Printed: 08/13/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED C			
		151575		B. WING		07/	07/16/2021	
	OVIDER OR SUPPLIER T HOSPICE OF IND	IANA, LLC	724 WES	ESS, CITY, STAT  ST NAVAJO : AFAYETTE,	STREET	•		
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGU			ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
E 000	Initial Comments			E 000				
	survey of a hospice	Emergency Preparednes agency. 6, 7, 8, 9, 12, 13, 14, 15						
	Facility Number: 0	03308						
	Provider Number: 1	151575						
	Unduplicated Admi	ssions for Last 12 Month	s: 364					
	Active Census: 144	1						
E 006	Plan Based on All F CFR(s): 418.113(a)	Hazards Risk Assessmen )(1)-(2)	t	E 006				
	§460.84(a)(1)-(2), § (1)-(2), §483.475(a §485.68(a)(1)-(2), § §485.727(a)(1)-(2),	§441.184(a)(1)-(2), §482.15(a)(1)-(2), §483.7 )(1)-(2), §484.102(a)(1)-	(2),					
	and maintain an en that must be review	nn. The [facility] must dev nergency preparedness p ved, and updated at least must do the following:]	olan					
	facility-based and o	nd include a documented, community-based risk ng an all-hazards approa						
	` '	es for addressing emerge the risk assessment.	ency					
	The Hospice must	§418.113(a):] Emergency develop and maintain an			TITI F		(X6) DATE	

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE			, ,	(X3) DATE SURVEY COMPLETED		
	151575		B. WING		07	C / <b>16/2021</b>	
NAME OF PROVIDER OR SUPPLIER		STREET ADDF	DDRESS, CITY, STATE, ZIP CODE				
VIAQUEST HOSPICE OF INDIA	NA, LLC		NEST NAVAJO STREET T LAFAYETTE, IN 47906				
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY TAG OR LSC IDENTIFYING INFORMATION)		GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
reviewed, and update plan must do the follo (1) Be based on and facility-based and cor assessment, utilizing (2) Include strategies events identified by the including the manage of power failures, nate emergencies that word ability to provide care *[For LTC facilities at Plan. The LTC facility an emergency prepareviewed, and update must do the following (1) Be based on and facility-based and cor assessment, utilizing including missing resi (2) Include strategies events identified by the *[For ICF/IIDs at §483 The ICF/IID must devemergency prepared reviewed, and update plan must do the following (1) Be based on and facility-based and cor assessment, utilizing including missing clie (2) Include strategies events identified by the This Standard is not Based on record reviewed and page of the standard is not Based on record reviewed reviewed and cor assessment, utilisating including missing clie (2) Include strategies events identified by the standard is not Based on record reviewed reviewed reviewed and cor assessment and the facility-based and cor assessment and the facility and the facil	ness plan that must be ed at least every 2 years wing: include a documented, mmunity-based risk an all-hazards approact for addressing emergenerisk assessment, ement of the consequent ural disasters, and other uld affect the hospice's expensive plant that must ed at least annually. The include a documented, mmunity-based risk an all-hazards approact idents. In a session of the ed at least every 2 years wing: include a documented, mmunity-based risk an all-hazards approact idents. In a session of the ed at least every 2 years wing: include a documented, mmunity-based risk an all-hazards approact includes a documented, mmunity-based risk an all-hazards approact includes a documented, mmunity-based risk an all-hazards approact includes a documented, mmunity-based risk as evidenced by:	ch. ncy nces r cy ntain be e plan ch, ncy Plan. s. The	E 006				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CL AND PLAN OF CORRECTION IDENTIFICATION NUMBER			1 ' '	E CONSTRUCTION	(X3) DATE SURVEY  COMPLETED		
		151575		B. WING		07/	C 1 <b>16/2021</b>
NAME OF PR	OVIDER OR SUPPLIER	•	STREET ADDR	ESS, CITY, STAT	TE, ZIP CODE	•	
VIAQUES	T HOSPICE OF INDIA	ANA, LLC		ST NAVAJO AFAYETTE,			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL RE OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
E 006	Preparedness Plan (addressing emergen risk assessment or recovID-19 pandemid affect all hospice path Findings include:  An agency policy title Management," policy 2/2017, stated "Policy Indiana conducts an emergencies and the these emergencies and the these emergencies recovered in the demand for servi Indiana will develop emergency manager process for disaster management and im Procedure: 1. Emerge that would constitute are not limited to: 1. floods, tornadoes, hostorms. 2. Natural disemergencies such as or utilities failure due and/or electricity. 4. threats, or civil disturdischarge from an actification for the control of the	EPP) included strategies by events identified by the elated to the current or, which had the potential ients and staff.  The defendance of the current or, which had the potential ients and staff.  The defendance of the current or, which had the potential ients and staff.  The defendance of the current or	of ential cts and of extern ex	E 006			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STA	TE, ZIP CODE		
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E 006	was reviewed on 7/1 the agency's Emerge indicated it was last reducator #1. The Eff Vulnerability Assessr by QAPI Educator #1 hazards " Civil Dis Event "were rated agency, the hazards Electrical Failure Level of Vulnerability agency, and the haza Earthquake Hurric Accident Civil Dis Event Terrorist Att Transportation Internet Environmental/Alterewere rated as "Low agency. The hazard Disease" was assess "Moderate" level of vhad "Moderate" preported the mergencies accidents. Power ous trikes. Natural disast Incidents of naturally outbreaks. Planned political conventions, agency's EPP failed addressing emergenrisk assessment or recovillation. An interview was con PM with the Administration.	6/2021. The binder inclency Preparedness Plant reviewed on 3/8/21 by CP included a "Hazard ment," completed on 3/8 l, which indicated the turbance Mass Caust as "High" probability for " Severe Winter Wea" were rated as "High /Degree of disruption" for ards " Tornado cane Hazardous Matturbance Mass Caust ack Water Failure uption Preparedness" for the "Pandemic/Infectious sed as "Low" probability ulnerability, and the agardness for this hazard aredness for this hazard at a This plan used dress all types of incide include: Fire Weath Hazardous material stages. Transit and worsters. Terrorist/WMD exports events, such as sports events" The to evidence strategies for events identified by telated to the current	a, and DAPI B/21 sality or the ather for the derial sality	E 006			

		(X1) PROVIDER/SUPPLIER/C	PROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER:		LE CONSTRUCTION	` '	(X3) DATE SURVEY COMPLETED	
		151575		B. WING			C <b>6/2021</b>	
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E 006	E 006 Continued From page 4 indicated the agency's Emergency Preparedness Plan should include strategies for addressing emergency events identified by the risk assessment and the agency did not have specific strategies within the EPP related to the COVID-19 pandemic.			E 006				
E 016	Hospice Follow up for CFR(s): 418.113(b)(1	)		E 016				
	§418.113(b)(1): Condition for Participation: [(b) Policies and procedures. The hospice must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. At a minimum, the policies and procedures must address the following:							
	patients to determine the event that there is during or due to an er must inform State and on-duty staff or patier contact. This Standard is not Based on record revie hospice agency failed Preparedness Plan (E contacting state and I staff and/or patients to contact, which had agency patients and experience of the event of the ev	met as evidenced by: ew and interview, the d to evidence its Emerg EPP) included a system local officials of any on- the agency had been ur I the potential to affect a	ed, in ices e to ency n for duty nable					
	Findings include:							
	An agency policy title	d "Emergency						

AND PLAN OF CORRECTION   IDENTIFICATION NUMBER:   A. BUILDING   COMPLETED   C   C   C   C   C   C   C   C   C	1
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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
VIAQUEST HOSPICE OF INDIANA, LLC 724 WEST NAVAJO STREET	
WEST LAFAYETTE, IN 47906	
PREFIX (FACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PREFIX (FACH CORRECTIVE ACTION SHOULD BE	(X5) IPLETION DATE
E 016 Continued From page 5 E 016	
E 016  Continued From page 5  Management, "policy number B-300 and revised 2/2017, stated "Policy. Viaquest Hospice of Indiana has an identified plan in place to ensure the safety and well-being of platients and employees during periods of an emergency or disaster that disrupts agency services  Viaquest Hospice of Indiana will develop and maintain a written emergency management plan describing the process for disaster readiness and emergency management and implements it as appropriate Procedure: 3. Emergency Preparedness Plan Areas addressed in the plan include: G. Patient, Family, Staff Emergency Preparedness Plan"  The agency's Emergency Preparedness binder was reviewed on 7/16/2021. The binder included the agency's Emergency Preparedness Plan and indicated it was last reviewed on 3/8/21 by OAPI Educator #1. The EPP included an "Organization Assignment Sheet," which indicated positions and responsibilities assigned to agency staff. The Organization Assignment Sheet," which indicated positions and responsibilities assigned to agency staff. The Organization Assignment Sheet indicated the "Logistics Officer" was responsible for the duty" identify patients and staff affected by the emergency, "the "Safety and Security Officer" was assigned the duty " Establist/maintain communication lines to local/stafe EMS/authorities to disseminate general information to/from agency," and the "Emergency Supervisor" was assigned the duty " Maintain list of contacted and available staff "The EPP stated " incident Command Center Patient Care & Planning. On admission, the admitting nurse will assign each patient a priority code, dictating that patient's emergency rating (Disaster Triage) Plan Activation. Emergency Call Down Procedure	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/S IDENTIFICATION NUMB			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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	OVIDER OR SUPPLIER T HOSPICE OF INDIA	NA, LLC	724 WE	NDDRESS, CITY, STATE, ZIP CODE WEST NAVAJO STREET ST LAFAYETTE, IN 47906				
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E 016	(Telephone Tree) persons listed below are unable to reach a telephone, they will person on the list. To office and list the emassistance Upon a minutes, a designate employees not found notify the Branch Direct pinpoint of be available Assignments: The [V and/or Branch Direct pinpointing patients and assigning clinicathose patients by utilipriority classification to evidence a system local officials of any owhich the agency was An interview was corp M with the Administ Hospice (VP #1). Duindicated the agency Plan should include and local officials of a patients which the agency Plan should include and local officials of a patients which the agency Plan should include and local officials of a patients which the agency Plan should include and local officials of a patients which the agency Plan should include and local officials of a patients which the agency Plan should include and local officials of a patients which the agency Plan should include and local officials of a patients which the agency Plan should include and local officials of a patients which the agency Plan should include and local officials of a patients which the agency Plan should include and local officials of a patients which the agency Plan should include and local officials of a patients which the agency Plan should include and local officials of a patients which the agency Plan should include and local officials of a patients which the agency Plan should include and local officials of a patients which the agency Plan should include and local officials of a patients which the agency Plan should include and local officials of a patients which the agency Plan should include and local officials of a patients which the agency Plan should include a patients	Each staff member will them on the call list. If an employee on the proceed to the next liste the staff member will call ployees available for arrival, every five (5) at staff member will try to the will the first call attempeter of any other employees or will work to assist affected by the emerger I staff member to check izing the Disaster Triagon system The EPP in for contacting state and on-duty staff and/or paties unable to contact.  Inducted on 7/16/21 at 2 trator and Vice Presider uring the interview, the vice Emergency Prepared a system for contacting any on-duty staff and/or gency was unable to contact in the co	they d If the those of and oyees ce in ncy is on e failed d dents  1), ), 1), (1), (1), 1), (1), (1),	E 016				
		develop and maintain a ness communication pl						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA			LE CONSTRUCTION		(X3) DATE SURVEY	
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VIAQUES	T HOSPICE OF INDIA	NA, LLC		ST NAVAJO _AFAYETTE,				
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E 030	that complies with Fe and must be reviewed 2 years [annually for communication plant following:]  (1) Names and contate following: (i) Staff. (ii) Entities providing (iii) Patients' physicia (iv) Other [facilities]. (v) Volunteers.  *[For Hospitals at §48 §485.625(c)] The coninclude all of the follo (1) Names and contate following: (i) Staff. (ii) Entities providing (iii) Patients' physicia (iv) Other [hospitals at (v) Volunteers.  *[For RNHCls at §403 communication plant following: (1) Names and contate following: (1) Names and contate following: (i) Staff.	deral, State and local lad and updated at least LTC facilities]. The must include all of the ct information for the services under arrange and CAHs at munication plan must wing: ct information for the services under arrange and CAHs].  3.748(c):] The must include all of the ct information for the	ewery ement.	E 030				
	*[For ASCs at §416.4 plan must include all (1) Names and conta		ion					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER				E CONSTRUCTION	(X3) DATE SUR' COMPLETE	ED	
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	OVIDER OR SUPPLIER T HOSPICE OF INDIA	ANA, LLC	724 WES	ESS, CITY, STAT ST NAVAJO AFAYETTE,	STREET		
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E 030	Continued From pa  (i) Staff. (ii) Entities providing (iii) Patients' physici (iv) Volunteers.  *[For Hospices at §4 communication plant following: (1) Names and cont following: (i) Hospice employe (ii) Entities providing (iii) Patients' physici (iv) Other hospices.  *[For HHAs at §484 plan must include at (1) Names and cont following: (i) Staff. (ii) Entities providing (iii) Patients' physici (iv) Volunteers.	ge 8 g services under arrange ans.  418.113(c):] The must include all of the fact information for the ses. g services under arrange ans.  102(c):] The communication for the following: fact information for the g services under arrange ans.	ment.	E 030		ROPRIATE	
	following: (i) Staff. (ii) Entities providing (iii) Volunteers. (iv) Other OPOs. (v) Transplant and of Donation Service Ar This Standard is not Based on record revenue hospice agency failed Preparedness Plan communication plant	g services under arrange donor hospitals in the OP rea (DSA). of met as evidenced by: view and observation, the ed to evidence its Emerg	PO's e ency				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		' '	LE CONSTRUCTION	, ,	(X3) DATE SURVEY COMPLETED		
AND I LAN O	CONNECTION	IDENTIFICATION NOMBE	.11.	A. BOILDING		C			
		151575		B. WING		07/1	6/2021		
NAME OF PR	OVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE				
VIAQUES	T HOSPICE OF INDIA	NA, LLC	724 WE	WEST NAVAJO STREET					
			WEST I	_AFAYETTE,	IN 47906				
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY			ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE		
E 030	Continued From page	<u> </u>		E 030					
€ 030	Continued From page 9 patient physicians, and other hospices, which had the potential to affect all hospice agency patients and employees.			€ 030					
	Findings include								
	An agency policy titled "Emergency Management," policy number B-300 and revised 2/2017, stated "Policy Viaquest Hospice of Indiana will develop and maintain a written emergency management plan describing the process for disaster readiness and emergency management and implements it as appropriate Procedure: 3. Emergency Preparedness Plan: Viaquest Hospice of Indiana will establish an Emergency Preparedness Plan Areas addressed in the plan include: G. Patient, Family, Staff Emergency Preparedness Plan"								
	was reviewed on 7/16 the agency's Emerger indicated it was last re Educator #1. The EP Assignment Sheet," wresponsibilities assign Organization Assignm "Liaison Officer" was Maintain open lines on health care facilities to to/from Hospice Supervisor" was resp Contact local facilities availability for displace The EPP stated " In Planning Each of a current list of contact vendors, emergency other appropriate com	." and the "Emergency onsible for the duty "	uded I, and DAPI zation s and he e y " ther  ter ntain I The						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	LE CONSTRUCTION	, ,	(X3) DATE SURVEY COMPLETED		
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E 030	Continued From pag	e 10		E 030					
	each county serviced by the agency, which contained contact information for the county's "Fire EMS State Emergency Office Local Emergency Office Hazmat Department of Health [local] Terrorism Tip Line Hospital County Highway Department Local Radio Station" The EPP failed to evidence its communication plan included contact information for entities providing services under arrangement, patient physicians, and other hospices.  An interview was conducted on 7/16/21 at 2:47 PM with the Administrator and Vice President of Hospice (VP #1). During the interview, VP #1 indicated the agency's Emergency Preparedness Plan should include a communication plan with contact information for entities providing services under arrangement, patient physicians, and other								
L 000	hospices. INITIAL COMMENTS			L 000					
	This was a federal recertification and state re-licensure survey of a hospice agency with 3 complaints.		ı 3						
	Federal findings Complaint # IN00311 Federal findings	687 - Substantiated wit 953 - Substantiated wit 327 - Unsubstantiated							
	Survey Dates: July 6, 2021	7, 8, 9, 12, 13, 14, 15,	16;						
	Facility Number: 003	308							
	Provider Number: 15	1575							
	Unduplicated Admiss	ions for Last 12 Months	s: 364						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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VIAQUES	T HOSPICE OF INDIA	NA, LLC		ST NAVAJO AFAYETTE,			
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L 000	Active Census: 144 Current Home Patient Cureent Patients Res Facility (ALF): 13 Current Patients Resi Facility (SNF): 39	ts: 92 iding in an Assisted Liv ding in an Skilled Nurs		L 000			
L 521	Quality review Area 2  INITIAL & COMPREHENSIVE ASSESSMENT OF PATIENT CFR(s): 418.54		NT OF	L 521			
	writing a patient-spec assessment that iden hospice care and serv for physical, psychoso spiritual care. This as of hospice care relate	tifies the patient's need vices, and the patient's	need				
	thorough comprehens patient's physical, psy spiritual needs were of which identified the pa hospice for 8 of 8 acti	_	and ented for ewed				
	Findings include:						
	number C-145 and re	itled "Initial nensive Assessment,"   vised 4/2017, stated "					

Printed: 08/13/2021 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		1	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	(
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	ROVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STA	TE, ZIP CODE		
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATO OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE C	(X5) COMPLETION DATE
L 521	Each patient admitted comprehensive asset [Registered Nurse] C Hospice IDG [Interdist complete the compre comprehensive asset patient's need for Hopatient's need for: Phand emotional care. Hospice care related management of the tronditions"  2. An agency policy "Reassessments/Upd Assessment," policy 3/2017, stated " Proposition of the policy of the comprehensive and accomplished by the consider changes the initial assessment comprehensive assessments of changes the initial assessment of changes assessments of changes the initial assessment of changes assessments of changes assessments of changes chronic Obstructive I intellectual disability, pressure ulcer to the to the left and right for the assessment complete. The assessment state Cognitive Status Legister in the comprehensive assessment state.	d will receive a sement. The RN ase Manager along wit sciplinary Group] must hensive assessment sement will identify the spice care and identify sysical care. Psychosoc Spiritual care. All areast to the palliation and erminal illness and related to the Comprehens number C-155 and revisocedure. 1. The updates sessment must be Hospice IDG and must have taken place since the palliation and must have taken place since the update to the sesment will include ges in physical, nal, and spiritual needs of Patient #1 was revisal and indicated a benefication and indicated as pulmonary fits including but not limit or pulmonary Disease (CC) cardiomegaly, anxiety, right ankle, and contractions.	the cial so of ted sive sed e of ust ce the cial brosis ed to: DPD), ctures	L 521			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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151575				B. WING		07/16	/2021
NAME OF PR	ME OF PROVIDER OR SUPPLIER			ESS, CITY, STA	TE, ZIP CODE	· ·	
VIAQUES	T HOSPICE OF INDIA	NA, LLC	724 WE	ST NAVAJO	STREET		
			WEST L	AFAYETTE,	IN 47906		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
L 521	Continued From pag	e 13		L 521			
L 521	Alertness: Moderately Consciousness: Alert Emotional/Behavioral of object/situation. Remental acts Plan of Status Mental Status Notes Patient has for anxiety], Buspar [r. Lexapro [medication ganxiety] for anxiety ar comprehensive assess thorough and comple assessment which ide behaviors the patient patient's current medicappropriate and effect mental status was list need for hospice care. The comprehensive a Review of Systems and indicated the ulcers to the right and also stated " Plan of Supplies: Wound Car Pads. Hydrogel. Ker Notes Patient has a shins measuring R 7cm x 4cm with active surrounding erythema warmth noted. Patien outer ankle Patient under abdominal aprodrainage at this time assessment failed to thorough assessment (amount of drainage addressing from stasis in the status of the same and the same active active and the same active active active and the same active act	wimpaired Level of Status: Anxiety: Persistent is epetitive behaviors or f Care - Other - Mentalus: Lethargic Nari Ativan [medication gimedication given for angiven for depression and behaviors" The sament failed to evidente emotional and behaviors entified the specific was exhibiting, if the dication regimen was tive, why the patient's exercises related to this exercises related to this exercises. The assessment also stated Integumentary Bruis patient had venous stated Integumentary Narrat oilateral stasis ulcers to [right] 5.5cm x 3cm, Le yellow drainage and	rative iven xiety], id/or ce a vioral ne s Ditive of [left] a R int of e nd s ce of	L 521			
	_	ressing; detailed descr					

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		1 ' '	LE CONSTRUCTION	(X3) DATE SUR COMPLETE	ED
		151575		B. WING	<del></del>		C 6/ <b>2021</b>
NAME OF PR			STREET ADDR	ESS, CITY, STA	TE, ZIP CODE		
VIAQUEST HOSPICE OF INDIANA, LLC				ST NAVAJO AFAYETTE,			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY  OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
L 521	of skin "issue" to the presence or absence  The comprehensive a - Pain Assessment able to verbalize: Yes Used: FLACC ["Face Consolability;" type oused by health profes non-verbal, with resu where 0 is no pain observable] T Severity The patie Comprehensive Pain and Follow Up: Patie treatment? Yes. Treatment? Yes. Treatment? Yes. Following treatmedication change: I Medications - Medicate Review New/change medication profile up [opioid medication given to the patient orders for Morphine Sper milliliter), administ orders for Morphine Sper milliliter), administ onco (hydrocodone-medication given to the table every 6 hours Fassessment failed to complete pain assess to complete a self-as as the 0-10 numeric spatient to be started of the pain assessment evidence an issue wiregimen, etc).	left hip, color of drainage of odor and dressing, of odor and dressing, of odor and dressing, of assessment stated " Pain Screening Patis Staff Observation S , Legs, Activity, Cry, of standardized pain scassionals when patients lits ranging from 0 - 10, oserved and 10 is the word of the following the control of the word of the w	Pain ient cale le are orst Pain me ent urrent d: fille ied, iete he which rams is and ind mg, ind able such pain	L 521			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 .	LE CONSTRUCTION	, ,	(X3) DATE SURVEY COMPLETED	
AND I LAN O	CONNECTION	IDENTIFICATION NOMBE	-11.	A. BOILDING	·		C	
	151575			B. WING		07/16/2021		
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STA	TE, ZIP CODE			
VIAQUES	T HOSPICE OF INDIA	NA, LLC	724 WE	ST NAVAJO	STREET			
			WEST L	AFAYETTE,	IN 47906			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
L 521	Continued From page	e 15		L 521				
L 521	on 7/8/21 and indicated 4/17/21, with the patie indicated as hyperten disease caused by his heart failure (CHF) ar including but not limit (inability to control uri history of falls.  The record included a comprehensive asses 6/30/21 by RN #1. To Care Plan Documenta intolerance. Note: Coendurance. Note: Coendurance. Note: Coendurance. Note: Coendurance. Vote: Coendurance of Care - Other - Active Permitted: Up as Tole Patient ambulates with unsteady gait Sup ambulate safely Performed for the permitted of the complete assessment failed to complete assessment failed to complete assessment intolerance and enduractivity is tolerated, dispersion of the patient ambulates with the prollator walker to ambulate safely	ed a benefit election day ent's terminal diagnosis is ive kidney disease (kingh blood pressure) with a related diagnoses ed to: urinary incontine nation), weakness, and a recertification is sment completed on the assessment stated ation Assess activity ompleted Assess ompleted Review of cular is Fatigues easily wities Permitted Activated Narrative Note that a rolling walker but her ervision is needed for the atient's resting SpO2 heasurement of the od cells saturated with ping to low 80s [%] on SOB [shortness of breats to recover"  Ition was conducted on heatient #2 and RN #7 atient was observed us bulate. The comprehence is to fithe patient's activity rance status (how mucloses patient experience	dney n nce d "  Plan vities es as an nim to  ath],  1. sing a sive nd / h	L 521				
		,	-					

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		, ,	LE CONSTRUCTION	(X3) DATE SUR COMPLETE	ĒD
		151575		B. WING			C 6/ <b>2021</b>
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STA	TE, ZIP CODE		
VIAQUES	T HOSPICE OF INDIA	NA, LLC		ST NAVAJO			
			WESTL	AFAYETTE,	IN 47906		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY  OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
L 521	Continued From pag	e 16		L 521			
	do to manage.						
	on 7/8/21 and 7/15/2 election date of 4/5/2 diagnosis indicated a and related diagnose COPD, hypothyroid, incontinence, insomn Gastro-esophageal re	iia, anxiety, eflux disease (GERD, acid into esophagus), a	it minal sease ed to:				
	comprehensive asses 6/23/21 by RN #3. To Care Plan Document respiratory status inconsecretions, and lung shortness of Breath of Systems - Respira Please refer to intervolve Clinical Findings: Respiration of the patient's respiration of the patient's respiration of the palliation of	ssment completed on he assessment stated "ation Intervention: As luding rate, pattern, sounds. Status: Respira Upon exertion Retory. Status: Respirator ention documentation spiratory. Clinical The assessment faile and complete assessmatory system (lung sour esence or absence of coand what the hospice wese symptoms.	atory. view y: d to ent nds, bugh				
	Nutrition - Nutritional Risk Assessment: No Notes [Patient #3' [pounds,] her weight assessment failed to thorough assessmen status despite the par	assessment stated " Status/Risks Nutrition of Assessed Narrativ s] weight 4/2021 was 1: today was 114 #" T evidence a complete ai t of the patient's nutrition tient's weight loss. If of Patient #4 was revie	e 20 # he nd n				

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	IENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			1	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		151575		B. WING		C 07/16/2021	
VIAQUEST HOSPICE OF INDIANA, LLC 724			724 WE	RESS, CITY, STA ST NAVAJO AFAYETTE,	STREET		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION	
L 521	on 7/9/21 and indica 4/21/21 with a termin kidney disease with including but not limiting pain, osteoarthritis our urinary incontinence. The record included comprehensive asse 6/28/21 by RN #4. Wound Assessment Medial Buttocks F [wound caused by p Assessment: Wound meaning unknown] #4] now has a stage area. Barrier cream used, as well as butt placed over wound f assessment failed to thorough assessment (color of wound bed drainage and odor, a changes).  7. The clinical record on 7/12/21 and indicated of 6/12/2020 with a talegeneration of the including but not limit behavioral disturbant anxiety, urinary inconhistory of prostate care. The record included comprehensive asse 5/18/21 by RN #5. Treview of Systems Emotional: Depressi	ted a benefit election dated a benefit election dated diagnosis of hyperter CHF and related diagnosited to: fibromyalgia, christ both knees, epilepsy, and a recertification essment completed on The assessment stated and Care. Right Posterioressure Ulcer Stage II rolonged pressure]. Bed CBD [acronym Narrative Notes [Page 2 pressure ulcer to cook with zinc and manuka haterfly adhesive Kerrafoar for protection" The protection The protection acromplete and the patient's wound appresence or absence of and frequency of dressing dof Patient #5 was reviewed a benefit election of the patient and related diagnosis of "see brain" and related diagnosis of the certification of the pressure ulcer ancer.	nsive ses sonic and or ratient cyx oney m nd f g ewed late nile oses r, and	L 521			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		151575		B. WING		C 07/16/2021	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STA	TE, ZIP CODE	•	
VIAQUEST HOSPICE OF INDIANA, LLC				ST NAVAJO AFAYETTE,			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RE ENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COM	(X5) PLETION DATE
L 521	to treat several mental depression and bipola to 3 times a day, Ativa anxiety] has been incomed to [sic] to increase recertification" The vidence if the medicor not improved the possessment and Care Buttocks/Decubitus/P Wound Bed: Clean area/Surgical Incision Clean" The assessment and thoroug patient's wounds (me bed and surrounding of drainage and odor, needed, etc), or intercomplete in regard to 8. The clinical record reviewed on 7/15/21 alection date of 6/3/2 of lung cancer with mand related diagnoses altered mental status, heart rhythm), hypoth chronic kidney disease fecal incontinence, his cancer, and pressure The record included a assessment complete assessment stated ". Care. Left Buttocks (buttocks)/Decubitus/F. Bed: Clean. Bed Cole	al health disorders, includer disorder] was increased in [medication given to reased to 0.5 ml from 0 and behaviors this eleasessment failed to ation changes had impatient's "behaviors."  stated " Wound ele Genital-urinary Public Assessment: Wound sment failed to evident and sment failed to evident and sment failed to evident assurements, color of we skin, presence or absellow wounds.  of Patient #18 was and indicated a benefit in with a terminal diagnor etastasis [spread] to be sincluding but not limit atrial fibrillation (irregulty of renal (kidney))	able: bic Bed: be a  ound nce g as to  osis one ed to: alar ,  The and ween and eri	L 521			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
151575			B. WING			C 6/ <b>2021</b>	
NAME OF PROVIDER OR SUPPLIER STRE		STREET ADDRE	ESS, CITY, STA	TE, ZIP CODE			
VIAQUES	T HOSPICE OF INDIA	NA, LLC		ST NAVAJO AFAYETTE,			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
L 521	limits]. Drainage: No Care Provided by: Cli Patient has reddened cleft, and left glute [but however [Patient #18] area is tender to touc [type of dressing used heel, area is red and [Skilled Nursing Facility preventative d/t rednefailed to evidence a consessment of the parabsence of dressing change to be dression. The assessment state Assessment Depre Emotional/Behavioral Depression Evaluation due to the following: In depression and fear a The assessment complete and thorough patient's depression (depression, etc).	None Dressing: Which area to sacrum, gluted area to sacrum, gluted attocks], no open areas a states entire reddened h. Patient has foam All don pressure sores] to blanchable at this time. ity] Staff reports dressingss" The assessment omplete and thorough tient's wounds (present treatment to reddened attock, frequency of the performed to wound of the performed to woun	es: al black delevyn L cong is nt ce or ed con left  cong is nt cong is n	L 521			

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER		` ′	LE CONSTRUCTION	(X3) DATE SU COMPLE	TED
		151575		B. WING		07/	C <b>16/2021</b>
	OVIDER OR SUPPLIER T HOSPICE OF IND	IANA, LLC	724 WE	RESS, CITY, STA ST NAVAJO AFAYETTE,	STREET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY M	Y STATEMENT OF DEFICIENCIES IUST BE PRECEDED BY FULL RE IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
L 521	#1). During the into	age 20 fice President of Hospice erview, VP #1 indicated the sessment should include health and psychosocial	he	L 521			
L 524	CONTENT OF CO ASSESSMENT CFR(s): 418.54(c)	MPREHENSIVE		L 524			
	The comprehensive assessment must identify the physical, psychosocial, emotional, and spiritual needs related to the terminal illness that must be addressed in order to promote the hospice patient's well-being, comfort, and dignity throughout the dying process.						
	Based on observatinterview, the hosp comprehensive assaddressed the physemotional needs reillness for 4 of 8 ac	ot met as evidenced by: ion, record review, and ice agency failed to ensu sessment identified and sical, psychosocial, and elated to the patient's tern tive records reviewed (#1 ale of 20 records reviewed	ninal , 2, 5,				
	number C-145 and Procedure II. Co The comprehensive patient's need to Psychosocial and of Hospice care relate management of the	orehensive Assessment," revised 4/2017, stated " comprehensive Assessment e assessment will identify or: Physical care. emotional care All area ed to the palliation and e terminal illness"	nt the				
	2. The clinical reco	ord of Patient #1 was revi	ewed				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		151575		B. WING		1	C <b>6/2021</b>	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE. ZIP CODE	L		
				ST NAVAJO	,			
VIAQUES	THOSPICE OF INDIA	NA, LLO		AFAYETTE,				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
L 524	Continued From pag	e 21		L 524				
		1 and indicated a benef	it					
	election date of 6/25/2							
		dicated as pulmonary fil	brosis					
		s including but not limit						
		Pulmonary Disease (CC						
		cardiomegaly, anxiety,	- /					
		right ankle, and contract	ctures					
	•	et. The record included						
		assessment completed						
	6/25/21 by RN #2. Th	he assessment stated "	·					
	Review of Systems -	Emotional/Behavioral						
	Status: Emotional/Be	havioral Anxiety						
	Persistent fear of obje	ect/situation. Repetitive	•					
	behaviors or mental a	acts Narrative Notes						
		[medication given for						
		dication given for anxiet						
		given for depression an	id/or					
		nd behaviors" The						
		ssment failed to eviden						
	•	elated to their "behavior	s"					
	and failed to evidence		_					
		patient's current anxiety	/					
	medication regimen.							
	2 The clinical record	l of Patient #2 was revi	owod					
		ed a benefit election da						
		ed a benent election da ent's terminal diagnosis						
		isive kidney disease (ki						
	· .	gh blood pressure) with	•					
	heart failure (CHF) ar		'					
	` ,	ed to: urinary incontine	nce					
	_	ination), weakness, and						
	history of falls. The re							
	recertification comprehensive assessment							
	completed on 6/30/21							
		Review of Systems -						
		cal Findings: Fatigue						
	_	s: Throughout the Day						
		uded a "Medication Pro						
		medication "Trazodone						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		151575		B. WING		1	C <b>6/2021</b>
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STA	TE, ZIP CODE		
	T HOSPICE OF INDIA	NA. LLC		ST NAVAJO			
		<b>,</b>		AFAYETTE,			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATO  OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUT CROSS-REFERENCED TO THE APPROPRIED TO THE APP	ULD BE	(X5) COMPLETION DATE
I 524	Continued From page	e 22		I 524			
L 524	A home visit observation 7/7/21 at 9:56 AM with During the visit, Patiestired I don't get enissues with fatigue and comprehensive assessment of the passessment of the passes assessment of effective sleep and fatigue and evaluation of effective sleep medication.  4. The clinical record on 7/12/21 and indicated of 6/12/2020 with a tedegeneration of the bincluding but not limit behavioral disturbance anxiety, urinary inconhistory of prostate carrecertification compressessment stated "Lemotional/Behaviors Behavioral: Appropria Gastrointestinal Be or stool softeners issues with constipation.	nelp treat insomnia] conce at bedtime' cion was conducted on h Patient #2 and RN #' nt #1 reported he was ' ough sleep," and indicated difficulty sleeping. The sement failed to evidence tient's needs related to l failed to evidence an eness of the patient's contents of Patient #5 was revie ted a benefit election de rminal diagnosis of "se rain" and related diagned to: dementia with thes, CHF, depression, tinence, pressure ulcer ncer. The record include thensive assessment by RN #5. The Review of Systems Emotional: Depress te Review of System owel Regimen Laxa Narrative Notes son on d/t [due to] decrease	I. "a lot ated ne ce an urrent ewed late nile oses ", and ded a ion. ms - tives ne eed	L 524	DEFICIENCY)		
	issues with constipation d/t [due to] decreased mobility Seroquel [medication given to treat several mental health disorders, including depression and bipolar disorder] was increase[d] to 3 times a day, Ativan [medication given to treat anxiety] has been increased to 0.5 ml from 0.25 ml do [sic] to increased behaviors this recertification" The assessment failed to evidence a thorough and complete assessment of the patient's anxiety and constipation, and failed to evidence an evaluation of the change in						

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE			LE CONSTRUCTION	(X3) DATE SUF COMPLET	ED
		151575		B. WING			C <b>6/2021</b>
NAME OF PR	PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE						
VIAQUES	T HOSPICE OF INDIA	NA, LLC		ST NAVAJO LAFAYETTE,			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL RE OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
L 524	election date of 11/22 of Alzheimer's disease including but not limit and agitation, dysuria incontinence, GERD, record included a recoassessment complete. The assessment state Emotional/Behaviora Wandering Narrat continues to wander [Patient #11] is easunderstand and follow given Depakote [mediagitation, seizures, and aily for behaviors, sitto treat anxiety] at nig Patient sleeps about assessment failed to thorough assessment related to her anxiety an evaluation of the eanxiety medication reconstruction.	d of Patient #11 was and indicated a benefit 2/19 with a terminal diagree and related diagnose ted to: anxiety, restless a, stress incontinence, b, and history of falls. The tertification comprehensed on 6/22/21 by RN #6 ed " Review of Syste I Behavioral: Pacing ive Notes: [Patient # all day throughout the histly agitated due to inably directions [the patient in dorning in the takes Xanax [medication given to treat and/or migraines] 2 times the takes Xanax [medication in the patient in the patie	gnosis sis ness powel ne sive o int full full full full full full full ful	L 524			
L 330	ASSESSMENT CFR(s): 418.54(c)(6)			L 330			
	[The comprehensive	assessment must take	into				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		151575		B. WING	<del></del>	07/	C 16/2021	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STAT	TE, ZIP CODE	•		
VIAQUEST HOSPICE OF INDIANA, LLC				ST NAVAJO _AFAYETTE,				
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES BY BE PRECEDED BY FULL REDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
L 530	prescription and over remedies and other a could affect drug the not limited to, identification of limited (iv) Drug side effects (iii) Actual or potentia (iv) Duplicate drug the (v) Drug therapy currel laboratory monitoring.  This Standard is not Based on record revisions agency failed comprehensive assess included indications of medications, detailed apply topical medications used for 3 of 8 active records total sample of 20 records include:  1. An agency policy Management," policy 2/2017, stated " Promprehensive patient at start of care and of and includes a review patient is taking Moreviewed with the particular is complete medication.	owing factors:] eview of all of the patien r-the-counter drugs, her alternative treatments th rapy. This includes, but cation of the following: rug therapy al drug interactions terapy tently associated with d.  met as evidenced by: tiew and interview, the d to ensure the ssment's medication list for all as needed (PRN) d instructions on where the tions, and detailed to administer multiple r symptomatic treatment reviewed (#1, 5, 11), in cords reviewed.  titled "Medication r number C-705 and rev	t to to are cation A	L 530				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
	N OF CORRECTION IDENTIFICATION NUMBE			B. WING			C 6/ <b>2021</b>	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDF	RESS, CITY, STA	TE, ZIP CODE	•		
,				ST NAVAJO .AFAYETTE,				
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REGENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
L 530	Continued From page	e 25		L 530				
L 530	amount and frequence limitations"  2. The clinical record on 7/6/21 and 7/14/2′ election date of 6/25/2′ terminal diagnosis incommon and related diagnoses. Chronic Obstructive Fintellectual disability, pressure ulcer to the to the left and right feinitial comprehensive 6/25/21 by RN #2, where Profile." The Medicat medications " Morp medication given to tree [milligrams per millilite Administer 0.25ml Norco [hydrocodon medication given to treat fungal infections topical [applied to the topical once a day to evidence an indicat Morphine Sulfate, failed directions on how to compensation of the proposed for the directions on how to compensation to administer failed directions on how to compensation to administer failed to the directions on how to compensation to administer failed to the directions on how to compensation to administer failed to the directions on how to compensation to administer failed to the directions on how to compensation to administer failed to the direction of the direction	PRN medications includy and any other time  of Patient #1 was reviel and indicated a benefect, with the patient's dicated as pulmonary files including but not limite pulmonary Disease (CC) cardiomegaly, anxiety, right ankle, and contract et. The record included assessment, complete assessment, complete citich contained a "Medication Profile included the othine Sulfate [opioid eat pain] 20 mg/ml er] oral concentrate; Q4H [every 4 hours] P e - acetaminophen, opi eat pain] 325 - 7.5 mg orally every 6 hours as systatin [medication give ]100000 units/g [gra skin] powder; Apply 1 e "The medication list fat tion for administration for	ewed it orosis ed to: DPD), ctures d an d on ation en to am] dose ailed or two s and	L 530				
			ate nile					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	C				C 07/16/2021		
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STA	TE, ZIP CODE		
VIAQUES	T HOSPICE OF INDIA	NA, LLC		ST NAVAJO AFAYETTE,			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RE ENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETIC	ON
L 530	behavioral disturbance anxiety, urinary incon history of prostate car recertification compressore completed on 5/18/21 a "Medication Profile. stated " Milk of macconstipation] 400mg/s milliliter(s) orally Daily Topical [medication urinfections] 100000 un [Apply] 2 times a day assessment failed to administration for Mill and failed to evidence apply the Nystatin por 4. The clinical record reviewed on 7/15/21 election date of 11/22 of Alzheimer's diseas including but not limit and agitation, dysurial incontinence, GERD, record included a record assessment complete The assessment incluwhich contained the rough the contained the rough for	tinence, pressure ulcerncer. The record include thensive assessment by RN #5 which contains a medication profilegresia [medication use of mile on the medication of the medication use of mile on the mile of the	ded a  ined e d for 30 n r r tatin o gnosis s ness powel lie sive 6. file" Kanax i gg/ml ally tepam r ke 1 cition illed mine	L 530			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1, ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		151575		B. WING			C 5/ <b>2021</b>
NAME OF PR	OVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE	•	
VIAQUES	T HOSPICE OF INDIA	NA, LLC		ST NAVAJO _AFAYETTE,			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REC ENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
L 530	PM with the Vice Pres During the interview, medication order sho administration, a topic include directions on medication orders sho directions on when to medications for the sa UPDATE OF COMPE CFR(s): 418.54(d)	conducted on 7/15/21 a sident of Hospice (VP # VP #1 indicated a PRN uld include the indicatio cal medication order should evidence clear administer multiple PR ame indication.  REHENSIVE ASSESSM	#1). on for ould e RN	L 530			
	must be accomplishe interdisciplinary group individual's attending consider changes that initial assessment. It the patient's progress as well as a reassess response to care. The be accomplished as f	d by the hospice o (in collaboration with to physician, if any) and no it have taken place since must include information to toward desired outcome	the nust be the on on nes, must ion of				
	Based on record reviet hospice agency failed comprehensive assess progress towards their records with recertification.	I to ensure the essment included the pat ir goals for 5 of 5 active cation comprehensive ed (#2, 3, 4, 5 11), in a t	<b>:</b>				
	1. An agency policy t	itled					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	NAME OF PROVIDER OR SURPLIER			B. WING		07/1	C 1 <b>6/2021</b>
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STA	TE, ZIP CODE		
VIAQUES	T HOSPICE OF INDIA	NA, LLC		ST NAVAJO .AFAYETTE,			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATOR  OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
L 533	"Reassessments/Upon Assessment," policy in 3/2017, stated " Proposed the comprehensive as information on the part desired outcomes  2. The clinical record on 7/8/21 and indicated 4/17/21, with the patic indicated as hypertendisease caused by his heart failure (CHF) ar including but not limit (inability to control uri history of falls. The recertification comprecompleted on 6/30/21 assessment stated " Goals Goals partial make progress accordassessment failed to progress towards goapatient's response to patient's goals were to modified.  3. The clinical record on 7/8/21 and 7/15/22 election date of 4/5/2 diagnosis indicated and related diagnoses COPD, hypothyroid, of incontinence, insomm Gastro-esophageal rebackflow of stomach history of falls. The recertification comprecompleted on 6/23/21	late to the Comprehens number C-155 and revisoredure: 1. The update sesessment must including the property of Patient #2 was revided a benefit election datent's terminal diagnosis sive kidney disease (kigh blood pressure) with a related diagnoses ed to: urinary incontine nation), weakness, and ecord included a schensive assessment by RN #1. The Visit Plan - Status of ally met; patient continuing to plan of care evidence the patient's als, reassessment of the care, and whether the continue or needed to of Patient #3 was revial and indicated a benefit, with the patient's terms hypertensive heart dissincluding but not limited to be a sincluding but not limited to steoarthritis, urinary it, anxiety, anxiety, anxiety, and thensive assessment schensive assessment schensive assessment	sed e of lude s ewed te of dney n nce f The e o be ewed it minal sease ed to:	L 533			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		` '	(X3) DATE SURVEY COMPLETED	
		151575		B. WING			C <b>6/2021</b>	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	ADDRESS, CITY, STATE, ZIP CODE				
VIAQUES	T HOSPICE OF INDIA	NA, LLC		ST NAVAJO .AFAYETTE,				
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RE ENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION SH	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
L 533	Goals Goals partial make progress accordances assessment failed to progress towards goal patient's response to patient's goals were to modified.  4. The clinical record on 7/9/21 and indicate 4/21/21 with a terminal kidney disease with Clincluding but not limite pain, osteoarthritis of urinary incontinence. recertification comprecompleted on 6/28/21 assessment stated " Goals Goals partial make progress accordances assessment failed to progress towards goal patient's response to patient's goals were to modified.  5. The clinical record on 7/12/21 and indicate of 6/12/2020 with a ted degeneration of the bincluding but not limite behavioral disturbance anxiety, urinary inconhistory of prostate car recertification comprecompleted on 5/18/21 stated " Care Plan Patient will be maintal and oriented as approximations."	ally met; patient continueding to plan of care evidence the patient's als, reassessment of the care, and whether the continue or needed to of Patient #4 was reviewed a benefit election datal diagnosis of hyperter CHF and related diagnosed to: fibromyalgia, chroboth knees, epilepsy, at The record included a chensive assessment by RN #4. The Visit Plan - Status of ally met; patient continueding to plan of care evidence the patient's als, reassessment of the care, and whether the continue or needed to of Patient #5 was reviewed a benefit election derminal diagnosis of "se rain" and related diagned to: dementia with es, CHF, depression, tinence, pressure ulcernoer. The record includence.	"The e b be ewed tte of nsive ses onic and es to "The e b be ewed date nile oses date ded a sment al: nt ease	L 533				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER			: CONSTRUCTION	(X3) DATE SU COMPLE	TED
		151575		B. WING		07/1	C 16/2021
	OVIDER OR SUPPLIER T HOSPICE OF INDI	ANA, LLC	724 WE	RESS, CITY, STATE ST NAVAJO S AFAYETTE, I	TREET	•	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL F OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
L 533	coccyx will not open Plan - Status of Go Goals partially met; progress according assessment failed the progress towards gipatient's response the patient's goals were modified.  6. The clinical reconserviewed on 7/15/2 election date of 11/2 of Alzheimer's diseast including but not line and agitation, dysurincontinence, GERI record included a reassessment complete The assessment strongers to find the patient's progress to find the patient's responsible of the patient's responsible of the patient's goals were modified.  7. An interview was patient's diseast patient's goals were modified.  7. An interview was patient's responsible of the patient's goals were modified.	n. Progress: 100% Visals. Progress Towards God Patient #11 was 1 and indicated a benefit 22/19 with a terminal diagase and related diagnose inted to: anxiety, restlessing, stress incontinence, but and history of falls. The certification comprehense ted on 6/22/21 by RN #6 ated " Visit Plan - Stationards Goals: No progressment failed to evidence owards goals, reassessment of the tocontinue or needed to see the continue or needed to see the conti	e o be gnosis es ness bowel he sive 6. us of es the nent her the to be at 3:32 #1).	L 533			
L 538	SERVICES CFR(s): 418.56 The plan of care mi	NING, COORDINATION Countries the specify the hospice construction to meet the patient of the specific that is a second contribution to the specific that is a se	are	L 538			
	family-specific need						

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		ON   IDENTIFICATION NUMBER:   A. BUILDING   COMPLETED   C   C   151575   B. WING   07/16/202					
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STA	TE. ZIP CODE		
	T HOSPICE OF INDIA	NA LLC		ST NAVAJO	,		
TIAGOLO	THOU ISE OF INDIA	1171, 220		AFAYETTE,			
(X4) ID	SUMMARY ST			ID	PROVIDER'S PLAN OF CORRECT	ION	(X5)
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX TAG	(EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	COMPLETION DATE
L 538	Continued From page	e 31		L 538			
	comprehensive asses	ssment as such needs i	relate				
	to the terminal illness	and related conditions					
	This Standard is not	met as evidenced by:					
	Based on record revie						
		to ensure the plan of o	care				
	` , .	are and services neces	ssary				
	•	needs for 4 of 8 active					
	records reviewed (#1, of 20 records reviewe	, 3, 18, 19), in a total sa	ample				
	of 20 records reviewe	eu.					
	Findings include:						
	Group] Care Planning	titled "IDG [Interdiscipling Process," policy numb 0/2020, stated " Proce	per				
	2. The plan of care	specifies the care and	cuire				
	family-specific needs	meet the patient and identified in the					
		ssment as such needs					
	related to the termina						
		dividualized written plar	n of				
	care is developed for	each patient"					
		of Patient #1 was revie 1 and indicated a benef					
	election date of 6/25/2		ıı				
		dicated as pulmonary fil	brosis				
	and related diagnoses	s including but not limit	ed to:				
		Pulmonary Disease (CC	PD),				
	_	cardiomegaly, anxiety,	nturo o				
	=	right ankle, and contract					
	to the left and right feet. The record included a plan of care for the benefit period of 6/25/21 -						
	8/23/21. The POC stated " Activity Level: Up						
		ional Services: Wound	'				
	treatment to bilateral	lower extremity shin sta	asis				
		with soap and water, dr	-				
		apply NA dressing [type	e of				
	wound dressing typica	ally used on ulcer-type					

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STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA		. ,	LE CONSTRUCTION	' '	(X3) DATE SURVEY	
AND PLAN OF	OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY  OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY  A. BUILDING (X3) DATE SURVEY  COMPLETED  C							
		151575		B. WING			6/2021	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STA	TE, ZIP CODE	CODE		
	T HOSPICE OF INDIA	NA. LLC	724 WF	ST NAVAJO	STREET			
711 (40-10		,		AFAYETTE,				
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RE ENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
L 538	3 Continued From page 32			L 538				
		tubi-grip [tubular dress	ina					
	<u>-</u> :	step in wound care]	9					
			72					
	Change catheter drainage bag Q72H [every 72 hours] and PRN [as needed]" The record also							
		nprehensive assessme						
	completed on 6/25/21	•						
		Review of Systems -						
		elling catheter: Assess						
		nge (specify: q [every] _						
		are - Other - Supplies .						
		e 4x4 dressing. AB						
	Pads. Hydrogel. Ker	lix Wrap (roll) Narrat	ive					
	Notes Patient does	s not ambulate, [two pe	rson					
	assist] or mechanical	lift assist for transfers	"					
	The POC failed to evi	idence patient-specific						
		s activity level, failed to						
		ressing change frequer	ncy					
	and supplies to the pa							
	· ·	evidence orders for the						
		's urinary catheter syste						
	(not just the catheter	bag) was to be change	d.					
		of Patient #4 was revi						
		ed a benefit election da						
		al diagnosis of hyperter						
	_	CHF and related diagno						
	_	ed to: fibromyalgia, chr						
		both knees, epilepsy, a						
	-	The record included a						
		ertification period 4/21/						
		ned service orders for s	killed					
	nursing visits. The re		/0.4					
		up Meeting" dated 4/30						
		Notes 4/26/21 [						
		nt #4's family member]						
		asked about possibility	y UI					
	PT [physical therapy]		Mill					
		k for transfers. [RN #4] lirector and MD and ge						
		sit" The POC failed						
	DACK TO HEL AT HEXT VIS	Sit THE FOC falled	10					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
	15157			B. WING		C 07/16/2021	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STA	TE, ZIP CODE		
VIAQUES	T HOSPICE OF INDIAI	NA, LLC		ST NAVAJO AFAYETTE,			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATOR'  OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COI	(X5) PMPLETION DATE
L 538	evidence orders for a and/or treatment were desire to treat the pat 4. The clinical record on 7/15/21 and indica of 6/3/21 with a termir with metastasis [spreadiagnoses including be mental status, atrial firhythm), hypothyroidiskidney disease, visual incontinence, history or pressure ulcer to left lincluded a plan of car period of 6/3/21 - 8/3′ Supplies: 4x4 Drest The record also include assessment, complete which stated " Revidenitourinary Indwoof Change (specify: q. Notes: Patient hast The POC failed to evident of the urinary catheter changed, as well as we changing.  5. The clinical record reviewed on 7/15/21 and but not limited to: essent open wound to left brownich included a plan of car 6/22/21 - 9/19/21. The skilled nursing service week then 2 visits per stated " Supplies:	physical therapy evalue placed per the family ient's weakness.  of Patient #18 was revited a benefit election of hal diagnosis of lung cand] to bone and related but not limited to: altere brillation (irregular hears, depression, chronic I hallucinations, fecal of renal (kidney) cance outtock. The record e for the initial certifica I/21. The POC stated issing; Catheters - Foleyted an initial comprehed on 6/3/21 by RN #2 iew of Systems - elling Catheter Frequencially and heel dressing to be who was responsible for	iewed late ancer I d rt c r, and tion " y" ensive r l" eency oe r l" eercy oe r l" ecord eriod of for 1 and l l l l l l l l l l l l l l l l l l l	L 538			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		I ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		151575		B. WING			C <b>6/2021</b>
NAME OF PR	OVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
VIAQUES	T HOSPICE OF INDIA	NA, LLC		ST NAVAJO LAFAYETTE,			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES IT BE PRECEDED BY FULL REI ENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF COP (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
L 538	Perform wound care/orecord also included a assessment complete. The assessment indice wounds to the left low chest. The nurse independent wound was packed with a "Border Dressi evidence patient-spec (type of dressing, free etc).  6. An interview was on PM with the Vice Presulting the interview, interventions to be printerdisciplinary group.	dressing change" Tan initial comprehensive of on 6/22/21 by RN #7 cated Patient #19 had wer breast and right uppicated the left breast wo Band-Aid" and the right with wet gauze and covering." The POC failed to cific dressing care ordequency of dressing chance conducted on 7/15/21 as sident of Hospice (VP #VP #1 indicated the ovided by the plisted on the plan of cid based on the patient's	eer ound chest ered rs nge, at 3:32 #1).	L 538			
L 548	the terminal illness ar including the following (3) Measurable outco implementing and cod This Standard is not Based on record review hospice agency failed (POC) contained patigoals and outcomes in	st include all services liation and managemen nd related conditions, g:] omes anticipated from ordinating the plan of ca met as evidenced by:	are. care irable wed	L 548			

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIEI IDENTIFICATION NUM			1 ' '	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		151575		B. WING		07/	C <b>16/2021</b>	
	OVIDER OR SUPPLIER			ESS, CITY, STAT				
VIAQUES	T HOSPICE OF INDIA	ANA, LLC		ST NAVAJO : AFAYETTE,				
(X4) ID PREFIX TAG	(EACH DEFICIENCY MU	STATEMENT OF DEFICIENCIES ST BE PRECEDED BY FULL RE DENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF C RY PREFIX (EACH CORRECTIVE ACTIV TAG CROSS-REFERENCED TO TI DEFICIENCY		OULD BE	(X5) COMPLETION DATE	
	Group] Care Plannir C-580 and revised 1 1. Hospice has de group which, in consattending physician plan of care for each care reflects patient interventions based the initial compreher comprehensive asse	essments. The plan of c	per pedure nary s s en an of ed in are					
	from implementing a care"  2. The clinical record on 7/6/21 and 7/14/2 election date of 6/25 terminal diagnosis in and related diagnosis in and related diagnosis. Chronic Obstructive intellectual disability pressure ulcer to the tothe left and right for plan of care for the constructive skin integrity Aide environment Aide needs will be met Pt [patient] remains symptoms] of pain a reduced and within redyspneic [feeling our plan of care failed to and measurable goals.	able outcomes anticipate and coordinating the plan of	ewed fit brosis ed to: DPD), ctures d a 5/21 mote e eam]: "The iic					

0K5811

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		151575		B. WING		C 07/16/2021		
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STA	TE, ZIP CODE			
VIAQUES.	T HOSPICE OF INDIAI	NA, LLC		ST NAVAJO AFAYETTE,				
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY		GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE CO	(X5) PMPLETION DATE	
L 548	4/17/21, with the patie indicated as hyperten disease caused by higheart failure (CHF) arincluding but not limite (inability to control urinistory of falls. The recare for the recertifica 7/15/21. The POC state Nurse]: Patient/caregion of disease process in signs/symptoms, components of care failed to earn measurable goals.  4. The clinical record on 7/8/21 and 7/15/21 election date of 4/5/22 diagnosis indicated as and related diagnoses COPD, hypothyroid, concontinence, insommon Gastro-esophageal rebackflow of stomach a history of falls. The recare for the recertifica 9/1/21. The POC state Promote safe personal MSW [Medical Social will be maintained as patient/primary caregisymptoms will be comprocess and problems disease process will a failed to evidence pat measurable goals.	ent's terminal diagnosis sive kidney disease (kigh blood pressure) with a related diagnoses ed to: urinary incontine nation), weakness, and ecord included a plan of a tion period 4/17/21 - ated " Goals: SN [Skighter verbalize understated unding prognosis, applications, effect of district what to report" The evidence patient-specific and indicated a benefit, with the patient's terms hypertensive heart district including but not limit betoarthritis, urinary ita, anxiety, and district district included a plan of a tion period of 7/4/21 - ated " Goals: Aide: all care and hygiene Worker]: Continuity of appropriate to iver needs SN: Paties in managed as well as allow" The plan of coals:	dney n nce di filled nding ease e ic ewed fit minal sease ed to: and of	L 548				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CL AND PLAN OF CORRECTION IDENTIFICATION NUMBER				LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		151575		B. WING		C 07/16/2021
	NAME OF PROVIDER OR SUPPLIER  VIAQUEST HOSPICE OF INDIANA, LLC			ESS, CITY, STA ST NAVAJO AFAYETTE,	STREET	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
L 548	4/21/21 with a termink kidney disease with Concluding but not limit pain, osteoarthritis of urinary incontinence. of care for the initial of 7/19/21. The POC si Maintenance of respievidenced by breathid disease parameters to evidence patient-signals.  6. The clinical record on 7/12/21 and indicated of 6/12/2020 with a tedgeneration of the bincluding but not limit behavioral disturbance anxiety, urinary incorhistory of prostate caplan of care for the result of 8/5/21. The POC starpersonal care needs will avoid contact with disease SN: Patie environment and oriestage of disease procable to tolerate approsigns/symptoms of amodifications SN: system patient and fucomplications The clinical record reviewed on 7/15/21 election date of 11/22 of Alzheimer's disease	al diagnosis of hyperter CHF and related diagnoted to: fibromyalgia, chrif both knees, epilepsy, a The record included a portification period 4/21/tated " Goals: IDT: iratory baselines as ing at optimal level withi" The plan of care fair specific and measurable dof Patient #5 was revie ated a benefit election derminal diagnosis of "sepecific and related diagnosis of "sepecific and related diagnosis of "sepecific and related diagnosis of "sepecification period 6/7/ted " Goals: Aide: Parwill be met IDT: Patient will be maintained in the enterior of the property of the composition of the plan of care failed to deficie and measurable goals of the plan of care failed to deficie and measurable goals.	ses onic and plan (21 -  n illed  ewed late nille oses  , and ded a (21 - tient's lent ble safe be inage  pals.	L 548		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		151575		B. WING		C <b>07/16/2021</b>	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STA	TE, ZIP CODE		
	T HOSPICE OF INDIAI	NALLIC	724 WF	ST NAVAJO	STREET		
				AFAYETTE,			
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L 548	Continued From page	e 38		L 548			
L 548	and agitation, dysuria incontinence, GERD, record included a plar recertification period of POC stated " Goals safe environment I safely at home SN describe measures-m nutrition/hydration, all SN: Patient will be acceptable pain level management regimer will demonstrate abilit patient Patient will functioning appropriat process, and provide The plan of care failed patient-specific and m 8. The clinical record reviewed on 7/15/21 a election date of 6/3/2 of lung cancer with m and related diagnoses altered mental status, heart rhythm), hypoth chronic kidney diseas fecal incontinence, his cancer, and pressure record included a plar certification period of	, stress incontinence, be and history of falls. The of care for the of 5/15/21 - 7/13/21. The first incomplete	he h	L 548	DEFICIENCY)		
	stated " Goals: Aide: Promote safe personal care and hygiene Aide: Patient's personal care needs will be met Aide: Promote healthful environment Aide: Maintain clean, safe environment Aide: Promote skin integrity IDT: Patient will be pain free or verbalize an acceptable plan of care level with current pain management regimen" The plan of care failed to evidence patient-specific and measurable						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
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NAME OF PR	OVIDER OR SUPPLIER		STREET ADD	EET ADDRESS, CITY, STATE, ZIP CODE					
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L 548	goals.		L 548						
	9. The clinical record of Patient #19 was reviewed on 7/15/21 and indicated a benefit election date of 6/22/21 with a terminal diagnosis of breast cancer and related diagnoses including but not limited to: essential hypertension and open wound to left breast and thorax. The record included a plan of care for the certification period 6/22/21 - 9/19/21. The POC stated " Goals: SN: Patient will be pain free or verbalize an acceptable pain level with current pain management regimen SN: Patient/caregiver demonstrates ability to cope with limitations SN: Patient/caregiver will cope with change in lifestyle SN: Complete healing of wound without complications Patient/Caregiver demonstrates knowledge of disease process and complications" The plan of care failed to evidence patient-specific and measurable goals.  10. An interview was conducted on 7/15/21 at 3:32 PM with the Vice President of Hospice (VP #1). During the interview, VP #1 indicated goals								
L 550	CONTENT OF PLAN CFR(s): 418.56(c)(5) [The plan of care mu necessary for the pal the terminal illness a including the followin	st include all services lliation and managemer nd related conditions, g:] and appliances necessa		L 550					
	Based on observatio interview, the hospic	met as evidenced by: n, record review, and e agency failed to ensur	re the						

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGUOR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
L 550	supplies and equipm records reviewed (#/records reviewed.  Findings include:  An agency policy title Group] Care Plannin C-580 and revised 1 2. The plan of car services necessary to family-specific needs comprehensive assecare includes Me necessary to meet the The clinical record of 7/8/21 and indicated 4/17/21, with the patindicated as hyperted disease caused by heart failure (CHF) a including but not limit (inability to control unhistory of falls. The care for the recertific 7/15/21 and a recert assessment completed The assessment stands Genitourinary Incomplete Incompleted Medical Equipment ambulates we pool to the recent of the recent of the following: Incompleted Incompleted Medical Equipment ambulates we pool to the recent of the recent of the following: Incompleted Medical Equipment ambulates we pool to the recent of the recent of the recent of the following: Incompleted Medical Equipment ambulates we pool to the recent of the recent o	nent needed for 1 of 8 ac 2), in a total sample of 2 ed "IDG [Interdisciplinar og Process," policy numb 0/2020, stated " Proc e specifies the care and to meet the patient and	y per edure an of ances" ed on of sidney	L 550			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	LE CONSTRUCTION	' '	(X3) DATE SURVEY COMPLETED	
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L 550	Continued From page 41  During the interview, VP #1 indicated the plan of care should include all patient supplies and equipment necessary to meet the patient's needs.			L 550				
L 552	REVIEW OF THE PL CFR(s): 418.56(d)	AN OF CARE		L 552				
	The hospice interdisciplinary group (in collaboration with the individual's attending physician, (if any) must review, revise and document the individualized plan as frequently as the patient's condition requires, but no less frequently than every 15 calendar days.							
	This Standard is not met as evidenced by: Based on observation, record review and interview, the interdisciplinary group (IDG) failed to review, revise, and document the individualized plan of care (POC) at least every 15 days for 1 of 8 active records reviewed (#4), in a total sample of 20 records reviewed, and 1 of 1 IDG meetings observed (parent branch), which had the potential to affect all agency patients.							
	Findings include:							
	1. An agency policy titled "IDG Care Planning Process," policy number C-580 and revised 10/2020, stated " Procedure 9. The IDG reviews, revises and documents the individualized plan as frequently as the patient's condition requires, but no less frequently than every 15 calendar days"							
	on 7/9/21 at 8:30 AM. IDG was observed re status and plans of ca patients assigned to t	bservation was conducton. During the meeting, the viewing the current patiers for 11 of 61 active the parent location of the 23, 24, 25, 26, 27, 28, 28, 28, 28, 28, 28, 28, 28, 28, 28	he ient e					

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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L 552	The Administrator the remaining active patibranch, and for each Case Manager indication. No further discussion was conducted by the review the plans of cevery 15 days.  3. The clinical record on 7/9/21 and indication 4/21/21 with a terminic kidney disease with a fincluding but not limit pain, osteoarthritis of urinary incontinence, of care for the initial arrows Sulfate (iron (supplement). The result of the supplement of the supplement of the supplement of the supplements were not the IDG failed to ensorders within the plant up-to-date with the modern of the IDG meeting the IDG meeti	en listed off the names of ients assigned to the partients assigned to the partients assigned R ated no concerns or issumed to review of these paties are of all patients at least of the are of all patients of the are	rent N Les. ents o st  ewed ate of nsive sess onic and plan /21 - or nin D2  0/21, al inical in D //21. ation  3:45 #1). G ts	L 552			
L 553	REVIEW OF THE PL CFR(s): 418.56(d)	LAN OF CARE		L 553			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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L 553	Continued From page	e 43		L 553			
	A revised plan of care must include information from the patient's updated comprehensive assessment and must note the patient's progress toward outcomes and goals specified in the plan of care.						
	This Standard is not met as evidenced by: Based on record review and interview, the hospice agency failed to ensure the revised plan of care (POC) included the patient's progress towards their goals for 4 of 5 active records reviewed with a revised plan of care (#2, 3, 5, 11), in a total sample of 20 records reviewed.						
	Findings include:						
	1. An agency policy titled "IDG [Interdisciplinary Group] Care Planning Process," policy number C-580 and revised 10/2020, stated " Procedure 9. The IDG reviews, revises and documents the individualized plan The revised plan of care notes the patient's progress toward and goals specified in the plan of care."						
	on 7/8/21 and indicate 4/17/21, with the patie indicated as hyperten disease caused by his heart failure (CHF) ar including but not limit (inability to control uri history of falls. The recare for the recertification 7/15/21 and a recertification assessment complete Nurse (RN) #1. The aplan - Status of Goals	ed to: urinary incontine nation), weakness, and ecord included a plan o	te of dney nce I f tered Visit				

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L 553	plan of care" The [Skilled Nurse]: Patie understanding of dis prognosis, signs/sym of disease on body s" The recertificatic evidence Patient #2' goals.  3. The clinical recomon 7/8/21 and 7/15/2 election date of 4/5/2 diagnosis indicated a and related diagnose COPD, hypothyroid, incontinence, insom Gastro-esophageal responsive falls. The care for the recertific 9/1/21 and a recertific assessment complet assessment stated "Goals Goals partimake progress acco POC stated " Goa personal care and hy Isolation/loneliness we patient/CG [caregive Social Worker]: Continuintained as approcaregiver needs It identify and access of assist with ADL care signs/symptoms of ir Patient's symptoms of ir Patient's symptoms of disease process a well as disease procepatient/caregiver care	e POC stated " Goals ent/caregiver verbalize ease process including optoms, complications, exystems and what to report plan of care failed to support to plan of care failed to plan of care failed to support to plan of care failed to plan of care faile	effect ort  ewed fit minal sease ed to:  and of  3. The less to "The less to "The less to "She less to "The l	L 553			

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L 553	Continued From page 45 recertification plan of care failed to evidence			L 553			
	Patient #3's progress						
	on 7/12/21 and indicate of 6/12/2020 with a ted degeneration of the bincluding but not limits behavioral disturbance anxiety, urinary inconhistory of prostate carplan of care for the resultance assessment complete. The assessment complete The assessment state Documentation Gomaintained in safe en appropriate for stage Progress: 80% Gonot open. Progress: 1 Status of Goals Gocontinues to make procare" The POC st Patient's personal care Chaplain: Pt will find of Salvation Chaplair fear and anxiety on a will avoid contact with disease IDT: Patied decreased feelings of member of Patient #5 mechanisms and sup process and pt's declimaintained in safe en appropriate for stage Patient will be able to without signs/symptomodifications SN:	es, CHF, depression, tinence, pressure ulcerncer. The record include certification period 6/7/sation comprehensive ed on 5/18/21 by RN #5 ed "" Care Plan bal: Patient will be vironment and oriented of disease process. Ital: Red area on coccystolal: Red area on coccys	date enile coses  T, and ded a /21 -  The state enile coses  To and ded a /21 -  The state enile coses  The state				
	open SN: CG can		tain				

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	OVIDER OR SUPPLIER T HOSPICE OF INDIA	NA, LLC	724 WE	RESS, CITY, STA ST NAVAJO AFAYETTE,	STREET			
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L 553	catheter/drainage sys without complication to verbalize he feels in" The recertification evidence Patient #3's goals.  5. The clinical record reviewed on 7/15/21 election date of 11/22 of Alzheimer's diseas including but not limit and agitation, dysuria incontinence, GERD, record included a pla recertification period POC stated " Goal able to leave the homand Thursday to run Maintain clean, safe Isolation/loneliness with patient/CG/staff Cface visits following the restrictionsIDT: Patient/Caregiver/Staunderstanding of ava IDT: Patient/family and understanding of Patient/caregiver/Staunderstanding/demore to reduce risk and av CoronaVirus MSW consult with staff as repatient/caregiver can measures-maintain a allow pt time eat [sic] free or verbalize an a current pain manager Family/caregiver will	stem patent and function Volunteer: Pt will be more socialized after 6 in plan of care failed to a progress towards their d of Patient #11 was and indicated a benefit 2/19 with a terminal diagree and related diagnose and related diagnose and related diagnose and history of falls. The of care for the of 5/15/21 - 7/13/21. The s: Aide: Caregiver who for 3 hours on Tuesderrands, etc Aide: environment Chapla will be decreased per chaplain: Resume face the lifting of the COVIDatient will be cared for second will acknowledge support of plan IDT: ff verbalize instrate necessary measoid the spread of we Patient caregiver [sich needed for support So describe dequate nutrition/hydra SN: Patient will be proceptable pain level will proceptable pain level will be green and the spread of we patient will be proceptable pain level will be pro	able visits  gnosis s ness powel he he rill be lay in: o 19 afely rces ort sures ] will SN: tion, pain th are	L 553				

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		` '	(X3) DATE SURVEY COMPLETED	
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	NA, LLC	724 WE	EST NAVAJO STREET				
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		GULATORY	ID PREFIX TAG	(EACH CORRECTIVE ACTION	SHOULD BE	(X5) COMPLETION DATE	
Ontinued From page 47 optimum level of functioning appropriate for stage of disease process, and provide a safe environment SN: Patient free of any signs/symptoms of infection SN: Patient/caregiver will be able to demonstrate safe and effective use of recommended DME [durable medical equipment] and assistive devices. Pt will be maintain [sic] a safe environment and free of falls w/o [without] injuries" The clinical record also included a recertification comprehensive assessment completed on 6/22/21 by RN #6, which stated " Visit Plan - Status of Goals. Progress Towards Goals: No progress made" The recertification plan of care failed to evidence Patient #11's progress towards their goals.  6. An interview was conducted on 7/15/21 at 3:32 PM with the Vice President of Hospice (VP #1). During the interview, VP #1 indicated the plan of care should evidence the patient's progress towards their goals.  9 PREVENTION CFR(s): 418.60(a) The hospice must follow accepted standards of practice to prevent the transmission of infections and communicable diseases, including the use of		L 553					
standard precautions.  This Standard is not met as evidenced by: Based on observation, record review, and interview, the hospice failed to ensure all employees followed standard precautions and agency policies and procedures to prevent the transmission of infections and communicable diseases for 2 of 3 home visit observations (#2, 5).  Findings include:							
	Continued From pag optimum level of function of disease process, a environment SN: F signs/symptoms of in Patient/caregiver will and effective use of remedical equipment] a be maintain [sic] a sa falls w/o [without] injuralso included a recert assessment complete which stated " Visit Progress Towards Go The recertification plate Patient #11's progress for An interview was on PM with the Vice Preduction of the progress o	THOSPICE OF INDIANA, LLC  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REOR LSC IDENTIFYING INFORMATION)  Continued From page 47 optimum level of functioning appropriate for of disease process, and provide a safe environment SN: Patient free of any signs/symptoms of infection SN: Patient/caregiver will be able to demonstrate and effective use of recommended DME [du medical equipment] and assistive devices. If be maintain [sic] a safe environment and free falls w/o [without] injuries" The clinical realso included a recertification comprehensive assessment completed on 6/22/21 by RN #6 which stated " Visit Plan - Status of Goals Progress Towards Goals: No progress made The recertification plan of care failed to evide Patient #11's progress towards their goals.  6. An interview was conducted on 7/15/21 a PM with the Vice President of Hospice (VP # During the interview, VP #1 indicated the placare should evidence the patient's progress towards their goals.  PREVENTION CFR(s): 418.60(a)  The hospice must follow accepted standards practice to prevent the transmission of infect and communicable diseases, including the ustandard precautions.  This Standard is not met as evidenced by: Based on observation, record review, and interview, the hospice failed to ensure all employees followed standard precautions ar agency policies and procedures to prevent the transmission of infections and communicable diseases for 2 of 3 home visit observations (5).	THEORITION NUMBER:  151575  STREET ADDITEDRATE THOSPICE OF INDIANA, LLC  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 47 optimum level of functioning appropriate for stage of disease process, and provide a safe environment SN: Patient free of any signs/symptoms of infection SN: Patient/caregiver will be able to demonstrate safe and effective use of recommended DME [durable medical equipment] and assistive devices. Pt will be maintain [sic] a safe environment and free of falls w/o [without] injuries" The clinical record also included a recertification comprehensive assessment completed on 6/22/21 by RN #6, which stated " Visit Plan - Status of Goals. Progress Towards Goals: No progress made" The recertification plan of care failed to evidence Patient #11's progress towards their goals.  6. An interview was conducted on 7/15/21 at 3:32 PM with the Vice President of Hospice (VP #1). During the interview, VP #1 indicated the plan of care should evidence the patient's progress towards their goals.  PREVENTION CFR(s): 418.60(a)  The hospice must follow accepted standards of practice to prevent the transmission of infections and communicable diseases, including the use of standard precautions.  This Standard is not met as evidenced by: Based on observation, record review, and interview, the hospice failed to ensure all employees followed standard precautions and agency policies and procedures to prevent the transmission of infections and communicable diseases for 2 of 3 home visit observations (#2, 5).	TOWNER OF CORRECTION  IDENTIFICATION NUMBER:  151575  B. WING  STREET ADDRESS, CITY, STA  724 WEST NAVAJO  WEST LAFAYETTE,  SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY  OR LSC IDENTIFYING INFORMATION)  Continued From page 47  optimum level of functioning appropriate for stage of disease process, and provide a safe environment SN: Patient free of any signs/symptoms of infection SN: Patient/caregiver will be able to demonstrate safe and effective use of recommended DME [durable medical equipment] and assistive devices. 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This Standard is not met as evidenced by: Based on observation, record review, and interview, the hospice failed to ensure all employees followed standard precautions and agency policies and procedures to prevent the transmission of infections and communicable diseases for 2 of 3 home visit observations (#2, 5).	THOSPICE OF INDIANA, LLC  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PREFIX TAGY OPTIME PROVIDER TO THE ACTION NUMBER:  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PREFIX TAGY OPTIME REPORT OF THE ACTION OF THE PRECEDED BY FULL REGULATORY PREFIX TAGY OPTIME REPORT OF THE ACTION OF THE PRECEDED BY FULL REGULATORY PREFIX TAGY OPTIME REPORT OF THE ACTION OF THE ACTION OF THE PROVIDERS PLAN OF COR (EACH CORRECTIVE ACTION).  Continued From page 47 Optime level of functioning appropriate for stage of disease process, and provide a safe environment. S.N: Patient free of any signs/symptoms of infection SN: Patient/caregiver will be able to demonstrate safe and effective use of recommended DME [durable medical equipment] and assistive devices. Pt will be maintain [sic] a safe environment and free of falls w/o [without] injuries 'The clinical record also included a recertification comprehensive assessment completed on 6/20/21 by RN #6, which stated " visit Plan - Status of Goals. Progress Towards Goals: No progress made" The recertification plan of care failed to evidence Patient #11's progress towards their goals.  6. An interview was conducted on 7/15/21 at 3:32 PM with the Vice President of Hospice (VP #1). During the interview, VP #1 indicated the plan of care should evidence the patient's progress towards their goals.  PREVENTION CFR(s): 418.60(a)  The hospice must follow accepted standards of practice to prevent the transmission of infections and agency policies and procedures to prevent the transmission of infections and agency policies and procedures to prevent the transmission of infections and agency policies and procedures to prevent the transmission of infections and agency policies and procedures to prevent the transmission of infections and agency policies and procedures to prevent the transmission of infections and agency policies and procedures to prevent the transmission of infections and agency policie	THOSPICE OF INDIANA, LLC  SUMMARY STATEMENT OF DEFICIENCY  (EACH DEFICIENCY MUST BE PRECEDED BY PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (EACH DEFICIENCY MUST BE PRECEDED BY PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  COntinued From page 47  Optimum level of functioning appropriate for stage of disease process, and provide a safe environment SN: Patient free of any signs/symptoms of infection SN: Patient/caregiver will be able to demonstrate safe and effective use of recommended DME [durable medical equipment] and assistive devices. Pt will be maintain [sic] a safe environment and free of falls w/o [without] injuries "The clinical record also included a recertification comprehensive assessment completed on 62/2/21 by RM #6, which stated " Visit Plan - Status of Goals. Progress Towards Goals: No progress made"  The recertification plan of care failed to evidence Patient #11's progress towards their goals.  6. An interview was conducted on 7/15/21 at 3:32 PM with the Vice President of Hospice (VP #1). During the interview, VP #1 indicated the plan of care should evidence the patient's progress towards their goals.  PREVENTION  CFR(s): 418.60(a)  The hospice must follow accepted standards of practice to prevent the transmission of infections and communicable diseases, including the use of standard precautions.  This Standard is not met as evidenced by: Based on observation, record review, and interview, the hospice failed to ensure all employees followed standard precautions and agency policies and procedures to prevent the transmission of infections and communicable diseases for 2 of 3 home visit observations (#2, 5).	

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L 579	Continued From pag	e 48		L 579				
L 579	1. An agency policy of Compliance Program revised 10/2020, state Indications for hand he direct patient care bag 2. All employes staff are responsible of hygiene procedures in prevent and/or contain communicable disease foal/gel/liquid [alcoho ABHS] is the preferate When using [ABHS], follows: Using frict until hands are comprocedure for handward water is as follows: liquid, antimicrobial substantials"  2. Centers for Disease (CDC, Revised 6/10/2 Your Hands." Retriew www.cdc.gov. " Fixwww.cdc.gov."	titled "Hand Hygiene Po ," policy number B-412 ed " Procedure: 1. hygiene are: Before and Before re-entering nur- ees, volunteers and con- for implementing hand in an on-going attempt to in infectious processes se. 3. Bacteriostatic I based hand sanitizer, ole hand hygiene metho the procedure is [as] tion, clean between fing impletely dry. 4. The pro- ashing when using soal Lather hands well with oap: use friction; wash the area around and und see Control and Preventic 21). "When & How to We	and d after sing htract do and od. gers opper p and h der	L 579				
	3. Healthwise Staff (3/17/2021). "Caregiving:							
	How to Give a Bed Bath." Obtained 7/27/21 from www.peacehealth.org. " Some things to remember: Use a new washcloth when you need one 7. Start with the cleanest areas of the body and finish with the areas that are less clean Using a new washcloth, clean the anal area"							
	Guidance." Retrieved	23/21). "Infection Control d 7/27/21 from www.cd	c.gov.					

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COVID-19 pandemic practices recommend healthcare delivery to practices are intende just those suspected infection One of the by HCP [health care   and for protection of encounters: A well selection of a facema a cloth mask over the conform to the weare conform to the weare 5. CDC (Revised 1/8 Healthcare Settings." www.cdc.gov. " W Hand Hygiene Afte patient's immediate e after glove removal 6. McGoldrick (1/201 Retrieved 7/27/21 frowww.nursingcenter.c 2. Perform hand hysupplies from the bag surface barrier 4 and then reenter the 7. McGoldrick (3/200 Disinfection of Patien the Home Setting." Fwww.cdss.ca.gov " Equipment vital sight of the equipment for use on another patients are intended to the placing the equipment for use on another patients.	ol practices during the all particles during with standard ded as part of routine of all patients. These do to apply to all patients or confirmed SARS-Cole following should be well-defended by the providers of the following should be well-defended by the providers of the following patient care of the following patient care of the following patient care of the following following for source control of the following following for source control of the following fo	ov-2 rorn ontrol nuse of n m the ately lique a e, l in Care olies o ack ontact	L 579			

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	L 579	disinfectant up throug disinfectant on the sur EPA-registered hospic contact time of 10 min member must follow the use directions on the product. If they do not contact time the product is directions on the product. If they do not contact time the product is directions of the product.  8. Missouri Departments Secondary Education Aide Student Manual http://mcce.org. " For Catheter [drain place stoma in the lower abbladder] Care 7. Cosite with mild soap are site with mild soap are site with mild soap are site without a drape, oper reviewed, then entered obtained the patient's and oxygen saturation from her nursing bag. After completing the sign equipment (thermonitor, and blood prostethoscope, then plate immediately into her to keep a barrier between patient's home surfact bag with only clean hygiene immediately failed to allow the cleen equipment to dry prior to dispense immediately failed to allow the cleen product is the surfact bag with only clean hygiene immediately failed to allow the cleen products.	up through complete drying of on the surface Most ed hospital disinfectants have of 10 minutes the hospice st follow the safety precautions son the labeling of each registery do not follow the specified the practice is considered as product"  Department of Elementary and ducation (2006). "Certified Instantial Manual." Retrieved 7/27/21 forg. " Procedure for Supraputain placed into a surgically creation placed into a surgically creation and warm water"  Isoap and warm water"  isit observation was conducted AM with Patient #2 and Regulation of the patient's chart and the patient's temperature, heart restaturation, retrieved a pair of going bag, and donned the glow ting the visit, RN #1 wiped her ent (thermometer, oxygen saturation ber of the equipment into her nursing bag. The RN trier between her equipment and the surface, failed to enter the restaturation of the clean hands, failed to perform ediately prior to donning glove we the cleanser used on the	a label staff and tered a Home om bic ated d the I on stered s table and ne RN ate, loves es. vital ration failed nd the aursing n hand s, and	L 579			

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Continued From page 51  10. A home visit observation was conducted on 7/13/21 at 09:25 AM with Patient #5 and Hospice Home Aide (HHA) #2. During the visit, HHA #2 was observed washing her hands for 34 seconds then adjusted her surgical face mask and hugged Patient #5's family member immediately prior to donning gloves. The aide tene performed a bed bath on Patient #5, and during the bath, HHA #2 changed gloves 4 times with no hand hygiene in between donning and doffing. The aide's mask also sat below the aide's nose for the majority of the bath. During the bath, HHA #2 cleaned around the suprapubic catheter with a washoloth previously used to wash other body areas. The aide cleaned the catheter in donward swiping motions, wiping from farther away from the catheter to closer. The aide assisted the patient in turning on his side, washed the patient's buttocks and rectum, then used the same washcloth to wash the patient's upper leg and hip area. HHA #2 washed her hands with soap and water once during the bath and once afterwards, with a scrub time of 14 seconds and 10 seconds respectively, and the 10 second hand wash was performed under water. HHA #2 failed to perform hand hygiene immediately prior to donning gloves and in between glove changes, failed to ensure her mask was positioned appropriately, failed to change out washcloths during the bed bath appropriately, and failed to perform hand washing according to agency policy and best practice.				WEST L	AFAYETTE,	IN 47906				
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11. An interview was conducted on 7/14/21 at 9:34 AM with the Vice President of Hospice #1 (VP #1). During the interview, VP #1 indicated all staff supplies should be placed on a drape when in the patient's home, hands should be clean when entering the nursing bag, and cleaned		10. A home visit obset 7/13/21 at 09:25 AM Home Aide (HHA) #2 was observed washir then adjusted her sur Patient #5's family me donning gloves. The bath on Patient #5, at changed gloves 4 time between donning and also sat below the aid the bath. During the around the suprapubil previously used to was aide cleaned the cath motions, wiping from catheter to closer. The inturning on his side, buttocks and rectum, washcloth to wash the area. HHA #2 washed water once during the with a scrub time of 1 respectively, and the performed under wath hand hygiene immed and in between glove her mask was position perform catheter care change out washcloth appropriately, and fail according to agency 11. An interview was 9:34 AM with the Vice (VP #1). During the istaff supplies should in the patient's home.	ervation was conducted with Patient #5 and Host. During the visit, HHA and her hands for 34 secregical face mask and humber immediately prior aide then performed a and during the bath, HHA are with no hand hygiend doffing. The aide's made's nose for the majorities bath, HHA #2 cleaned in catheter with a washed in catheter with a washed ash other body areas. The aide assisted the patient's upper leg and the hands with soap the bath and once afterward seconds and 10 second hand washed the patient's appropriately, failed to perior to donning good the chands with soap the chands with soap the bath and once afterward seconds and 10 second hand washed the patient's upper leg and the patient's upper	spice #2 conds agged or to bed A #2 ne in ask ty of cloth The ing tient and hip and ards, onds was erform gloves ure d to o ashing e. at #1 ced all when o						

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L 579	equipment should be placing it back in the President of Hospic should be positioned of the employee, we and water, hands a seconds outside of hygiene should be donning gloves and VP #1 also indicate performed with a new place in the performed should be a second soutside of the performed should be donning gloves and the performed with a new place in the performed should be performed with a new place in the performed should be presented by the presented should be presented by the place of the presented should be positioned by the presented should be presented by	be allowed to dry prior to be allowed to dry prior to be nursing bag. The Vice ce #1 stated the surgical red "over the nose and mothen washing hands with should be scrubbed for 60 the running water, and he performed immediately performed immediately performed immediately performed in between glove changed catheter care should be sew washcloth, wiping in the immediate insertion	uth" soap and rior to es.	L 579			
L 591	CFR(s): 418.64(b)(  (1) The hospice muservices by or underegistered nurse. Note that the nursing need identified in the pat		sure	L 591			
	This Standard is not met as evidenced by: Based on observation, record review, and interview, the Registered Nurse (RN) failed t perform an assessment according to best practice, failed to obtain physician orders pri adjusting a patient's medication dosage, and failed to notify the patient's medical provider change in the patient's condition for 1 of 1 he visit observations of a nurse assessment (#2 2 of 8 active records reviewed (#4, 18), in a sample of 20 records reviewed.  Findings include:		or to d for a ome 2) and				
	1. An agency job d	lescription titled "Job					

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L 591 Continued From page Description. Position: Manager/Registered N " Process: Assume patient/family caseload assessing phases of 2. Sheps, M.D (2/2/20 monitors: Are they acc from www.mayoclinic.oreading when taking your wrist monitor, your arm level"  3. A home visit observed 7/7/21 at 9:56 AM with date 4/17/21) and RN was observed obtainin pressure using an autopressure monitor. The cuff on the patient's left bend his arm at the elft monitor being above the reported the patient's left bend his arm at the elft monitor being above the reported the patient's left bend his arm at the elft monitor being above the patient's left bend his arm at the patient's left bend his arm at the elft monitor being above the patient's left bend his arm at the elft monitor being above the patient's left bend his arm at the elft monitor being above the patient's left bend his arm at the elft monitor being above the patient's left bend his arm at the elft monitor being above the patient's left bend his arm at the elft monitor being above the patient's left bend his arm at the elft monitor being above the patient's left bend his arm at the elft monitor being above the patient's left bend his arm at the elft monitor being above the patient's left bend his arm at the elft monitor being above the patient's left bend his arm at the elft monitor being above the patient's left bend his arm at the elft monitor being above the patient's left bend his arm at the elft monitor be	RN Case Nurse," dated 2/1/19, s primary responsibility of that includes the of the nursing process (221). "Wrist blood prescurate?" Obtained 7/26 (org. " To get an accour blood pressure with and wrist must be at vation was conducted of a Patient #2 (benefit eleft). During the visit, Rong the patient's blood omated wrist blood omated wrist blood omated wrist blood on he patient's heart. RN blood pressure reading with the patient ereading with the patient ereading with the patient and blood pressure ated these readings was baseline blood pressure ated these readings was baseline blood pressure ated the enurse failed to obtain the patient for significant patient for significant patient for significant part of fatigue and difficalled to perform an	for a" ssure 8/21 urate th a heart  on ection RN #1  nitor tient #1 g was d a ent's od as ere sure. //e get he e n a gns to ficulty	L 591			

	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL R OR LSC IDENTIFYING INFORMATION)  Continued From page 54 a method of symptom assessment which had patient and/or caregiver rate the degree of distress for the following symptoms: pain, for nausea and/or vomiting, depression, anxiet drowsiness, shortness of breath, and appet Each symptom was rated from 0-10, with 0 meaning no distress and 10 meaning the modistress possible).  4. The clinical record of Patient #4 was revon 7/9/21 and indicated a benefit election of 4/21/21 with a terminal diagnosis of hyperters.		l ` ′	LE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED		
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L 591	a method of symptom patient and/or careging distress for the follow nausea and/or vomiting distress for the follow nausea and/or vomiting distress for the follow nausea and/or vomiting distress possible.  4. The clinical record on 7/9/21 and indicated 4/21/21 with a terming kidney disease with 0 including but not limit pain, osteoarthritis of urinary incontinence, of care for the initial of 7/19/21 which contain nurse visits 1 visit per visits per week for 12 also included orders (Furosemide, diuretical fluid levels) 40 mg in the evening, and Nor (Hydrocodone-Acetal opioid and Tylenol, gitablet, administer 3 timeluded a "Skilled Nedocumented on 5/12/ Family and [patien decrease her pain meto 7.5mg as she does pain [due to] not move the total discontinued the patiestarted the patient on clinical record also in Note dated 5/14/21 we discontinued the patiestarted the dated 5/14/21 we discontinued the dated 5/14/21 we discontin	n assessment which had ver rate the degree of ving symptoms: pain, fating, depression, anxiety is of breath, and appetitiated from 0-10, with 0 and 10 meaning the model of Patient #4 was revieted a benefit election datal diagnosis of hyperter CHF and related diagnosis of hyperter chart and related to the record included a patient of the medications: Last a given to decrease exception of the medications: Last a given to decrease exception of the medications of the morning and 20 mg and committee the record included a patient of the medications. Last a given to decrease exception of the medications of the morning and 20 mg and the record included a patient of the medications. Last a given to decrease exception of the medications of the morning and 20 mg and the record included a patient of the medications. Last a patient of the medications of the medicati	rigue, re.  est  ewed te of nsive ses onic and plan 21 - killed 2 re six ess y in  of an 25mg d  ted "  mg ] her " d by h and e on ent's	L 591			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  NAME OF PROVIDER OR SUPPLIER				1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		RECTION    Total   Tot	B. WING 07/16/2021				
NAME OF PR	OVIDER OR SUPPLIER STREE			ESS, CITY, STA	TE, ZIP CODE		
VIAQUEST HOSPICE OF INDIANA, LLC							
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L 591	increased pain and so extremities. The on-cadvised Patient #4's fination patient's previous dos administer a one-time to aide with the swellifailed to evidence the order for the medication.  5. The clinical record reviewed on 7/15/21 and election date of 6/3/2 of lung cancer with mand related diagnoses altered mental status, heart rhythm), hypoth chronic kidney disease fecal incontinence, his cancer, and pressure record included a plan certification period of contained orders for so visit per week for 13 wincluded a "Skilled Nudocumented 7/5/21 be note stated" Woun Right Foot Heel is Redeclined [dressing], heart measure intact. Patient declined area measure intact. Patient declined area" The clinical the nurse notified the wound.  6. An interview was called the wound.  6. An interview was called the i	welling to the patient's I call nurse documented a camily to administer the se of Norco (10-325 mg a dose of Furosemide 4 ng. The clinical record nurse obtained a physion changes.  If of Patient #18 was and indicated a benefit 1 with a terminal diagnoral etastasis [spread] to be a including but not limit, atrial fibrillation (irregulyroidism, depression, se, visual hallucinations story of renal (kidney) ulcer to left buttock. The of care for the initial 6/3/21 - 8/31/21 which skilled nursing services weeks. The record also weeks. The record also weeks. The nurse visual hallucinations of the department of the patient's provider of the conducted on 7/14/21 a sident of Hospice #1 (View, VP #1 indicated we blood pressure using a	she  i) and 0 mg  ician  osis one ed to: allar  for 1  osit re ot tive all Skin er the ce e new  it 9:34 'P	L 591			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 1	LE CONSTRUCTION	(X3) DATE SU COMPLE	
		151575		B. WING		07 <i>l</i> ·	C <b>16/2021</b>
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STA	TE, ZIP CODE		
	T HOSPICE OF INDIA	NA, LLC		ST NAVAJO _AFAYETTE,			
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L 625	president reported if a was lower than the ba assess the patient for hypotension. VP #1 a reported excessive fa further assess the patient patient assess the patient assess the patient assess the patient assess the patient assessment assessme	patient's] heart." The via patient's blood pressure aseline, the nurse should resign and symptoms of also indicated if the patient's complaint.  conducted on 7/15/21 a sident of Hospice (VP # VP #1 indicated the nurse month of the patient's medical promote and patient vising each patient of advise a discontinued medical all doses of medications.  IGNMENTS AND DUTIES assigned to a specific of nurse that is a membrate proup. Written patient copice aide must be prepared who is responsible for pice aide as specified unsection.  met as evidenced by:	are Id Id Id If Id If Id If Id If Id Id If Id	L 625			
	-	titled "Aide Care Plan,"	policy				

AND PLAN OF CORRECTION IDENTIFICATION		(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE			LE CONSTRUCTION	(X3) DATE SURVEY	Υ		
		151575		B. WING		07/16/20	021		
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	ADDRESS, CITY, STATE, ZIP CODE					
			724 WE	ST NAVAJO	STREET				
	·		WEST L	AFAYETTE,	IN 47906				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		I	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFULL DEFICIENCY)	D BE C	(X5) COMPLETION DATE		
I 625	Continued From page 57			I 625					
L 625	number C-751 and re Procedure 1 a part care and supportive of a Registered Nurse [Fishall be developed in terms and identify the such as, but not limited Ambulation 3 Adeveloped by the RN clear, complete and a current needs identify to the conjuitive and function when it is appropriate choice between multipulation date of 6/25/2 terminal diagnosis incomplete and related diagnoses. Chronic Obstructive Fintellectual disability, appressure ulcer to the left and right feeplan of care for the ceeplan of care for t	vised 10/2020, stated "plan identifying personal care services is prepare RN] 2. The Care Plan plain, non-technical layed duties to be performed to the Personal care. Aide care plans are with documentation the ddresses the patient's at ability is to be utilized for the patient to make ple types of care, such over or a sponge bath of Patient #1 was revied and indicated a benefication of the patient's dicated as pulmonary files including but not limited by the patient with the patient's discated as pulmonary files including but not limited and indicated a benefication period of 6/2 ained an order for hospitis per week for 9 week ded an "Aide Care Plantsks" 1. Activity- Assistioning, alignment applete 12. Hygiene spice aide care plan face was to ambulate the the aide was to perform wer for the patient.	all ad by n y d at is at is as a as a"  ewed fit brosis ed to: DPD), ctures d a 5/21 ice as. " ist 11. Bath ailed ks a ewed	L 625					
		of Patient #2 was revie							

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER			E CONSTRUCTION	(X3) DATE SI COMPLE	TED
		151575		B. WING		07/	C <b>16/2021</b>
NAME OF PR	OVIDER OR SUPPLIER	STREET ADDR	ESS, CITY, STAT	TE, ZIP CODE			
VIAQUEST HOSPICE OF INDIANA, LLC			ST NAVAJO AFAYETTE,				
(X4) ID PREFIX TAG	SUMMARY S (EACH DEFICIENCY MU: OR LSC II		ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
L 625	4/17/21, with the patindicated as hypertedisease caused by heart failure (CHF) a including but not limit (inability to control unhistory of falls. The care for the recertific 7/15/21, which contaide services for 2 viand for the medication to thin the blood and strokes]." The record Plan" which contained Assist with transfers precautions" The failed to evidence patasks related to how patient with ambulating precautions related to the bleeding.  4. The clinical record on 7/9/21 and indicated 4/21/21 with a terminal kidney disease with including but not limit pain, osteoarthritis our urinary incontinence of care for the initial 7/19/21, which include home aide visit for 5 then 1 visit per week initially declined aided placed on 5/9/21). The Activity-Recognize a patient's skin conditional control of the care Plan" who Activity-Recognize a patient's skin conditional care for the initial patient's skin conditional care for the initial placed on 5/9/21). The patient's skin conditional care for the initial placed on 5/9/21). The patient's skin conditional care for the initial placed on 5/9/21). The patient's skin conditional care for the initial placed on 5/9/21 and indicated placed placed on 5/9/21 and indicated placed pl	cient's terminal diagnosis nsive kidney disease (kinigh blood pressure) with and related diagnoses ited to: urinary incontine rination), weakness, and record included a plan of cation period 4/17/21 - ained an order for hospidisits per week for 13 were on "Eliquis [medication of also included an "Aide ed the tasks" 1. Activ 5. Safety- Fall et hospice aide care plan atient-specific and details the aide was to assist the aide was to assist the other patient's increased to the patient's increased to the patient's increased to the patient #4 was revieted a benefit election danal diagnosis of hyperter CHF and related diagnosited to: fibromyalgia, chrif both knees, epilepsy, and the certification period 4/21, ded an order for hospice wisits per week for 10 was for 1 week (family had experience, then order was for 1 week (family had experience).	dney n nce d of ce eks used nd/or Care ity - ed ne ce d risk ewed ate of nsive uses onic and plan plan /21 - e //eeks, as an "	L 625			
	Triot of all agency pe	aucinio with specialized					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  A. BUILDING COM			(X3) DATE SURVEY COMPLETED				
	VIDER OR SUPPLIER HOSPICE OF INDIANA, LLC  SUMMARY STATEMENT OF DEFICIENCY (EACH DEFICIENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION  Continued From page 59 transfer equipment was received on 7/15, ist indicated Patient #4 had a "electric lift"			B. WING	<del></del>	C <b>07/16/2021</b>	
NAME OF PROVIDER OR SUPPLIER  VIAQUEST HOSPICE OF INDIANA, LLC		724 WES	ESS, CITY, STA ST NAVAJO AFAYETTE,	STREET			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	ST BE PRECEDED BY FULL RE		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD BE COMPLET	TION
L 625	transfer equipment wilst indicated Patient hospice aide care plate patient-specific and of the aide was to ambute 5. The clinical record reviewed on 7/15/21 election date of 6/3/2 of lung cancer with mand related diagnose altered mental status heart rhythm), hypother chronic kidney disease fecal incontinence, hid cancer, and pressure record included a plate certification period of care included orders services for 1 visit per week, and medication Sodium [Lovenox, mand decrease the rist stroke] 100 mg/ml every 12 hours" Care Plan" which cord Shower or complete Signs - Report patient weight The aid evidence patient-specincluding whether the shower or bed bath, to report to the nurse regarding patient weisomething else?). The evidence what tast to due to the patient's	was received on 7/15/21 #4 had a "electric lift." an failed to evidence detailed description of hulate the patient.  d of Patient #18 was and indicated a benefit electron with a terminal diagnometastasis [spread] to be estimated in the second of the seco	The ow  Dosis Dosis Done Dosis Done Dosis	L 625			

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(X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING \_ AND PLAN OF CORRECTION COMPLETED 151575 B. WING 07/16/2021 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **VIAQUEST HOSPICE OF INDIANA, LLC 724 WEST NAVAJO STREET** WEST LAFAYETTE, IN 47906 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION COMPLÉTION PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE DATE OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) L 625 Continued From page 60 L 625 PM with the Vice President of Hospice (VP #1). During the interview, VP #1 indicated the aide care plan should be detailed and patient-specific, and the care plan should include bleeding precautions if the patient was an increased risk for bleeding. L 626 HOSPICE AIDE ASSIGNMENTS AND DUTIES L 626 CFR(s): 418.76(g)(2) (2) A hospice aide provides services that are: (i) Ordered by the interdisciplinary group. (ii) Included in the plan of care. (iii) Permitted to be performed under State law by such hospice aide. (iv) Consistent with the hospice aide training. This Standard is not met as evidenced by: Based on observation, record review, and interview, the hospice agency failed to ensure the hospice home aide (HHA) performed tasks only according to the aide care plan and failed to ensure the HHA performed a Hoyer transfer according to the Hoyer's manufacturer's instructions for 1 of 2 home visit observations of a hospice home aide (HHA) performing care (#5) and 4 of 7 active records reviewed with hospice aide services (#1, 3, 4, 5), in a total sample of 20 records. Findings include: 1. An agency policy titled "Aide Services," policy number C-220 and revised 10/2020, stated " ... Policy. 1. Aide Service ... A. Aide Services may include but are not limited to: ... Making observations of the client's condition and reporting the results to the Registered Nurse [RN] ... B. A specific care plan is developed documenting the Aide services to be provided.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED			
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L 626	OR LSC IDENTIFYING INFORMATION)		L 626						

FORM CMS-2567(02-99) Previous Versions Obsolete

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/ AND PLAN OF CORRECTION IDENTIFICATION NUMBER			1 ' '	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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NAME OF PROVIDER OR SUPPLIER			STREET ADDR	ESS, CITY, STA	ΓE, ZIP CODE		
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			ed on visit he BM to to to the date of his ve on ic and plan visit he is 10 hilly er a 2/21				

FORM CMS-2567(02-99) Previous Versions Obsolete

NAME OF PROVIDER OR SUPPLIER  VIAQUEST HOSPICE OF INDIANA, LLC  (XA) ID PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY TAG  (EACH DEFICIENCY)  L 626  Continued From page 63  record failed to evidence HHA #3 notified the patient's nurse of Patient #4's fall consistent with aide training.  6. The clinical record of Patient #5 was reviewed on 71/12/1 and indicated a benefit election date of 6/12/2020 with a terminal diagnosis of "senile degeneration of the brain" and related diagnoses including but not limited to: dementia with behavioral disturbances, CHF, depression, anxiety, urinary incontinence, pressure ulcer, and history of prostate cancer. The record included a plan of care for the recertification period 6/7/21 - 8/5/21, which included an "Aide Care Plan" which indicated the aide tasks to be performed were " Empty Foley catheter every visit	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		, ,	(X3) DATE SURVEY COMPLETED	
VIAQUEST HOSPICE OF INDIANA, LLC  724 WEST NAVAJO STREET WEST LAFAYETTE, IN 47906  (X4) ID PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  L 626  Continued From page 63 record failed to evidence HHA #3 notified the patient's nurse of Patient #4's fall consistent with aide training.  6. The clinical record of Patient #5 was reviewed on 7/12/21 and indicated a benefit election date of 6/12/2020 with a terminal diagnosis of "senile degeneration of the brain" and related diagnoses including but not limited to: dementia with behavioral disturbances, CHF, depression, anxiety, urinary incontinence, pressure ulcer, and history of prostate cancer. The record included a plan of care for the recertification period 6/7/21 - 8/5/21, which included an order for hospice home aide services for 2 visits per week for 9 weeks. The record also included an "Aide Care Plan" which indicated the aide tasks to be performed		151575			B. WING 07/			C <b>16/2021</b>	
WEST LAFAYETTE, IN 47906	NAME OF PROVIDER OR SUPPLIER STREET AI			STREET ADDR	RESS, CITY, STA	TE, ZIP CODE			
CACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX TAG   CROSS-REFERENCED TO THE APPROPRIATE	VIAQUEST HOSPICE OF INDIANA, LLC 724 W								
record failed to evidence HHA #3 notified the patient's nurse of Patient #4's fall consistent with aide training.  6. The clinical record of Patient #5 was reviewed on 7/12/21 and indicated a benefit election date of 6/12/2020 with a terminal diagnosis of "senile degeneration of the brain" and related diagnoses including but not limited to: dementia with behavioral disturbances, CHF, depression, anxiety, urinary incontinence, pressure ulcer, and history of prostate cancer. The record included a plan of care for the recertification period 6/7/21 - 8/5/21, which included an order for hospice home aide services for 2 visits per week for 9 weeks.  The record also included an "Aide Care Plan" which indicated the aide tasks to be performed	PRÉFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY			PREFIX	(EACH CORRECTIVE ACTION SECTION SECTIO	TION SHOULD BE COMPLETION DATE		
Incontinent Care every visit Clean bathroom after patient care every visit Clean living area of the patient every visit Assist patient with dressing after personal care every visit Bath - Bed each visit"  A home visit observation was conducted on 7/13/21at 09:25 AM with Patient #5 and HHA #2. During the visit, HHA #2 was observed applying calmoseptine lotion (thick lotion used as barrier for moisture) to the patient's rectum, inner buttocks, and scrotum. After completing the patient's bath, HHA #2 was observed shaving Patient #2's face and neck using an electric razor. The aide then transferred the patient using an electric Best Care 500 Hoyer lift. The aide placed the Hoyer sling underneath the patient, connected the sling straps to the lift bar with the leg straps connected to the closest hook, raised the patient up out of the bed with the Hoyer legs closed, and transferred the patient positioned facing to the side of aide. HHA #2 failed to follow the aide care	L 626	record failed to evide patient's nurse of Pata aide training.  6. The clinical record on 7/12/21 and indicated for 6/12/2020 with a ted degeneration of the bincluding but not limit behavioral disturband anxiety, urinary incombistory of prostate caplan of care for the re8/5/21, which include aide services for 2 vis The record also inclus which indicated the awere " Empty Fole Incontinent Care everafter patient care everafter patient care everafter patient every volvesing after person Bed each visit"  A home visit observation 7/13/21at 09:25 AM volve During the visit, HHA calmoseptine lotion (for moisture) to the putient #2's face and The aide then transferelectric Best Care 50 the Hoyer sling under the sling straps to the connected to the closup out of the bed with transferred the patient	ance HHA #3 notified the tient #4's fall consistent dof Patient #5 was revieted a benefit election derminal diagnosis of "secorain" and related diagnosis of the detection of the detection of the description of the descript	ewed late enile oses  T, and ded a lete exile oses  T, and ded a lete exile oses  T, and ded a lete exile ose exile exile oses  T, and ded a lete exile ose exile	L 626				

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