold is met and then quarterly with their QAPI committee. Responsible Person: Executive Director	

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L 530	Continued From page 4 laboratory monitoring. This STANDARD is not met as evidenced by: Based on observation, interview and document review, the facility failed to complete a comprehensive medication review during a nursing visit 1 of 1 patients (P2) observed on a home visit. Findings include: P2's Hospice Benefit Period Summary Report for certification date 8/4/22 to 11/1/22, indicated a start of care date 5/6/22. P2's diagnoses included malignant neoplasm of lung, hypertension and dementia. The report identified multiple medications including Haldol (an antipsychotic medication) 0.5 milligrams (mg) orally (po) every hour as needed (PRN) for agitation, Lisinopril (to treat blood pressure) 20 mg po two times per day, lorazepam (a psychotropic medication to treat anxiety) 0.5 mg po every hour PRN for anxiety, metoprolol (to treat blood pressure) 100 mg po two times per day, mirtazapine 15 mg po at bedtime, and morphine (narcotic to treat pain) 5 mg po every hour PRN for pain or shortness of breath. P2's plan of care (POC) with problem date 7/6/22, identified nursing interventions to assess the need for medication management and instruction, assess response to current medications, instruct regarding medication purpose, actions, potential side effects and when to report to hospice staff. Goals were patient or caregiver to verbalize understanding of why each medication was prescribed, understanding of the medication schedule, and to understand when to utilize PRN	L 530		

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L 530	Continued From page 5 medications and to document each PRN usage. A home visit was conducted on 8/24/22, at 1:00 p.m. registered nurse (RN)-A obtained P2's blood pressure, oxygen saturation, heart, lung and bowel sounds. P2 denied any discomfort or concerns and reported no problems with voiding or bowel movements. The hospice skilled nurse visit concluded with no further assessment. - After exiting P2's room, RN-A asked an unidentified nursing assistant if P2 was incontinent of bladder or if there were any concerns or problems she was aware of. The nursing assistant indicated she was not aware of any issues and stated P2's nurse was currently busy on another wing. RN-A completed a Hospice Communication Note which identified a hospice skilled nursing visit was completed for disease management and vital signs. The written comment included P2 was forgetful but pleasant, had no symptoms of pain or respiratory distress and there were no changes to her plan of care. RN-A included her phone number and noted she wanted to be called to obtain P2's last current weight. RN-A pushed the form under P2's nurses door of her locked office and exited the building. During interview on 5/24/22, at 1:30 p.m. RN-A indicated her visit was completed and she only asked the assistant living nurse to call her as she would like to obtain P2's current weight. She confirmed the assisted living did have a comfort kit (a packet of medications commonly used for terminal patient symptom control, that include psychotropic and narcotic medications) that hospice issued P2 at her SOC. RN-A did not check on the medications, and would just verify none of the medications had expired, as the	L 530		

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L 530	Continued From page 6 assisted living staff tracked the medications. Further, RN-A did not review P2's medication or ask the assisted living staff about P2's medication use. She did not know if P2 had required any of her as needed medications for pain or anxiety since the last hospice visit. Asking about the use of PRN medications would be important to see if the patient had experienced any symptoms other than during the time of hospice visits. RN-A stated she should have reviewed P2's medications and PRN medication use. During interview on 6/24/22, at 8:45 a.m., the hospice director stated she would expect medications to be reviewed during each hospice skilled nursing visit. A policy on medication review was requested, however none were provided.	L 530		
L 533	UPDATE OF COMPREHENSIVE ASSESSMENT CFR(s): 418.54(d) The update of the comprehensive assessment must be accomplished by the hospice interdisciplinary group (in collaboration with the individual's attending physician, if any) and must consider changes that have taken place since the initial assessment. It must include information on the patient's progress toward desired outcomes, as well as a reassessment of the patient's response to care. The assessment update must be accomplished as frequently as the condition of the patient requires, but no less frequently than every 15 days. This STANDARD is not met as evidenced by: Based on interview and record review, the	L 533	Action: All leaders, IDG, team assistants will complete training in the learning management system by 9/23/22 on policy 214 plan of care, policy 212 patient and family assessment, policy 213 patient and family reassessment, protocol 2037 triage guidelines, protocol 2022 visit strings, policy 102 adverse events, protocol 5002 adverse events, and protocol 2050 death pronouncement. The training will also include information on HCHB scheduling process, Symptom management, and symptoms of death and dying. There will be two new processes initiated. The first process change will be to for the Team Assistant to print the patient scheduling calendar report for the certification period with every admission and recertification to be delivered to the home chart along with the updated plan of	9/23/22

care. All current patients will receive a calendar schedule report in their home chart.

The second process change will be for the team to standardize a stand -up and stand down phone call everyday Monday-Friday to increase communication. As a part of the stand-up process, the team director will review the on-call report and MUSE analytics to identify patients with increased symptoms. All team clinical leaders will have a verbal handoff with the administrator on-call to ensure a seamless handoff of patient care needs are met afterhours.

Monitoring: The leadership team will complete 3 RN supervisory visits per week to oversee assessment, symptom management, care planning process, verification of calendar report, and provide instruction in real time until a threshold of 80% audit compliance with medication reconciliation is met for 4 consecutive weeks. The leadership team will prioritize patients identified on the Stand-up meeting with increased symptoms to complete the supervisory visits. After the threshold is met, this will be monitored with routine supervisory visits.

Reporting: The leadership team will review trends of supervisory visits weekly until the threshold is met and then quarterly with their QAPI committee. The leadership team will review standup and stand down sheets daily as an ongoing process.

Responsible Person: Executive Director

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L 533	Continued From page 7 agency failed to comprehensively reassess and communicate a patients significant change in condition for an increase in services for 1 of 3 patient's (P1) reviewed for patient assessments. Findings include: P1's Hospice Plan of Care (POC) for episode 7/13/22 through 10/10/22, indicated a start of care (SOC) 7/13/22. Diagnoses included Parkinson's disease, dementia with lewy bodies, hallucinations, repeated falls, dysphagia and malignant neoplasm of lung. Hospice nursing visits were ordered two visits per week for eleven weeks, three visits a week for one week, two visits a week for one week and three visits as needed (PRN) for symptom management or crisis management. - The hospice nurse was to assess and evaluate the patient and caregiver which included the following: assess and evaluate for signs and symptoms of anxiety or terminal agitation and provide instruction regarding origin and management, assess medication response and instruct, evaluate patient and develop the POC with the physician, instruct on pain management, perform wound care to the right sacrum and change the dressing as ordered every three days and PRN and instruct on urinary incontinence. - Social Worker visits were ordered one visit a week for one week, one visit every three weeks for three weeks then one visit every four weeks for eight weeks plus two PRN for coping, or crisis management. The social worker was to assess and evaluate the patient and caregiver which included the following: evaluate social, emotional and financial factors; need for additional care or	L 533		

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L 533	Continued From page 8 resources, and adjustment to care; assess for emotional and spiritual preparation for imminent death and provide emotional support and counseling. Goals were identified in the POC including establishing a POC that would meet the patient needs, manage medications and pain appropriately, and minimize patients anxiety and agitation. P1's Hospice Recertification Summary Report (HRS) with interdisciplinary Group (IDG) meeting, dated 7/19/22, identified problems of anxiety and terminal agitation, need for medication management and instruction, need for skilled teaching regarding pain, altered comfort, community resources and urinary incontinence and the need for wound care. P1's IDG note dated 7/19/22, indicated P1 had an indicator of red acuity (an internal agency measure of intensity of nursing care required by a patient). Orders and changes were made in relation to the patient's pain and anxiety. P1 had recent increases in medications for ongoing symptom management issues. Registered nurse (RN)-A's notation identified P1 appeared to be in early phases of transitioning to the active dying phase. The skilled nurse plan including progress toward goals, visits planned for the upcoming two week period, including visit frequency and evidence of declining status, these area's were not completed and was blank. P1's care coordination notes identified the following: - 7/13/22, the hospice triage team received a call from family member (FM)-A with concerns P1 was agitated and combative. FM-A was	L 533		

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L 533	Continued From page 9 instructed on medications to administer to P1 for symptom control. - 7/14/22, a hospice nurse visit was performed. P1 displayed symptoms of agitation and combativeness. Medications were scheduled every six hours and FM-A was instructed on medication administration. It was noted to assess need to increase dosage or frequency of medications at the next nurse visit and assess signs and symptoms of anxiety and comfort level. - 7/17/22, a hospice nurse visit was performed at the request of FM-A due to P1 was having increase agitation. An assessment and cares were performed and PRN and scheduled medications were increased. FM-A was instructed on the increase in medication dosages and frequency's and questions were answered. - 7/21/22, RN-A phoned FM-A and was updated on P1's general condition. RN-A indicated she planned a nurse visit in two days. - 7/22/22, a home health aide (HHA) visit was made. Prior to starting cares, P1 was observed to have expired. When interviewed on 8/22/22, at 3:40 p.m. FM-A stated she received a document when P1 was admitted to hospice that indicated a nurse visit would be made two to three times per week and more if needed. The agency left her with a booklet with the contact information on the front. FM-A stated she had no help about the dying process and was talking to friends and neighbors for advice along. Also there was no nurse visits without requesting one. The chaplain called her on 7/20/22, and she asked if P1 had used up all her nursing visits, as P1 was having trouble swallowing and no nurse had been out to visit. The chaplain told her someone would reach out to her.	L 533		

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L 533	Continued From page 10	L 533		

Further, the only reason a nurse came out on 7/17/22, was a result of FM-A calling triage on Saturday 7/16/22, and the triage team scheduled an as needed visit. The nurse who visited on 7/17/22, very clearly explained the medications and changes in dose and frequency. FM-A was not aware if the agency had ever assigned a nurse to P1 and no one was providing a scheudle of nursing visits.

- When FM-A called the agency with her concerns after P1 passed, she was told P1 had a significant change in status on 7/17/22, and someone should have been out to see her every day. Nobody called or visited to follow up on the 7/17/22, nurse visit and changes with medications. FM-A stated she received no nursing calls or visits after 7/17/22. RN-A called FM-A on the 7/21/22, as the nurse had heard FM-A called and complained about being ingnored. RN-A may have asked about P1, but she never offered to come out and just indicated she would ensure medications would be delivered to P1 that evening.

- When FM-A called the agency after P1 died, she was told to call the funeral home herself. Then she called the funeral home as instructed and was told she had to have the hospice agency call them. The the social called her and got it straightened out. FM-A thought that had all been taken care of on admissio and was never given additional information through out the course of her care.

During interview on 8/23/22, at 3:14 p.m. HHA-A stated she cared for P1 on two occasions. She was able to assist with P1's bath and felt P1 was

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	241514	A. BUILDING _____ B. WING _____	C 08/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCENTCARE FAIRVIEW HOSPICE - WEST, LLC	767 EUSTIS STREET #150 SAINT PAUL, MN 55114

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comfortable at the time. The aides were not instructed to do P1's dressing changes, as the nurses were to complete the dressing change. FM-A was there during the visits and was very active in P1's cares. HHA-A did not recall FM-A having a lot of questions during her visit. When a patient was nearing the end of life the agency tended to amp up the patient's visits to daily, unless family requests it was not needed. She did not know why P1 did not get increase nurse visits.

During a telephone interview on 8/24/22, at 4:00 p.m. RN-A stated when a patient started to transition to the active dying process, the nurse would have a discussion with family regarding transitioning and ask about increase visits. At the time of a patient's death, the hospice agency would verify what funeral home the patient chose and contact the funeral home and notify the medical examiner of the death. She was P1's case manager but only seen her one time as she had time off. She assigned multiple visits for P1 to other nurses because she knew P1 needed to be seen. RN-A knew FM-A had lots of questions and concerns and would need frequent visits. When RN-A performed a nurse visit on 7/14/22, she could tell, based on interactions with the family, that they would need more support. She sent a request to the manager and scheduler to schedule an increase in hospice nurse visits for P1. She was not sure why the nurse visits were note completed as directed.

When interviewed on 8/23/22, at 4:45 p.m. RN-B stated she was an as needed nurse, and picked up nurse visits on the weekends. She made a visit to P1 on 7/17/22, after family requested a visit and it was scheduled by the triage team.

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When RN-B arrived, P1 was unresponsive and lying in bed. RN-B assisted FM-A with hands on care. RN-B instructed FM-A on potential symptoms and medications to try for symptom control. FM-A was very, very anxious, so she discussed end of life care. A call was made to the physician and medications dose and frequency changes were made.

- RN-B asked FM-A when she was expecting the nurse and FM-A indicated she expected a nurse visit the next day. RN-B concerned about who would follow up when she made changes or started a medication or treatment on her PRN visits to patients. RN-B would complete a communication note and the then the scheudled nurse would follow up on the note made. RN-B never received any feed back from anyone at the agency following her visits. RN-B was under the impression there was a scheduled visit for 7/18/22, as reported by FM-A.

When interviewed on 8/24/22, at 8:45 a.m.. the hospice director stated the agency had received email requests from RN-A to increase P1's nursing visits. She was not sure why the visits were not scheduled. The agency had a color system in each patient's chart. Green was for routine care, yellow was for increase symptoms and possibly a need for increase visits and red was for end of life patents that had more acute needs and need for increase nursing visits. The agency had a call process that consisted of a triage team that answered calls and another team that made the visits. All the call staff were employees of the agency and were registered nurses. The nurse taking the call would give instruction and if needed would deploy one of the team members to make a visit. An on call report

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L 533	Continued From page 13 was run every morning, Monday through Friday, which identified everything that occurred during call. Each nurse was to review the call log prior to the agency morning huddle, where they discussed cases. Each nurse was to plot patient visits on a calendar in the patient's chart. There is a calendar in the admission packet and the primary nurse would record all the upcoming planned visits on the calendar on the visit that is made after admission. - The director identified it would be important for patients and families to know what to expect and when visits were going to occur. The calendar for visits in P1's chart was blank. The director indicated visits may not be show up on P1's calendar, as it was now a discharged chart. P1 did have orders for nurse visits every three days to perform wound dressing changes. The director indicated the agency was well aware P1 should have had nurse visits scheduled every three days for the dressing changes and felt it the fact the visits had not been scheduled for the dressing changes was part of the problem. There was a breakdown in communication when RN-A the case manager was off the schedule. Further, the agency was in the process of making changes to daily procedures to ensure the same issue did not occur with other patients. The agency's policy Patient and Family Reassessment revised 2/21/20, identified patients and families would be reassessed regularly to determine their response to care and treatment and to determine if significant changes in their condition warranted a change in the plan of care. If there were observed or communicated significant changes in the patients' condition or needs, such findings would be communicated to	L 533		

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L 533	Continued From page 14 the caregiver, the attending physician and the interdisciplinary group. The comprehensive assessment would be updated by the hospice IDG in collaboration with the individual's physician with changes that have taken place since the initial assessment, to include information on the patient's progress toward desired outcomes, as well as a reassessment of the patient's response to care and as frequently as the condition of the patient required, including at the time of the change in level of care, when changes in the patient's physical, social, emotional or spiritual status changed and at the time of recertification.	L 533		