STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	151516	A. BUILDING 00 B. WING	12/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ASCENSION AT HOME	2015 JACKSON ST ANDERSON, IN 46016

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. 00	An Emergency Preparedness Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 418.113. Survey Dates: December 2, 3, 4, 5, 6, 11, 12; 2019 Facility Number: 005829 Provider Number: 151516 Current census: 52 At this Emergency Preparedness survey, Ascension At Home, was found to be in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR418.113.	E 0000		
L 0000 Bldg. 00	This visit was for a Federal and State Hospice Recertification survey. Survey Dates: December 2, 3, 4, 5, 6, 11, 12; 2019 Facility Number: 005829 Provider Number: 151516 Unduplicated admissions past 12 months: 471 Current home patients: 32 Current facility patients: 20	L 0000		

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	151516	A. BUILDING 00 B. WING	12/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ASCENSION AT HOME	2015 JACKSON ST ANDERSON, IN 46016

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Sample selection: Records with home visits: 3 Records without home visits: 10 Bereavment records: 3 Total records reviewed: 15 During this survey, Ascension at Home (Hospice) was found to be out of compliance with the Conditions of Participation 42 CFR Sub Part D 418.100 Organization/ Administration of Services. Quality Review Completed on 01/14/2020 SFF			
L 0521 Bldg. 00	418.54 INITIAL & COMPREHENSIVE ASSESSMENT OF PATIENT The hospice must conduct and document in writing a patient-specific comprehensive assessment that identifies the patient's need for hospice care and services, and the patient's need for physical, psychosocial, emotional, and spiritual care. This assessment includes all areas of hospice care related to the palliation and management of the terminal illness and related conditions. Based on record review, the hospice failed to ensure the comprehensive assessment reflected all the patient's physical needs for 1 of 8 active records reviewed (#5). Findings include: An agency policy dated 4/1/18 and titled "Comprehensive assessment of the patient," Policy # 3.004 stated "... The hospice nurse	L 0521	**Corrective Action** ·Agency Registered Nurses will receive education on the Initial & Comprehensive Assessment of Patient with emphasis on documentation of the integumentary and cardiac systems. Training was initially completed on 12/17/19 and 12/19/19 with additional training on 1/28/20 and 1/30/20. All agency	01/30/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	151516	A. BUILDING 00 B. WING	12/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ASCENSION AT HOME	2015 JACKSON ST ANDERSON, IN 46016

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	coordinates the comprehensive assessment process and ensures the patient's physical , emotional , psychosocial, spiritual and bereavement needs are assessed ...." An agency policy dated 4/1/18 and titled "Comprehensive assessment content," Policy # 3.005 stated "... Policy: The comprehensive assessment identifies the physical, psychosocial, emotional and spiritual needs of the patient related to the terminal illness that must be addressed in order to promote the well-being, comfort, and dignity throughout the dying process ...." The clinical record of patient #5 was reviewed on 12/4/19 at 8:00 AM and indicated an Election date of 11/15/19. The record contained a plan of care for the benefit period of 11/15/19-2/12/20, which indicated the patient had a left ventricular assist device (LVAD) and a primary hospice diagnosis of ischemic cardiomyopathy. The agency initial/ comprehensive nursing assessment completed on 11/15/19 stated the patient had a blood pressure of 98/83. The integumentary system stated the family was to care for the LVAD driveline dressing every other day and the nurse failed to assess the LVAD site (evidenced no documentation), and failed to document what the site care order was. In the cardiovascular status it stated the patient had edema but failed to identify the location and degree of edema). The administrator was notified of this concern on 12/12/19 at 11:49 AM, and had nothing additional to submit for review.		Registered Nurses education will include a review of policies: **Policy 3.003 Comprehensive Assessment-Initial, policy 3.004 Comprehensive Assessment of the Patient, policy 3.005 Comprehensive Assessment Content and hospice process guide HO Nursing Admission Minimum Documentation Requirements.** **Evaluation for compliance** Beginning 2/3/2020, agency Director and/or Clinical Manager will audit 100% of admissions for 6 weeks to validate a patient-specific comprehensive assessment. If 100% compliance is not achieved in 6 weeks, audits will continue until 100% compliance is achieved for 6 consecutive weeks. Once 100% compliance is achieved for 6 consecutive weeks, 25% of admissions will be audited quarterly to monitor continued compliance that nursing needs of the patient are met.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	151516	A. BUILDING 00 B. WING	12/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ASCENSION AT HOME	2015 JACKSON ST ANDERSON, IN 46016

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
L 0523 Bldg. 00	418.54(b) TIMEFRAME FOR COMPLETION OF ASSESSMENT The hospice interdisciplinary group, in consultation with the individual's attending physician (if any), must complete the comprehensive assessment no later than 5 calendar days after the election of hospice care in accordance with §418.24. Based on record review and interview, the hospice failed to ensure a spiritual assessment was conducted as part of the comprehensive assessment within 5 days after the election of hospice care for 1 of 8 active records reviewed (#3) Findings include: An agency policy dated 4/1/18 and titled "Comprehensive assessment - initial," Policy # 3.003 stated "... Based on the patient's needs and findings from the initial assessment, the hospice RN [registered nurse] coordinates and designates disciplines that must participate in the comprehensive assessment of the patient within 5 days of his or her election of hospice care ...." The clinical record of patient #3 was reviewed on 12/3/19 at 11:51 AM and indicated an Election date of 11/26/19. The record contained a plan of care for the benefit period of 11/26/19-2/23/20. The hospice document titled "Hospice initial/ comprehensive nursing assessment was completed on 11/26/19 and failed to evidence a spiritual assessment. Review of the record failed to evidence a spiritual assessment completed by the chaplain.	L 0523	**Corrective Actions** Agency Registered Nurses will receive education on maintaining the Medication profile and performing ongoing reconciliation including a review of policy 8.002 Medication Profile. Training was initially completed on 12/17/19 and 12/19/19 with follow up training completed on 1/28/20 and 1/30/20. **Agency RNs will obtain a copy of all facility patient's MARs and compare and reconcile the MAR to the hospice Medication Profile prior to each IDG meeting.** **Agency RNs will audit and revise all active patient Medication Profiles and medication orders to ensure accuracy.** p="" paraid="512391526" paraeid="{ab8c8336-99da-4c6e-bff4-d43b07423e5e}{67}">**Evaluation for compliance** · Beginning 2/3/2020, Hospice Director and Clinical Manager will audit the Comprehensive Assessment on 100% of admissions for 6 weeks	01/30/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	151516	A. BUILDING 00 B. WING	12/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ASCENSION AT HOME	2015 JACKSON ST ANDERSON, IN 46016

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	During an interview on 12/11/19 at 11:06 AM, the administrator stated the spiritual assessment should be completed within 5 days of election of the hospice benefit unless the patient/family refuses. During an interview on 12/12/19 between 12:00 PM-1:30 PM the administrator was asked when reviewing records what the agency's process was to contact patients so that a spiritual assessment can be completed within 5 days if they had trouble contacting the patient/caregiver. The administrator stated "I don't know if we do anything ...he just keeps leaving messages ...he doesn't want to hound them ...the other thing he could do is draft a letter and put his business card in the letter."		to ensure physical, spiritual and psychosocial needs are identified and documented by the Interdisciplinary team. If 100% compliance is not achieved in 6 weeks, audits will continue until 100% compliance is achieved for 6 consecutive weeks. · Once 100% compliance is achieved for 6 consecutive weeks, 25% of admissions will be audited each quarter to monitor continued compliance.	
L 0530 Bldg. 00	418.54(c)(6) CONTENT OF COMPREHENSIVE ASSESSMENT [The comprehensive assessment must take into consideration the following factors:] (6) Drug profile. A review of all of the patient's prescription and over-the-counter drugs, herbal remedies and other alternative treatments that could affect drug therapy. This includes, but is not limited to, identification of the following: (i) Effectiveness of drug therapy (ii) Drug side effects (iii) Actual or potential drug interactions (iv) Duplicate drug therapy (v) Drug therapy currently associated with laboratory monitoring. Based on record review and interview, the hospice failed to ensure a review of the patient's medications was completed and accurately	L 0530	**Corrective Action** · Agency Registered Nurses will receive education on maintaining the Medication profile and	01/30/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	151516	A. BUILDING 00 B. WING	12/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ASCENSION AT HOME	2015 JACKSON ST ANDERSON, IN 46016

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	maintained for 4 of 13 records reviewed (#2, 4, 6, 10). Findings include: 1. An agency policy dated 4/1/18 and titled "Medication profile," Policy # 8.002 stated "... The patient's medication profile review includes, but is not limited to: a determining accuracy and completeness of the profile ...." 2. The clinical record of patient #4 was reviewed on 12/3/19 at 1:57 PM and indicated an Election date of 4/29/19. The record contained a plan of care for the benefit period of 10/26/19-12/24/19. The hospice medication profile stated the patient's medications were as followed: Acetaminophen oral 500 milligrams (mg) 1 tablet every 6 hours as needed (PRN) pain or fever, and butt paste topical application four times per day. The facility where patient #4 resided (entity N) printed out their medication orders which included medications as followed: acetaminophen 160 mg/5ml (milliliters) give 20 ml oral every 4 hours PRN pain, vincent bear butt cream small amount applied to buttocks and groin area three times a day, and a bowel protocol when no bowel movment after 72 hours which included natural laxative, if not effective milk of magnesia, and if that was not effective dulcolax supository. The agency failed to ensure their medication profile and entity N were consistent and mirror eachother. During an interview on 12/11/19 at 1:17 AM, the administrator stated the hospice and facility medication lists should mirror eachother. 3. The clinical record of patient #10 was reviewed		performing ongoing reconciliation including a review of policy 8.002 Medication Profile. Training was initially completed on 12/17/19 and 12/19/19 with follow up training completed on 1/28/20 and 1/30/20 **Agency RNs will obtain a copy of all facility patient's MARs and compare and reconcile the MAR to the hospice Medication Profile prior to each IDG meeting.** **Agency RNs will audit and revise all active patient Medication Profiles and medication orders to ensure accuracy.** p="" paraid="512391526" paraeid="{ab8c8336-99da-4c6e-bff4-d43b07423e5e}{67}"> **Evaluation for compliance** Beginning 2/3/2020 the Hospice Director or Clinical Manager will perform on-site supervisory visits with each agency RN to ensure medication reconciliations are completed per agency Policy 8.002 Medication Profile. **Beginning 2/03/2020, Hospice Director or Clinical Manager will audit 100% Medication Profiles on all newly admitted patients to ensure that all physician orders are transcribed accurately.** **Once 100% compliance is achieved for 6 consecutive weeks, Medication Profile**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	151516	A. BUILDING 00 B. WING	12/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ASCENSION AT HOME	2015 JACKSON ST ANDERSON, IN 46016

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	on 12/3/19 at 2:15 PM and indicated an Election date of 6/21/19. The record contained a plan of care for the benefit period of 6/21/19-9/18/19. The hospice medication profile listed the patient's medications, but not limited to, Keflex (antibiotic) 500 mg 1 capsule twice per day for 7 days for infection and Lamisil external 1% rub thin layer to affected areatwice daily for redness and irritation until healed. The record failed to evidence what type of infection the Keflex was treating and what area of the body the lamisil was treating. During an interview on 12/11/19 at 11:22 AM, the administrator stated antibiotic orders should have an indication for use and creams should indicate the site of application. 4. The clinical record of patient #2 was reviewed on 12/3/19 and indicated an Election date of 3/29/19. The record contained a plan of care for the benefit period of 9/25/19 - 11/23/19. The hospice failed to ensure that the medication list was maintained with the correct regimen as evidenced by: An agency document titled, "Hospice Initial Order" dated 3/29/19 and signed by Employee L, MD (medical doctor) on 4/16/19 stated, " ... Oxygen 3 liters continuous to prevent sob (shortness of breath). An agency document titled, "Hospice Face - to - Face Documentation" dated 11/12/19 signed by Employee Z, stated, "... She (patient #2) uses blowing respirations between every few words and wears O 2 (oxygen) continuously at 4 L (liters) ...." An agency document titled, "Physician Face to Face Encounter / Recertification of Terminal Illness", dated 11/21/19 and signed by Employee		**audits will decrease to 25% of all newly admitted patients.** p="" paraid="798154408" paraeid="{ab8c8336-99da-4c6e-bff4-d43b07423e5e}{112}">	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	151516	A. BUILDING 00 B. WING	12/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ASCENSION AT HOME	2015 JACKSON ST ANDERSON, IN 46016

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	E, MD stated, "... She (patient #2) uses blowing respirations between every few words and wears O 2 (oxygen) continuously at 4 L (liters) ...." An agency document titled, "HOSPICE MEDICATION PROFILE," dated signed by Employee L, LPN (Licensed Practical Nurse) on 11/25/19, evidenced Oxygen 3 liters continuous to prevent sob. An agency document titled, "Hospice Nursing Clinical Note", dated 11/25/19 signed by Employee J, RN (Registered Nurse) stated, " ... Respiratory O 2 at 3.5 l (liters)...." An agency document titled, "Hospice Nursing Clinical Note", dated 12/2/19 signed by Employee J, RN stated, " ... Respiratory O 2 at 3.5 l (liters)...." During a home visit on 12/4/19 at 11:10 AM with patient #2 in an assisted living facility observed the patient's oxygen concentrator setting to be at 4 liters per minute (lpm). The hospice failed to update the Medication Profile to reflect the current oxygen rate and the RN failed to verify the correct oxygen rate during home visits. 5. The clinical record of patient #6 was reviewed on 12/5/19 and indicated an Election date of 11/22/19. The record contained a plan of care for the benefit period of 11/22/19 - 2/19/20. The hospice failed to ensure that the medication list was maintained with the correct regimen as evidenced by: An agency document titled, "HOSPICE MEDICATION PROFILE," dated signed by Employee AA, RN on 11/24/19, evidenced,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	151516	A. BUILDING 00 B. WING	12/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ASCENSION AT HOME	2015 JACKSON ST ANDERSON, IN 46016

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Resinol 2% to be applied topically 3 x (times) a day to "affected area". The hospice did not indicate the area to which the Resinol was to be applied.			
L 0531 Bldg. 00	418.54(c)(7) CONTENT OF COMPREHENSIVE ASSESSMENT [The comprehensive assessment must take into consideration the following factors:] (7) Bereavement. An initial bereavement assessment of the needs of the patient's family and other individuals focusing on the social, spiritual, and cultural factors that may impact their ability to cope with the patient's death. Information gathered from the initial bereavement assessment must be incorporated into the plan of care and considered in the bereavement plan of care. Based on record review and interview, the hospice failed to ensure an initial bereavement assessment was completed within 5 days of election of hospice benefit as part of the comprehensive assessment for 1 of 8 active records reviewed (#3) Findings include: An agency policy dated 4/1/18 and titled "Bereavement assessment," Policy # 3.014 stated "... During the comprehensive assessment of the patient upon admission, an initial bereavement assessment is documented in the patient medical record ...." The clinical record of patient #3 was reviewed on 12/3/19 at 11:51 AM and indicated an Election date of 11/26/19. The record contained a plan of care for the benefit period of 11/26/19-2/23/20. A hospice social worker bereavement assessment	L 0531	**Corrective Action** Agency Registered Nurses, chaplains and social workers will receive education on the requirement to complete the Comprehensive Assessment, including the Initial Bereavement Assessment, within 5 days of the patient admission. Education will include review of policy 3.004 Comprehensive Assessment of the Patient, policy 3.005 Comprehensive Assessment Content, policy 3.014 Bereavement Assessment, hospice process guide HO Nursing Admission Minimum Documentation Requirements, HO Social Worker Minimum Documentation Requirements, and	02/03/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	151516	A. BUILDING 00 B. WING	12/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ASCENSION AT HOME	2015 JACKSON ST ANDERSON, IN 46016

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	was completed by the social worker on 12/2/19 (more than 5 days after election of hospice). During an interview on 12/11/19 at 11:06 AM, the administrator stated the initial bereavement assessment should be completed within 5 days of election of the hospice benefit unless the patient/ family refuses.		HO Chaplain Minimum Documentation Requirement Training was initially completed on 12/17/19 and 12/19/19 with follow up training on 1/28/20 and 1/30/20. Training will be complete on 2/3/2020 Evaluate**tion for compliance** Beginning 2/03/2020, Hospice Director and Clinical Manager will audit the Comprehensive Assessment on 100% of admissions for 6 weeks to ensure an Initial Bereavement Assessment was completed and documented by the Interdisciplinary team. Once 100% compliance is achieved for 6 consecutive weeks, Initial Bereavement Assessment audits will decrease to 25% of all newly admitted patients.	
L 0543 Bldg. 00	418.56(b) PLAN OF CARE All hospice care and services furnished to patients and their families must follow an individualized written plan of care established by the hospice interdisciplinary group in collaboration with the attending physician (if any), the patient or representative, and the primary caregiver in accordance with the patient's needs if any of them so desire. Based on record review and interview, the hospice failed to ensure staff followed the plan of care for 2 of 8 active records reviewed (#3, 4) Findings include:	L 0543	**Corrective Action** Agency Nurses, Social Workers, Chaplains, Volunteer Coordinators, and Hospice Aides will receive education on the requirement for an individual plan	02/03/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	151516	A. BUILDING 00 B. WING	12/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ASCENSION AT HOME	2015 JACKSON ST ANDERSON, IN 46016

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	1. An agency policy dated 4/1/18 and titled "Comprehensive assessment of the patient," Policy # 3.004 stated "... 2. The clinical record of patient #3 was reviewed on 12/3/19 at 11:51 AM and indicated an Election date of 11/26/19. The record contained a plan of care for the benefit period of 11/26/19-2/23/20 which included a hospice initial order that stated "SN [skilled nurse] frequency ... 3 x [times] week for 1 week starting 11/26/2019 (week 1) ...." On week 1 visits were made by the SN on 11/26/19 and 11/29/19 only. Skilled nursing failed to follow the plan of care. 3. The clinical record of patient #4 was reviewed on 12/3/19 at 1:57 PM and indicated an Election date of 4/29/19. The record contained a plan of care for the benefit period of 10/26/19-12/24/19 which included a SN frequency of 1 x per week. On week 3 (11/3/19-11/9/19) a missed visit was noted on 11/6/19 stated "pt [patient] was on a outing with other women and the staff from the facility. Hospice RN waited and saw all the other patients first but still did not return talked with the nurse and [facility nurse] stated there were no changes and did not need anything this visit, and stated they would call if they needed anything or changes ...." The record failed to evidence an attempted visit later in the week to make up for the missed visit. 4. During an interview on 12/11/19 at 11:07 AM, the administrator stated staff should be following the ordered frequency, and if a missed visit occurred then the staff should attempt to make the visit up later in the week.		of care that includes the scope and frequency of visits by discipline. Education will include documentation requirements for Visit Frequency and Missed Visits and include a review of process guides HO Visit Frequency Orders and HH/HO Missed Visit Process. Training was initially completed on 12/17/19 and 12/19/19 with follow up training on 1/28/20 and 1/30/20. Training will be complete on 2/3/2020 Effective 2/3/2020, Hospice Director or Clinical Manager will attend 100% of IDG meetings ensuring that each patient is assessed appropriately for planned scope and frequency of visits including a review of all missed or additional visits that occurred outside of the plan of care. **Evaluation for compliance** Beginning 2/3/2020, each week the Hospice Director and Clinical Manager will utilize the Devero visit compliance report to validate frequency of visits are made in accordance to plan of care. All inconsistencies noted will be addressed with the hospice clinician and documented in the medical record. If 100% compliance is not achieved in 4 weeks, a performance development plan will be initiated for clinicians not following policies/processes.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	151516	A. BUILDING 00 B. WING	12/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ASCENSION AT HOME	2015 JACKSON ST ANDERSON, IN 46016

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
L 0544 Bldg. 00	418.56(b) PLAN OF CARE The hospice must ensure that each patient and the primary care giver(s) receive education and training provided by the hospice as appropriate to their responsibilities for the care and services identified in the plan of care. Based on record review and interview, the hospice failed to ensure the patient and caregiver received education on admission regarding smoking with oxygen for 1 of 1 records reviewed of patients on oxygen who smoked (#8). Findings include: The clinical record of patient #8 was reviewed on 12/3/19 at 3:35 PM and indicated an Election date of 3/29/19. The record contained a plan of care for the benefit period of 3/29/19-6/26/19. An agency document titled "Hospice additional admission page," dated 3/29/19 indicated under section IV: oxygen safety and that instruction was provided to the caregiver. Education that could have been provided was: 6 inch clearance around concentrator, Back-up O2 (oxygen) supply, change connecting tubing at least every 3 months, change O2 cannula every other week when using O2 continuously, clean filer at least weekly, Do not use electrical appliance while using O2, ear care/ nasal care, keep concentrator cord away from wet/ damp areas, keep flammable materials away from O2, keep O2 tubing at least 6 feet away from heat/ flame, no smoking sign posted, preventative maintenance, secure O2 cylinders on cart or laying down, soak O2 humidifier weekly for 30 minutes in 1:2 vinegar/water solution, and wash humidifier jar/lid	L 0544	**Corrective Action** Staff who provide direct patient contact will be on providing education to patients and caregivers regarding the use of Oxygen in the home. Education will include a review of Section IV of Patient & Family Training Guide for Hospice Care and its use in patient education. Training was initially completed on 12/17/19 and 12/19/19 with additional training completed on 1/28/20 and 1/30/20. Agency RNs, under the supervision of the Hospice Director and Clinical Manager, will audit medical record documentation for all active patients with oxygen, provide and document Oxygen education by 1/31/2020 Evaluation for compliance Beginning 2/03/2020, all admission plans of care will be audited to validate education on oxygen safety has been provided to patient and/or caregiver. If 90% compliance is not achieved in 4 weeks, 100% admissions will be audited until compliance is achieved for 4 consecutive weeks.	01/30/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	151516	A. BUILDING 00 B. WING	12/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ASCENSION AT HOME	2015 JACKSON ST ANDERSON, IN 46016

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	daily with warm water/ non-lotion soap. The document failed to evidence a checkmark by any of the oxygen safety topics instructed on. An agency complaint logged on 5/7/19 indicated the HHA called the office to report that the patient was smoking with 4 liquid oxygen bases close by. She instructed patient to not smoke around the oxygen and notified the nurse. During an interview on 12/11/19 at 11:20 AM, the administrator stated nurses always discuss not smoking with oxygen on admission. During an interview on 12/12/19 between 11:05 AM-1:30 PM, employee D stated the agency document for patient #8 titled "Hospice additional admission page," was completed by social worker and that section should be completed by nurse when they give the instruction.		Once 90% compliance is achieved for 4 consecutive weeks, 25% of admissions will be audited monthly to monitor continued compliance with Oxygen safety education.	
L 0545 Bldg. 00	418.56(c) CONTENT OF PLAN OF CARE The hospice must develop an individualized written plan of care for each patient. The plan of care must reflect patient and family goals and interventions based on the problems identified in the initial, comprehensive, and updated comprehensive assessments. The plan of care must include all services necessary for the palliation and management of the terminal illness and related conditions, including the following: Based on record review and interview, the hospice failed to ensure the plan of care contained wound care orders for 2 of 3 records reviewed of patients with wounds (#5,) Findings include:	L 0545	Corrective Action Agency Registered Nurses will receive education on the Initial & Comprehensive Assessment of Patient with emphasis on obtaining and documentation of accurate Wound Care Orders.	01/30/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	151516	A. BUILDING 00 B. WING	12/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ASCENSION AT HOME	2015 JACKSON ST ANDERSON, IN 46016

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	The clinical record of patient #5 was reviewed on 12/4/19 at 8:00 AM and indicated an Election date of 11/15/19. The record contained a plan of care for the benefit period of 11/15/19-2/12/20 which indicated the patient had a left ventricular assist device (LVAD) and a primary hospice diagnosis of ischemic cardiomyopathy. The agency initial/ comprehensive nursing assessment completed on 11/15/19 in the integumentary system stated the family was to care for the LVAD driveline dressing every other day. The plan of care failed to evidence what the wound care/ site care order was to be performed. During an interview on 12/11/19 at 11:26 AM, the administrator stated there should be a written order for wound/ dressing treatments.		Education will include review of policy 3.003 Comprehensive Assessment-Initial, policy 3.004 Comprehensive Assessment of the Patient, policy 3.005 Comprehensive Assessment Content, 3.006 Comprehensive Assessment Updates, policy 7.002 Plan of Care, hospice process guide HO Nursing Admission Minimum Documentation Requirements, and hospice process guide HO Nursing Minimum Documentation Requirements. raining was initially completed on 12/17/19 and 12/19/19 with additional training completed on 1/28/20 and 1/30/20 Agency RNs, under the supervision of the Hospice Director and Clinical Manager, will audit all active patient medical records with wound care to ensure physician orders are accurate on the plan of care, documentation reflects wound care administered per physician orders and documented accurately. Any plan of care found to be inaccurate will be revised per physician order. Evaluation for compliance Beginning 2/03/2020, Hospice Director and Clinical Manager will identify active patients with wound care interventions and audit 100 % of medical records for wound care physician orders, with nursing documentation evident of compliance with plan of care. If	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	151516	A. BUILDING 00 B. WING	12/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ASCENSION AT HOME	2015 JACKSON ST ANDERSON, IN 46016

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			100% compliance is not achieved in 6 weeks, audits will continue until 100% compliance is achieved for 6 consecutive weeks. ·Once 100% compliance is achieved for 6 consecutive weeks, 25% of patients with wounds will be audited quarterly to monitor continued compliance.	
L 0552 Bldg. 00	418.56(d) REVIEW OF THE PLAN OF CARE 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. Based on observation, record review, and interview, the hospice failed to ensure that the IDG (Interdisciplinary Group) discussed all problems identified on the care plan and its progress toward those goals for 2 of 2 observations during the IDG meeting (#3, 4). Findings include: 1. An agency policy dated 4/1/18 and titled"comprehensive assessment updates," stated "Policy: The hospice's IDG updates the comprehensive assessment and reassesses the patient's response to care on a regular basis. A patient's progress toward desired outcomes and response to care is reassessed as often as required by the patient's condition but no less frequently than every 15 days. Information from the updated comprehensive assessment is	L 0552	Corrective Action Agency Nurses, Social Workers, Chaplains, Volunteer Coordinators and BereavementCoordinators will receive education on the Update of the Comprehensive Assessment with emphasis on documentation of the patient's progress toward goals and desired outcomes and response to care reassessed as often as required by the patient's condition and required documentation of the IDG meeting review of the ongoing reassessment of the patient / caregiver's status. · Education will include a review of policy 3.006 Comprehensive Assessment Updates, policy 3.015 Interdisciplinary Group,	02/03/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	151516	A. BUILDING 00 B. WING	12/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ASCENSION AT HOME	2015 JACKSON ST ANDERSON, IN 46016

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	reviewed by the IDG at care planning meetings and is used to revise the patient's plan of care as needed. Documentation of the IDG's care planning meetings reflects the ongoing reassessment of the patient / caregiver's status and needs. 2. The clinical record of patient #3 was reviewed on 12/3/19 at 11:51 AM and indicated an Election date of 11/26/19. The record contained a plan of care for the benefit period of 11/26/19-2/23/20 that included a hospice initial order which stated orders for discipline and treatments of "terminal care ... impending death interventions/imminence of death ... assess need for volunteer ... asses need for caregiver relief ... assess spiritual needs of the patient and caregiver ... mobility interventions ... pt [patient] will remain free from falls ... ADL [activities of daily living] interventions ...pt's hygiene needs will be met over the next 90 days ... fall prevention ... pain management ... respiratory ... assess respiratory status... O2 [oxygen] administration ... response to medications and treatment nebulizer inhalation treatment ... assess cardiovascular status ... edema ... fluid retention and dehydration ... assess nausea/vomiting ... assess bowel status ... assess patients swallowing ability ... pt and family will verbalize understanding of aspiration risks ... assess level of consciousness ... medication interventions ... equipment interventions ...." During an observation on at 12/5/19 at 12:00 PM, an IDG meeting was observed with the medical director, registered nurse (RN), licensed practical nurse (LPN), chaplain, social worker, bereavement coordinator, volunteer coordinator, clinical manager, and administrator. During review of patient #3 the nurse indicated the patient had a hospitalization was put on bipap which continued		hospice process guide HO IDG Process, and hospice process guides HO Nursing Minimum Documentation Requirements, HO Social Worker Minimum Documentation Requirements, and HO Chaplain Minimum Documentation Requirements. Training was initially completed on 12/17/19 and 12/19/19 with additional training completed on 1/28/20 and 1/30/20 Training will be complete on 2/3/2020 Evaluation for compliance · Beginning 2/03/2020, Hospice Director or Clinical Manager will audit 100% of all updated comprehensive assessments for 6 weeks to ensure the interdisciplinary documents all changes that have occurred since initial assessment, includes patient's goals and progress towards desired outcomes, reassessment of the patient's response to care. If 100% compliance is not achieved in 6 weeks, audits will continue for an additional 6 weeks or later until compliance is achieved. Once 100% compliance is achieved for 6 consecutive weeks, 25% of updated comprehensive assessments will be audited each quarter to monitor continued compliance with updating comprehensive assessment.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	151516	A. BUILDING 00 B. WING	12/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ASCENSION AT HOME	2015 JACKSON ST ANDERSON, IN 46016

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	at home. Patient was a long term smoker, looked older than 63, signed own consents on admission, was weak and frail. Had HHA (home health aide) 3 times per week, skilled nurse 2 times per week. She stated patient was on oxygen via nasal cannula, medications were in a lock box and there was a medication agreement in place due to drug diversion. Patient had morphine for pain and no longer refilling Norco. Medications were reviewed and new orders from the medical director to discontinue premarin (due to risk of stroke with use with smoking) and omega supplement. Patient was on spiriva and had several inhalers. She stated this could be discontinued after the patient runs out of the medication. The social worker stated they had seen patient and patient's daughter had significant medical history with drug addiction in past. The nurse indicated family/ staff were writing down every dose of medications being given and counted by nursing staff so that all are accounted for. The IDG failed to discuss, review, and update the careplan regarding spiritual needs, falls, hygiene needs, edema, nausea, vomiting, and swallowing difficulties and progress towards goals. 3. The clinical record of patient #4 was reviewed on 12/3/19 at 1:57 PM and indicated an Election date of 4/29/19. The record contained a plan of care for the benefit period of 10/26/19-12/24/19 that indicated needs of the patient which included "terminal care ... impending death interventions ... anticipatory grief ... assess need for volunteer ... pain management ... assess cardiovascular status ... assess urinary status... nutrition/hydration ... assess bowel status ... assess patients swallowing ability ... spiritual needs status ... social/emotional needs will be met ...." During an observation on at 12/5/19 at 12:00 PM,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	151516	A. BUILDING 00 B. WING	12/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ASCENSION AT HOME	2015 JACKSON ST ANDERSON, IN 46016

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	an IDG meeting was observed with the medical director, RN, LPN, chaplain, social worker, bereavement coordinator, volunteer coordinator, clinical manager, and administrator. During review of patient #4 discussion was held about the patient's baby doll and how patient took care of it. The administrator stated at the last visit patient was up in wheelchair, confused, vital signs were normal. Described patient as anxious and confused, had no needs. The administrator tod the nurse practitioner of the need for a face to face visit. Social worker had nothing to discuss. Chaplain indicated he saw the previous day and the patient had no changes since last visit. The IDG failed to discuss, review, and update the careplan regarding cardiovascular, urinary, nutrition/hydration, swallowing ability, and social/emotional needs and progress towards goals. 4. During an interview on 12/11/19 at 10:52 AM, the administrator was asked if during IDG meetings all active careplan problems should be reviewed. The administrator stated yes the nurse should be updating everything and if it is not an active problem they should document no changes.			
L 0565 Bldg. 00	418.58(b)(3) PROGRAM DATA (3) The frequency and detail of the data collection must be approved by the hospice's governing body. Based on record review and interview, the governing body failed to approve the hospice's data collection for the quality assurance performance improvement (QAPI) program for 1 of 1 agency.	L 0565	**Corrective Action · Governing Body, in collaboration with the Hospice Director, revised the Ascension at Home QAPI Program for Hospice. Revised QAPI program includes the**	01/28/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	151516	A. BUILDING 00 B. WING	12/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ASCENSION AT HOME	2015 JACKSON ST ANDERSON, IN 46016

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Findings include: An agency policy dated 4/1/18 titled "Quality assessment and performance improvement," Policy # 3.018 stated "Policy: The hospice program is committed to the highest level of quality ns safe care for its hospice service recipients. The hospice's governing body must ensure that the program: reflects the complexity of its organization and services, involves all hospice services (including those services provided under contract or arrangement) focuses on indicators related to improved palliative outcomes and takes actions to demonstrate improvement in hospice performance ... PROCEDURE: ... The governing body will be responsible to ensure that an ongoing program for quality improvement and patient safety is defined, maintained and evaluated annually and that the hospice wide quality assessment and improvement efforts address priorities for improved quality of care and safety ... The governing body will assure that one or more individuals are designated to operate the QAPI program." Agency governing body minutes dated 10/12/18 at 9:30 AM, stated "... The governing board members reviewed the following items prior to the meeting ... Quality Assessment Performance reports for each agency ... QAPI summaries reviewed by governing body members. No additions. Employee T will review AAH [ascension at home] hospice QAPI program behalf of the governing board and approve ...." The governing body failed to approve the hospice's data collection. During an interview on 12/11/19 at 12:54 PM, employee C was asked if the governing body approved the data that was collected. She stated		**identification of Quality Indicators for the improving palliative outcomes, requirement of Performance Improvement Projects (PIPs) for demonstrating improved performance, oversight of contracted services, QAPI Meeting documentation standards to ensure agency analyzes and tracks quality indicator data, QAPI Meeting schedule for quarterly meetings with timeline for Hospice Director to submit meeting minutes and PIPs summary to the Governing Body. QAPI Quality Indicators include required data collection determined to provide the Governing Body and Hospice Director with an overall evaluation of patient care and safety.** **Policy 3.018: Quality Assessment and Performance Improvement Program-Hospice Service Line (revised 1/17/2020) revised in collaboration with the Governing Body to accurately reflect the new QAPI program for Hospice Service Line.¿ ¿¿ Director received training on revised QAPI program from member of the governing body on 1/22/2020. The revised Hospice Quality Assessment Performance Improvement (QAPI) Program and Hospice**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	151516	A. BUILDING 00 B. WING	12/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ASCENSION AT HOME	2015 JACKSON ST ANDERSON, IN 46016

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	"I'm guessing yes," that all information regarding QAPI is given to employee W (national director of QAPI) and she was not sure what happened after that. When asked if the governing body was involved in the development and ongoing evaluation of QAPI she stated she thought they had had the greater oversight, but everything would be ran through employee W. When asked who the QAPI team is she stated herself, employee D, administrator, medical director, and a member from spiritual care, social work, bereavement, and volunteer.		**Operations Policy Manual were approved by the governing body on 01/28/2019.** **Evaluation for compliance: VP of Hospice Operations, appointee to Governing Body, will attend and audit the agency QAPI Committee Meeting on 2/04/2020. Agency QAPI Meeting Minutes (Quality Indicators), PIPS and Quarterly Director Summary documentation reviewed by the VP of Hospice Operations, in collaboration with Hospice Director and Regional Director of Hospice for accuracy. Review included recommendations for additional PIPs and/or data collection to ensure a thorough evaluation of patient care and safety was conducted by the QAPI Committee the QAPI Meeting Minutes (Quality Indicators), PIPS and Quarterly Director Summary documentation will be reviewed by the VP of Hospice Operations, appointed member of the Governing Body, in collaboration with Hospice Director and Regional Director of Hospice. Review recommendations for additional PIPs and/or data collection to ensure a thorough evaluation of patient care and**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	151516	A. BUILDING 00 B. WING	12/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ASCENSION AT HOME	2015 JACKSON ST ANDERSON, IN 46016

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			safety was conducted by the QAPI Committee. Beginning Q 1 2020, VP of Hospice Operations will present QAPI Committee summary and PIPs to the Governing Body for review and approval.	
L 0576 Bldg. 00	418.58(e)(3) EXECUTIVE RESPONSIBILITIES [The hospice's governing body is responsible for ensuring the following:] (3) That one or more individual(s) who are responsible for operating the quality assessment and performance improvement program are designated. Based on record review, the governing body failed to follow their policy to ensure that individual (s) were designated to be responsible for operating the QAPI program for 1 of 1 agency. Findings include: An agency policy dated 4/1/18 titled "Quality assessment and performance improvement," Policy # 3.018 stated "... PROCEDURE: ... The governing body will assure that one or more individuals are designated to operate the QAPI program." Governing body meeting minutes dated 10/12/18 at 9:30 AM, failed to designate individual(s) to operate the QAPI program. During this survey, the Governing body held a meeting 12/9/19 where employees Q, R, S, T, U, and V attended. Review of the minutes reflected the appointment of new board members [employees Q, R, V]. Attached to the minutes of	L 0576	Corrective Action Governing Body met on 12/9/19 and appointed an agency director to oversee the QAPI program. **The revised Hospice Quality Assessment Performance Improvement (QAPI) Program was approved on 1/28/2020, which included education on the structure regarding the roles and responsibilities of the Governing Body, the Agency Director, and the Agency QAPI committee.** Evaluation for compliance · VP of Hospice Operations, appointee to Governing Body, will attend and audit the agency QAPI Committee Meeting on 2/03/2020. Agency QAPI Meeting Minutes (Quality Indicators), PIPS	01/28/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	151516	A. BUILDING 00 B. WING	12/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ASCENSION AT HOME	2015 JACKSON ST ANDERSON, IN 46016

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	the meeting were the leadership and interdisciplinary group (IDG) members for all hospice agencies in Indiana, Alabama, Michigan, Oklahoma, Texas, and Wisconsin that were approved during the meeting and not just reflective of this agency.		and Quarterly Director Summary documentation reviewed by the VP of Hospice Operations, in collaboration with Hospice Director and Regional Director of Hospice for accuracy. Review included recommendations for additional PIPs and/or data collection to ensure a thorough evaluation of patient care and safety was conducted by the QAPI Committee the QAPI Meeting Minutes (Quality Indicators), PIPS and Quarterly Director Summary documentation will be reviewed by the VP of Hospice Operations, appointed member of the Governing Body, in collaboration with Hospice Director and Regional Director of Hospice. Review recommendations for additional PIPs and/or data collection to ensure a thorough evaluation of patient care and safety was conducted by the QAPI Committee. Beginning Q 1 2020, VP of Hospice Operations will present QAPI Committee summary and PIPs to the Governing Body for review and approval.	
L 0579 Bldg. 00	418.60(a) PREVENTION The hospice must follow accepted standards of practice to prevent the transmission of infections and communicable diseases, including the use of standard precautions.	L 0579	Corrective Action ·	01/30/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	151516	A. BUILDING 00 B. WING	12/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ASCENSION AT HOME	2015 JACKSON ST ANDERSON, IN 46016

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Based on observation, record review, and interview, the agency failed to ensure that hospice staff followed infection control policies for 3 of 3 home visits observed (#1, 2, 4). Findings include: 1. An agency policy dated 3/18 titled "clinical bag technique," Policy 3.019 attachement C stated "... The bag contains a designated clean area(the inside of the bag), aand a dirty area (the pockets on the outside of the bag). The clean area contais unused or cleaned supplies/equipment and the dirty is designated for frequently used materials (i.e., soap, paper towels, waterless hand cleanser, bag barriers, ectc.) ... Hand hygiene must always be performed using alcohol based hand cleanser or soap and water before reaching into the ag for supplies/equipment ...." 2. An agency policy dated 4/1/18 and titled "Infection control program," stated "... The agency administrator or designee is responsible for ensuring all clinical staff receive instruction regading identification, transmission, prevention, and control of infection as well as communicable disease sources ... These prevention and / or control precautions may include, nut are not limited to the following: ... Appropriate use of aseptic techniques during dressing changes ... as defined in standard precautions ...." 3. During a home visit on 12/4/19 at 12:35 PM, employee I, home health aide (HHA), was observed providing personal care to patient #4 (hospice election date of 4/29/19). Employee I transfered patient to shower chair and into the shower. While in the shower the patient had a bowel movement on the shower floor. Employee I washed body and rinsed, then washed the		Hospice Director will ensure the Interdisciplinary Team members will receive training on standards of practice to prevent the transmission of infections, including the use of standard precautions, proper bag technique. All members of The Interdisciplinary Team will review the Hand Hygiene Policy and Bag Technique. All Hospice Nurses and Hospice Aides will review Relias checklists Bathing-Perineal Care Female and Bathing - Perineal Care Male. Training was given on 12/17/19, 12/19/19 with follow up training completed on 1/28/2020 and 1/30/2020. Hospice Director will provide education to all nursing staff on infection control standards when performing wound dressing changes including proper hand hygiene intervals, utilization of and changing gloves between tasks, cleansing of equipment to prevent potential transmission of disease from a patient with weeping, draining wounds. Training was given on 12/17/19, 12/19/19 with follow up training completed on 1/28/2020 and 1/30/2020. Evaluation for compliance · Beginning 2/3/2020, Hospice Director or Clinical Manager will perform at least 1 onsite supervisory home visit with each clinical staff member to observe staff for competency in the standards of practice to prevent	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	151516	A. BUILDING 00 B. WING	12/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ASCENSION AT HOME	2015 JACKSON ST ANDERSON, IN 46016

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	perinium and anal area last. After washing the anal area (which had stool on washcloth), employee immediately rinsed patient, wrapped a towel around the patient and then moved the shower chair out of the shower before removing gloves. Employee I failed to remove gloves immediately after washing anal area and before rinsing to avoid contamination to the patient and patient's belongings. 4. During an interview on 12/11/19 at 11:30 AM, the administrator stated after using vital sign equipment all equipment should be placed on a barrier, then wiped down together, then placed back in bag. 5. During a home visit on 12/4/19 at 11:10 AM with patient #1 in her home, Employee K, Registered Nurse (RN), was observed providing skilled care. Employee K began the visit with hand hygiene using hand gel and applied non-sterile gloves. Employee K followed by removing abdominal dressing, then gloves and utilized hand gel. Patient #1's abdomen revealed a drainage tube to the right middle-upper quadrant with a suture in place. The drainage tube insertion site was visibly leaking fluid onto the patient's abdomen and the bed. The employee opened the plurex (fluid draining system) drainage tube package and placed beside the patient on the bed. The employee followed by opening sterile dressing pack and placed on the patient's bed, then without gloves, picked up the plurex drain bottle and placed it on the sterile barrier beside the patient. Employee K then donned sterile gloves and contaminated the fingers of the gloves on the left hand while pulling on the right hand glove cuff. The employee followed by opening 3 alcohol swabs, and placed on the barrier. Employee K wiped the drainage tube cap exterior, removed the cap and attached to the plurex drain		the transmission of infections, including the use of standard precautions, proper bag technique. Any staff who does not demonstrate compliance with standards of practice for hand washing and perineal care will be reeducated and scheduled for an additional onsite managerial supervisory visit. · Beginning 2/3/2020, Hospice Director or Clinical Manager will perform at least 1 onsite supervisory home visit with each nursing staff member to observe staff for competency in the standards of practice to standards when performing wound dressing changes including proper hand hygiene intervals, utilization of and changing gloves between tasks, cleansing of equipment to prevent potential transmission of disease from a patient with weeping, draining wounds. · Any staff who does not demonstrate compliance with standards of practice for hand washing and perineal care will be reeducated and scheduled for an additional onsite managerial supervisory visit. · Each staff member will be given a maximum of 3 retraining sessions and subsequent onsite supervisory visits to demonstrate competency. If competency is not achieved after 3 attempts, the staff member will be terminated from employment.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	151516	A. BUILDING 00 B. WING	12/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ASCENSION AT HOME	2015 JACKSON ST ANDERSON, IN 46016

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	container. The plurex drain evacuated 1/2 bottle of cloudy yellow fluid, the employee verbalized the volume removed was approximately 300 ml (milliliters), then she placed the drainage and bottle into a bag. The employee then clamped the tubes on the abdomen and plurex drainage bottle, swabbed the connection between the tubing's and applied a new cap to the end of the abdominal drainage tube. The employee then continued by using the last alcohol swab left on the barrier and began cleansing in the drainage tube insertion site, then followed by rubbing the wipe approximately 3 fingerbreadth's from the insertion site and then returned to the insertion site and back out again before discarding the wipe in a bag at the bedside. The employee then applied a split dressing to the abdomen and curled the excess tubing on top of the dressing and then covered the tubing with a 4 x 4 gauze. The employee removed her gloves and immediately placed her bare hand atop the dressing while she began to apply the clear, occlusive dressing to the abdominal dressing and held in place for 5 seconds. While the employee held the dressing in place with her right, ungloved hand, she reached up and scratched the left side of her head, switched hands on the abdomen, placing the right hand on the abdomen and removed the remaining outer adhesive portion of the dressing. The employee then discarded the trash in a bag, placed both hands on her hips, observed the dressing. She then retrieved an adult incontinence brief from across the room and placed it in her lap as she applied hand gel. The employee then reached into her bag that had been placed on the patients floor to retrieve scissors and paper tape and placed on the patient's dresser. The employee cut the adult incontinence brief ends to cover the abdominal dressing and placed scissors in her pocket. The employee			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	151516	A. BUILDING 00 B. WING	12/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ASCENSION AT HOME	2015 JACKSON ST ANDERSON, IN 46016

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	utilized the paper tape to secure the brief over the abdominal dressing and followed by placing the tape in her pocket. The employee reached again into her bag, retrieved hand gel and performed hand hygiene and placed wrist blood pressure cuff on the patient's left wrist, and the pulse oximeter to the patient's right index finger. The employee then retrieved her phone from her pocket to verify the time for respiratory rate and when completed, placed it back in her pocket. When vital signs were complete, the employee placed her tablet for documentation partly on her knees and partly on the bed. The employee then began a physical assessment with bare hands. The patient was observed to exhibit swollen lower extremities with open, weeping sores and scabs. The employee performed an assessment of the lower extremities by both observation and palpation without gloves. After the physical assessment, the employee began to document on her tablet without performing hand hygiene and placed the tablet, scissors and paper tape back into her bag. Employee K failed to perform proper hand hygiene at appropriate intervals, failed to utilize and change gloves between tasks, and failed to cleanse equipment to prevent potential transmission of disease from a patient with weeping, draining wounds. 6. During a home visit on 12/4/19 at 11:10 AM with patient #2 in an assisted living facility, Employee J, Registered Nurse (RN), was observed providing skilled care. Employee J began the visit by placing her bag directly on the patient's chair and then applied clean, non-sterile gloves. The employee reached into her bag, removed a cleansing wipe and cleansed the assisted living's blood pressure equipment and stethoscope, then placed the wipe on her paper tablet on the patient's dining table. After the employee			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	151516	A. BUILDING 00 B. WING	12/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ASCENSION AT HOME	2015 JACKSON ST ANDERSON, IN 46016

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	cleansed the equipment, she removed her gloves and proceeded to obtain vital signs. After taking vital signs she placed the assisted living agency blood pressure cuff in her nursing bag. The employee began the patient physical assessment, then the employee indicated her nose was running. She reached into her pocket, retrieved a tissue and blew her nose. The employee then went into the patient's restroom, turned on the water and rinsed her hands in water (no soap was used) for 3 seconds and dried hands with a paper towel. She immediately went back to the patient and palpated the patient's lower legs and feet and followed by removing a pen from her pocket and documented the information on the paper tablet from the patient's dining table. After the employee completed the documentation, she filled the patient's oxygen concentrator humidifier container and CPAP (continuous positive airway pressure) reservoir with distilled water. The employee then obtained a repeat blood pressure and when she finished, she retrieved the stethoscope from her nursing bag and the previously used cleansing wipe from the dining table from the beginning of the visit to wipe down the agency equipment. The employee performed hand hygiene utilizing hand gel after wiping off equipment with previously used cleansing wipe. Employee J failed to perform proper hand hygiene at appropriate intervals, failed to utilize gloves appropriately and failed to cleanse multi-use equipment in a manner to prevent potential disease transmission to and from patients in an assisted living facility.			
L 0590 Bldg. 00	418.64(a) PHYSICIAN SERVICES The hospice medical director, physician employees, and contracted physician(s) of the hospice, in conjunction with the patient's			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	151516	A. BUILDING 00 B. WING	12/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ASCENSION AT HOME	2015 JACKSON ST ANDERSON, IN 46016

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	attending physician, are responsible for the palliation and management of the terminal illness and conditions related to the terminal illness. (1) All physician employees and those under contract, must function under the supervision of the hospice medical director. (2) All physician employees and those under contract shall meet this requirement by either providing the services directly or through coordinating patient care with the attending physician. (3) If the attending physician is unavailable, the medical director, contracted physician, and/or hospice physician employee is responsible for meeting the medical needs of the patient. Based on record review and interview, the agency failed to ensure the hospice physician was knowledgable of his job title and that he was to report to the medical director for 1 of 1 physician designee interviewed (F). Findings include: An agency policy dated 4/1/18 titled "Medical director & contract," Policy # 4.001 stated " Policy ... The hospice Medical Director assumes the overall responsibility for the medical component of the patient care program. ... When the Medical director is not available, a physician designated by the hospice assumes the same responsibilities and obligations as the Medical Director...." The agency hospice physician agreement was reviewed on 12/12/19 and stated "This agreement is effective as of the 15 th day of August, 2018, by and between [entity K], an Indiana limited liability company, hereinafter referred to as [entity L] and	L 0590	Corrective Action · Hospice Director educated Medical Director and Hospice Physician on job description and delineation of job responsibilities using the NHPCO Physician compliance training guide. Training was provided on 1/29/2020 and will be completed on 2/3/2020. **The Hospice Director will collaborate with contracting services and legal department to revise Medical Director and hospice physician employment contracts to include delineation of job responsibilities of each position, including organizational reporting structure. Medical Director and hospice physician will sign revised and compliant employment contract no later**	02/03/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	151516	A. BUILDING 00 B. WING	12/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ASCENSION AT HOME	2015 JACKSON ST ANDERSON, IN 46016

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	[employee F] ... Schedule 2.01A Designated Medical director [employee F] ... Responsibilities ...Direct and assume responsibility for the medical component of the program, oversee the palliation and management of the terminal illness and conditions related to the terminal illness of program patients and ensure that the medical needs of program patients are being met ...." During an interview on 12/3/19 at 10:00 AM, employee F was asked what his job title was, to which he did not know and asked the administrator who was sitting next to him. When asked who he reported to, he stated employee A. He stated he was responsible for the medical component of the hospice and employee E was the "official" medical director.		**than 2/3/2020. Review Employment Agreement and Physician Onboarding Process including Clinical Onboarding Competency Checklist with any new physician during the onboarding process.** Evaluation for compliance · Beginning 2/3/2020, Hospice Director and Regional Director of Hospice will audit 100% of all medical director and hospice physician files to validate presence of signed employment agreement which includes description of duties and reporting structure. Audits will continue until 100% compliance. · Hospice Director will meet at least monthly with Medical Director to review agency clinical and physician service needs, including physician scheduling.	
L 0591 Bldg. 00	418.64(b)(1) NURSING SERVICES (1) The hospice must provide nursing care and services by or under the supervision of a registered nurse. Nursing services must ensure that the nursing needs of the patient are met as identified in the patient's initial assessment, comprehensive assessment, and updated assessments. Based on observation, record review, and interview, the agency failed to ensure the skilled nurse (SN) performed a complete physical assessment per professional standards for 3 of 3 nursing home visits observed (#1, 2, 4).	L 0591	**Corrective Action** Hospice Director will ensure that all agency Registered Nurses will receive education on accurate and complete documentation of the Initial & Comprehensive Assessment of Patient with	01/30/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	151516	A. BUILDING 00 B. WING	12/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ASCENSION AT HOME	2015 JACKSON ST ANDERSON, IN 46016

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Findings include: 1. An agency policy dated 4/1/18 and titled "Nursing services," Policy # 4.005 stated "... Nursing services are provided in accordance with accepted standards of practice ...." 2. Constantine, L., MSN, RN, C-FNP. (2004, June 15). Overview of Nursing Health Assessment. Retrieved December 12, 2019, from rn.com "... PULMONARY ASSESSMENT: When examining the pulmonary system ... Inspect the thoracic cage, palpate the thoracic cage, Auscultate the anterior and posterior chest: Have patient breath slightly deeper than normal through their mouth, Auscultate from C-7 to approximately T-8, in a left to right comparative sequence. You should auscultate between every rib ... Identify any adventitious breath sounds. ... Assessing the Abdomen/Gastrointestinal System: When examining the abdomen/gastrointestinal system, ASK about the following ... Any abdominal pain, Any change in bowel habits ... Auscultate for bowel sounds and bruits. Begin by dividing the abdomen into 4 quadrants, by drawing an imaginary line vertically and horizontally across the abdomen to intersect the umbilicus. Right Upper Quadrant, Left Upper Quadrant, Right Lower Quadrant, Left Lower Quadrant. Auscultation should begin in the right lower quadrant. If bowel sounds are not heard, in order to determine if bowel sounds are truly absent, listen for a total of five minutes." 3. During a home visit on 12/4/19 at 11:10 AM with patient #1 in her home, Employee K, Registered Nurse (RN), was observed providing skilled care. Employee K obtained the patient's blood pressure, oxygen saturation, pulse, temporal temperature and respiratory rate. During		emphasis on documentation of the integumentary, wound care, gastrointestinal, and pulmonary. Education will include a review of policies: Policy 3.003 Comprehensive Assessment-Initial, policy 3.004 Comprehensive Assessment of the Patient, policy 3.005 Comprehensive Assessment Content; policy 3.006 Comprehensive Assessment Updates, policy 4.005 Nursing Services, policy 7.001 Clinical Record Content, and hospice process guide HO Nursing Minimum Documentation Requirements; Relias training physical assessment. Training was initially completed on 12/17/19 and 12/19/19 with additional training completed on 1/28/20 and 1/30/20 **Evaluation for compliance** Beginning 2/3/2020, Hospice Director and Clinical Manager will identify active patients with wound care interventions and audit 100% of medical records for wound care physician orders, with nursing documentation evident of compliance with plan of care. If 100% compliance is not achieved in 6 weeks, audits will continue until 100% compliance is achieved for 6 consecutive weeks. Beginning 2/3/2020, Hospice Director and Clinical Manager will perform at least 1 onsite	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	151516	A. BUILDING 00 B. WING	12/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ASCENSION AT HOME	2015 JACKSON ST ANDERSON, IN 46016

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	the physical assessment, the employee utilized her stethoscope to auscultate right upper and middle, then left upper and middle anterior lung sounds followed immediately by auscultation of the right upper, right middle and left lower abdominal bowel sounds. Employee K remarked, bowel sounds were, "minimal." The employee failed to auscultate all lung fields posteriorly and failed to auscultate all four abdominal quadrants for bowel sounds. 4. During a home visit on 12/4/19 at 11:10 AM with patient #2 in an assisted living facility, Employee J, Registered Nurse (RN), was observed providing skilled care. Employee J obtained the patient's blood pressure, oxygen saturation, pulse, oral temperature and respiratory rate. During the physical assessment, the employee utilized the agency stethoscope and auscultated patient's right upper and left upper anterior breath sounds followed by auscultating right lower and left lower abdominal bowel sounds. The employee remarked the patient "basically has no breath sounds." The employee failed to auscultate all lung fields anteriorly and posteriorly and failed to auscultate all four abdominal quadrants for bowel sounds 5. During a home visit on 12/4/19 at 11:06 AM, employee AA, registered nurse (RN), was observed providing skilled care to patient #4 (hospice election date of 4/29/19). Employee AA touched ankles to look at edema (patient had socks and shoes on), auscultated anterior lung sounds in 2 areas and one time on each side. Employee AA failed to assess feet for edema or mottling and failed to auscultate posterior lung fields. 6. The clinical record of patient #11 was reviewed on 12/10/19 at 1:16 PM and indicated an Election date of 2/13/19. The record contained a plan of		supervisory home visit with each registered nurse to observe for competency in performing a complete physical assessment per professional standards. Any staff who does not demonstrate competence will be reeducated and scheduled for an additional onsite managerial supervisory visit.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	151516	A. BUILDING 00 B. WING	12/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ASCENSION AT HOME	2015 JACKSON ST ANDERSON, IN 46016

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	care for the benefit period of 10/11/19-12/9/19. The RN failed to ensure that wound assessment and documentation was thorough and consistent to fully identify the type of wound being treated. The agency hospice nursing clinical note obtained initial wound documentation which started 11/6/19. One wound was a Stage I buttock wound. On 11/13/19 the wounds were documented as a stage 1-2 on right buttock with one extension. On 11/21/19 the wound was described as a coccyx wound. On 12/4/19 the wound was described as a buttock/coccyx wound. 7. During an interview on 12/11/19 at 11:23 AM, the administrator stated if the same nurse is seeing a patient, then the wound documentation should be consistent, nurses should listen anteriorly and posteriorly to lungs fields during auscultation, and all four bowel sounds should be auscultated during a nursing assessment.			
L 0596 Bldg. 00	418.64(d)(1) COUNSELING SERVICES Counseling services must include, but are not limited to, the following: (1) Bereavement counseling. The hospice must: (i) Have an organized program for the provision of bereavement services furnished under the supervision of a qualified professional with experience or education in grief or loss counseling. (ii) Make bereavement services available to the family and other individuals in the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	151516	A. BUILDING 00 B. WING	12/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ASCENSION AT HOME	2015 JACKSON ST ANDERSON, IN 46016

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	bereavement plan of care up to 1 year following the death of the patient. Bereavement counseling also extends to residents of a SNF/NF or ICF/MR when appropriate and identified in the bereavement plan of care. (iii) Ensure that bereavement services reflect the needs of the bereaved. (iv) Develop a bereavement plan of care that notes the kind of bereavement services to be offered and the frequency of service delivery. A special coverage provision for bereavement counseling is specified in §418.204(c). Based on record review and interview the hospice failed to ensure bereavement careplans delineated individualized, specific, types of bereavement services that would be offered with the frequency they would be delivered for 3 of 3 bereaved records reviewed (#8, 14, 15). Findings include: 1. An agency policy dated 4/1/18 titled "Bereavement assessment," Policy #3.014 stated "...The bereavement plan of care reflects the assessed needs of the bereaved and notes the kind of bereavement services to be offered and the frequency of delivery ...." 2. The clinical record of patient #8 was reviewed on 12/3/19 at 3:35 PM and indicated an Election date of 3/29/19 and date of death 5/14/19. The bereavement interventions were "duration of bereavement program 13 months after patient's death ... complete bereavement initial assessment / Care plan within 28 days of patient's death ... Other: Provide grief education and support through bereavement correspondence program for 13 months (condolence letter, information on	L 0596	**Corrective Action** Hospice Director will ensure the interdisciplinary team receives education on assessing bereavement needs and developing a bereavement plan of care that notes the kind of bereavement services to be offered and the frequency of service delivery. Education will include review of policy 3.014 Bereavement Assessment and policy 4.007 Bereavement Counseling. Training was initially completed on 12/17/19 and 12/19/19 with additional training on 1/28/20 and 1/30/20. Training will be complete on 2/3/2020 Bereavement Counselor will develop the bereavement care plan and obtain Interdisciplinary team input on the development of the bereavement care plan at the first IDG meeting post death. Evaluation for compliance Beginning 2/03/2020, Hospice	02/03/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	151516	A. BUILDING 00 B. WING	12/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ASCENSION AT HOME	2015 JACKSON ST ANDERSON, IN 46016

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	bereavement services and benefits, grief education packet, 5 months needs & issues survey, holiday grief support; closure letter; bereavement team may place 'Ambassador Call' to the bereaved ...." As contact is made with the bereaved the date, type of contact and initials with what was mailed was filled out. The record failed to evidence specific types and duration of bereavement care that was also individualized for the bereaved on the bereavement plan of care. 3. The clinical record of patient #14 was reviewed on 12/12/19 indicated a death date of 9/11/19. The bereavement interventions were "duration of bereavement program 13 months after patient's death ... complete bereavement initial assessment / Care plan within 28 days of patient's death ... Other: Provide grief education and support through bereavement correspondence program for 13 months (condolence letter, information on bereavement services and benefits, grief education packet, 5 months needs & issues survey, holiday grief support; closure letter; bereavement team may place 'Ambassador Call' to the bereaved ...." As contact was made with the bereaved the date, type of contact and initials with what was mailed was filled out. The record failed to evidence specific types and duration of bereavement care that was also individualized for the bereaved on the bereavement plan of care. 4. The clinical record of patient #15 was reviewed on 12/12/19 indicated a death date of 8/5/19. The bereavement interventions were "duration of bereavement program 13 months after patient's death ... complete bereavement initial assessment / Care plan within 28 days of patient's death ... Other: Provide grief education and support through bereavement correspondence program for 13 months (condolence letter, information on		Director and Clinical Manager will audit 100% of deaths for 4 weeks to validate bereavement assessment and plan of care contain individualized and specific goals and interventions including the types of bereavement services offered and the frequency were completed at the first IDG meeting post death. If 100% compliance is not achieved in 4 weeks, 100% deaths will be audited until compliance is achieved for 4 consecutive weeks.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	151516	A. BUILDING 00 B. WING	12/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ASCENSION AT HOME	2015 JACKSON ST ANDERSON, IN 46016

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	bereavement services and benefits, grief education packet, 5 months needs & issues survey, holiday grief support; closure letter; bereavement team may place 'Ambassador Call' to the bereaved ...." As contact was made with the bereaved the date, type of contact and initials with what was mailed was filled out. The record failed to evidence specific types and duration of bereavement care that was also individualized for the bereaved on the bereavement plan of care. 5. During an interview on 12/11/19 at 4:20 PM, the administrator stated the bereavement plan of care should have specific type and frequency of bereavement services.			
L 0602 Bldg. 00	418.70 FURNISHING OF NON-CORE SERVICES A hospice must ensure that the services described in §418.72 through §418.78 are provided directly by the hospice or under arrangements made by the hospice as specified in §418.100. These services must be provided in a manner consistent with current standards of practice. Based on record review and interview, the hospice failed to ensure the skilled nurse obtained wound measurements upon admission for 1 of 3 records with wounds (#6). Findings include: The clinical record of patient #6 was reviewed on 12/5/19 and indicated an Election date of 11/15/19. The record contained a plan of care for the benefit period of 11/15/19 - 1/15/20. The hospice failed to ensure wound measurements were obtained upon admission.	L 0602	**Corrective Actions** ·Hospice Director will ensure that the agency provides quality nursing services as directed in the patient's individualized plan of care. All agency Registered Nurses will receive education on accurate and complete documentation of wound care, including obtaining wound measurements on every physical assessment, per current standards of practice. Training was initially completed on 12/17/19 and 12/19/19 with	01/30/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	151516	A. BUILDING 00 B. WING	12/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ASCENSION AT HOME	2015 JACKSON ST ANDERSON, IN 46016

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	An agency document titled, "Hospice Initial / Comprehensive Nursing Assessment" dated 11/15/19 signed by Employee K evidenced the following: " ... Co-Morbidities ...h. Pressure Ulcer of sacral region, stage 1 ... Pt (patient) has a stage 1 pressure ulcer to the coccyx. There are currently no open areas. Writer will order magic butt paste and will instruct pt's daughter to apply a think layer to the area...." An agency document titled, "Hospice Interdisciplinary Care Plan" dated 11/15/19 and signed by Employee K, evidenced the following, "... Integumentary Status ...Intervention #2: Assess characteristics of wound including color, size, (length, width, depth), drainage and odor...." During an interview on 12/11/19 at 11:23 AM, the administrator stated the nurses should be measuring wounds weekly at the first visit of the week.		additional training on 1/28/20 and 1/30/20. Post education, Registered Nurses will demonstrate wound care competency, including the measurement of the wound, per current standards of practice, through teach back to the Clinical Manager. **Evaluation for compliance** Beginning 2/3/2020, Hospice Director and Clinical Manager will audit 100% of medical records with wound care interventions for 4 weeks for nursing documentation that includes wound measurements and interventions per current standard practice. If 100% compliance is not achieved in 4 weeks, 100% deaths will be audited until compliance is achieved for 4 consecutive weeks.	
L 0625 Bldg. 00	418.76(g)(1) HOSPICE AIDE ASSIGNMENTS AND DUTIES (1) Hospice aides are assigned to a specific patient by a registered nurse that is a member of the interdisciplinary group. Written patient care instructions for a hospice aide must be prepared by a registered nurse who is responsible for the supervision of a hospice aide as specified under paragraph (h) of this section. Based on record review and interview, the hospice registered nurse failed to complete written care instructions on the aide care plan to include the frequency the tasks are to be completed for 4 of 13 records reviewed (#2, 5, 7, 12).	L 0625	**Corrective Action** ·Hospice Director will ensure all Registered Nurses receive education and training on completing written patient care instructions for a hospice aide that	01/30/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	151516	A. BUILDING 00 B. WING	12/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ASCENSION AT HOME	2015 JACKSON ST ANDERSON, IN 46016

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Findings include: 1. An agency policy dated 4/1/18 and titled "Comprehensive assessment of the patient," Policy # 5.002 stated "... The hospice RN [registered nurse] develops and maintains a hospice aide plan of care that provides instructions to the hospice aide on the patient-specific care to be provided ...." 2. The clinical record of patient #5 was reviewed on 12/4/19 at 8:00 AM and indicated an Election date of 11/15/19. The record contained a plan of care for the benefit period of 11/15/19-2/12/20. The home health aide (HHA) careplan dated 11/19/19 indicated tasks the aide was to complete: urinal, linen change, make bed, mouth care, clean nails, minimal assistance with dressing, all which failed to evidence a frequency of how often the tasks were to be completed. 3. The clinical record of patient #12 was reviewed on 12/10/19 at 4:01 PM and indicated an Election date of 9/10/19. The record contained a plan of care for the benefit period of 9/1/19-12/8/19. The agency document titled "hospice initial/comprehensive nursing assessment," stated the patient had a catheter which required changing every month and as needed with a 16 french 10 milliliter balloon. The home health aide (HHA) careplan dated 9/23/19 indicated the patient had a foley catheter, but failed to evidence tasks for the aide to complete catheter care or empty the catheter bag (which is required for anyone with a catheter). 4. During an interview on 12/11/19 at 11:34 AM,		include frequency and type of tasks to be performed and any specific safety precautions. Education will include a review of policy 5.002 Hospice Aide Services and policy 5.003 Hospice Aide Assignments & Duties. Training was initially completed on 12/17/19 and 12/19/19 with additional training on 1/28/20 and 1/30/20. Under the direction of the Clinical Manager, Registered Nurses will audit and revise 100% of current patients with hospice aide written instructions to ensure type, frequency of tasks and specific safety precautions are included. **Evaluation for compliance** Beginning 2/03/2020, Hospice Director and Clinical Manager will audit 100% of hospice aide written patient care instructions for all new admissions for 4 weeks to ensure that patient safety precautions, type and frequency of tasks are present. If 100% compliance is not achieved in 4 weeks, 100% admissions will be audited until compliance is achieved for 4 consecutive weeks.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	151516	A. BUILDING 00 B. WING	12/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ASCENSION AT HOME	2015 JACKSON ST ANDERSON, IN 46016

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	the administrator stated the aide care plan should contain the frequency that tasks are to be completed. 5. The clinical record of patient #2 was reviewed on 12/5/19 and indicated an Election date of 3/29/19. The record contained a plan of care for the benefit period of 9/25/19 - 11/23/19. The record included an "HHA Care Plan" dated 3/29/19, completed by Employee J, RN (Registered Nurse), indicating services the Aide is to provide during each visit which included "... Special Instruction: Refer to patient POC (plan of care) for safety precautions ...." the care plan failed to indicate the specific safety precautions on the aide care plan to indicate supplies or equipment required to provide this care and prevent harm. 6. The clinical record of patient #7 was reviewed on 12/5/19 and indicated an Election date of 11/22/19. The record contained a plan of care for the benefit period of 11/22/19 - 2/19/20. The record included an "HHA Care Plan" dated 11/24/19, completed by Employee AA, RN, indicating services the Aide is to provide during each visit which included tasks to be performed without frequency: oral care, lotion, 'clean nails' for hands and feet, upper and lower dressing assistance, transfers, and commode. Further, the aide care plan evidenced the following: "... Special Instruction: Refer to patient POC (plan of care) for safety precautions ...." the aide care plan failed to indicate the frequency of the specified tasks or specific safety precautions to indicate supplies or equipment required to provide this care and prevent harm.			
L 0626	418.76(g)(2) HOSPICE AIDE ASSIGNMENTS AND			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	151516	A. BUILDING 00 B. WING	12/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ASCENSION AT HOME	2015 JACKSON ST ANDERSON, IN 46016

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
Bldg. 00	DUTIES (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. Based on observation, record review, and interview, the hospice aide failed to provide services in accordance with the plan of care for 1 of 9 records reviewed with aide services (#4). Findings include: An agency policy dated 4/1/18 and titled "Hospice aide assignments & duties," Policy # 5.003 stated "... A hospice aide provides services that are: a. ordered by the interdisciplinary group b. included in the plan of care ...." The clinical record of patient #4 was reviewed on 12/3/19 at 1:57 PM and indicated an Election date of 4/29/19. The record contained a plan of care for the benefit period of 10/26/19-12/24/19. The aide care plan contained tasks of oral care and shampoo to be completed at each visit. During a home visit observation on 12/4/19 at 12:35 PM, employee I was observed providing personal care to patient #4. Employee I failed to shampoo patient's hair or complete oral care during visit. During an interview on 12/11/19 at 11:!1 AM, the administrator stated the home health aide should follow the plan of care.	L 0626	**Corrective Action** Hospice Director will ensure that all hospice aides receive education and training on following the hospice aide written patient care instructions prepared by the RN. Included in the training will be education clarifying that the 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. Education will include a review of policy 5.002 Hospice Aide Services and policy 5.003 Hospice Aide Assignments and Duties. Training was initially completed on 12/17/19 and 12/19/19 with additional training on 1/28/20 and 1/30/20. **Evaluation for compliance** Beginning 2/03/2020, Clinical Manager or designee will audit 100% of hospice Aide visit documentation for 4 weeks to validate hospice aide only provided	01/30/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	151516	A. BUILDING 00 B. WING	12/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ASCENSION AT HOME	2015 JACKSON ST ANDERSON, IN 46016

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			care as directed in the written patient care instructions prepared by the RN. If 100% compliance is not achieved in 4 weeks, audits will continue until compliance is achieved for 4 consecutive weeks. Beginning 2/03/2020, Registered nurses will perform at least 1 onsite supervisory home visit with each hospice aide to observe aide is following written patient care instructions. Any hospice aide who does not demonstrate compliance with providing care per patient care instructions will be reeducated and scheduled for an additional onsite RN supervisory visit. Each staff member will be given a maximum of 3 retraining sessions and subsequent onsite supervisory visits to demonstrate competency. If competency is not achieved after 3 attempts, the hospice aide will be terminated from employment.	
L 0648 Bldg. 00	Based on record review and interview, the hospice agency failed to ensure; all contracts in place reflected the hospice's legal name, all staff orientation, coding, human resources (HR); quality assurance performance improvement (QAPI) was not delegated to another entity; contracts were in place if outside sources were utilized to assist the hospice; employee files were managed by the hospice (See Tag L649); the	L 0648	**Corrective Action** Hospice Director, in collaboration with a representative of the Governing Body, completed a 100% audit of the agency contracts to ensure vendor contracts for DME, pharmacy, and medical reflected the hospice agency's legal name. Audit was completed on 1/16/2020.	02/04/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	151516	A. BUILDING 00 B. WING	12/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ASCENSION AT HOME	2015 JACKSON ST ANDERSON, IN 46016

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	administrator reported to the governing body; the governing body assumed full responsibility for the management of the hospice; the governing body provided management and oversight of the hospice's quality assessment performance improvement (QAPI) program; the governing body appointed the administrator and alternate administrator into their positions (See Tag L651); proper chain of command on the agency organizational chart to delineate administrative control of staff who worked daily in the hospice and over the multiple site location; staff knew who the administrator was (See Tag L658); and staff received orientation for specific job duties (See Tag L662). These practices impacted contracts, employee files, and the day to day functions of the hospice. The cumulative effect of this systemic problem resulted in the agency being out of compliance with the Condition of Participation 42 CFR 418.100 Organization/Administration of Services.		**Vendor contracts for DME, pharmacy and medical supplies will be revised to accurately reflect the Ascension Health at Home name as well as covered entities Administrator for agency was appointed by the governing body on 12/9/19. Governing Body, in collaboration with the Hospice Director, revised the Ascension at Home QAPI Program for Hospice. Revised QAPI program includes the identification of Quality Indicators for the improving palliative outcomes, requirement of Performance Improvement Projects (PIPs) for demonstrating improved performance, oversight of contracted services, QAPI Meeting documentation standards to ensure agency analyzes and tracks quality indicator data, QAPI Meeting schedule for quarterly meetings with timeline for Hospice Director to submit meeting minutes and PIPs summary to the Governing Body. QAPI Quality Indicators include required data collection determined to provide the evaluation of patient care and safety was conducted by the QAPI Committee the QAPI Meeting Minutes (Quality Indicators),**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	151516	A. BUILDING 00 B. WING	12/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ASCENSION AT HOME	2015 JACKSON ST ANDERSON, IN 46016

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			PIPS and Quarterly Director Summary documentation will be reviewed by the VP of Hospice Operations, appointed member of the Governing Body, in collaboration with Hospice Director and Regional Director of Hospice. Review recommendations for additional PIPs and/or data collection to ensure a thorough evaluation of patient care and safety was conducted by the QAPI Committee. Beginning Q 1 2020, VP of Hospice Operations will present agency QAPI Committee summary and PIPs to the Governing Body for review and approval. On 12/9/2019: Governing Body appointed Administrator, Alternate Administrator, and QAPI Core group members for the Organizational charts will be reviewed and revised to accurately reflect reporting structure of Anderson branch location in Kokomo with completion on 1/30/2020. Training was initially completed on 12/17/19 and 12/19/19 with additional training on 1/28/20 and 1/30/20. Training will be complete on 2/3/2020 Effective 12/6/2019, St. Vincent Hospice-Anderson, LLC entered into an agreement with Ascension Health at Home, LLC to include: coding,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	151516	A. BUILDING 00 B. WING	12/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ASCENSION AT HOME	2015 JACKSON ST ANDERSON, IN 46016

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			QA auditing, and education. Hospice Director with assistance from administrative assistant will audit 100% of employee human resource files for evidence of documentation of orientation. Incomplete orientation records will be updated to ensure accurate record of training and education to job with completion on 2/3/2020. Regional Director of Hospice and Hospice Director reviewed policy 6.010 Orientation and collaborated and revised the agency process for ensuring every employee receives a complete orientation and onboarding upon hire. Regional Director of Hospice and Hospice Director reviewed the agency Director job specific responsibilities and provided training on QAPI, budgeting, overseeing hospice multiple locations, emergency preparedness. **Evidence of compliance Effective immediately, Hospice Director or the Regional Director of Operations will review any new contract's content to ensure the hospice agency legal name is accurately documented prior to obtaining signature. VP of**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	151516	A. BUILDING 00 B. WING	12/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ASCENSION AT HOME	2015 JACKSON ST ANDERSON, IN 46016

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			Hospice Operations, appointee to Governing Body, will attend and audit the agency QAPI Committee Meeting on 2/4/2020 Agency QAPI Meeting Minutes (Quality Indicators), PIPS and Quarterly Director Summary documentation reviewed by the VP of Hospice Operations, in collaboration with Hospice Director and Regional Director of Hospice for accuracy. Review included recommendations for additional PIPs and/or data collection to ensure a thorough evaluation of patient care and safety was conducted by the QAPI Committee the QAPI Meeting Minutes (Quality Indicators), PIPS and Quarterly Director Summary documentation will be reviewed by the VP of Hospice Operations, appointed member of the Governing Body, in collaboration with Hospice Director and Regional Director of Hospice. Review recommendations for additional PIPs and/or data collection to ensure a thorough evaluation of patient care and safety was conducted by the QAPI Committee Beginning Q 1 2020, VP of Hospice Operations will present QAPI Committee summary and PIPs to the Governing Body for review and approval Regional Director of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	151516	A. BUILDING 00 B. WING	12/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ASCENSION AT HOME	2015 JACKSON ST ANDERSON, IN 46016

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			Hospice, as appointee of governing body, will conduct a quarterly review of agency organizational charts with the Hospice Director to ensure timely revisions occur to maintain accuracy. Beginning 2/03/2020, 100% of all new employee files will be audited after completion of orientation for 3 months to validate that the orientation addressed the employee's specific job duties. If 100% compliance is not achieved in 3 months, audits will continue until compliance is achieved for 3 consecutive months. Once 100% compliance is achieved for 3 consecutive months, quarterly audits of 25% of all new employee files will be audited to monitor continued compliance	
L 0649 Bldg. 00	418.100 ORGANIZATION AND ADMINISTRATION OF SERVICES The hospice must organize, manage, and administer its resources to provide the hospice care and services to patients, caregivers and families necessary for the palliation and management of the terminal illness and related conditions. Based on record review and interview, the hospice failed to ensure all contracts in place reflected the hospice's legal name and not the corporation for 4 of 4 contracts reviewed, all staff orientation, coding, human resources (HR) and quality	L 0649	**Corrective Action Hospice Director, in collaboration with a representative of the Governing Body, will complete a 100% audit of the agency**	01/16/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	151516	A. BUILDING 00 B. WING	12/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ASCENSION AT HOME	2015 JACKSON ST ANDERSON, IN 46016

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	assurance performance improvement (QAPI) was not delegated to another entity and contracts were in place if outside sources were utilized to assist in the hospice, and employee files were managed by the hospice for 1 of 1 agency. Findings include: An agency contract was reviewed on 12/12/19 with the durable medical equipment (DME) company and stated "This vendor agreement is entered into by and between [entity A] and [entity B]...." (Neither of which were Ascension at Home). An agency contract was reviewed on 12/12/19 with the pharmacy and stated "This pharmacy services agreement (the"Agreement") is entered into as of December 1, 2015 ("Effective date") by and between [entity D] ... and [entity C] ...." (Neither of which were Ascension at Home). An agency contract was reviewed on 12/12/19 with the supply company which was between [entity E] and [Entity F] (Neither of which were Ascension at Home). An agency contract was reviewed on 12/12/19 between the home care and hospice agencies in order to share staff. The agreement was between entity G and entity H (Neither of which were Ascension at Home). During an interview on 12/2/19 at 1:55 PM, the administrator stated the employee files are kept in Indianapolis in human resources. She said she had a few items at the hospice, but they are managed by HR. During an interview on 12/3/19 at 3:30 PM, employee C stated she did quality assurance for		**contracts to ensure vendor contracts for DME, pharmacy, medical supplies and accurately reflected the hospice agency's legal name. Audit was completed on 01/16/2020.** **Vendor contracts for DME, pharmacy and medical supplies will be revised to accurately reflect the Ascension Health at Home name as well as covered entities.** p="" paraid="1767783345" paraeid="{016b762d-28b6-4624-a840-051516ebb384}{60}">> Evidence of compliance Effective immediately, Hospice Director or the Regional Director of Operations will review any new contract's content to ensure the hospice agency legal name is accurately documented prior to obtaining signature.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	151516	A. BUILDING 00 B. WING	12/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ASCENSION AT HOME	2015 JACKSON ST ANDERSON, IN 46016

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Indiana, and was a national employee not employed by the hospice. During an interview on 12/3/19 at 4:17 PM, the administrator stated that all QAPI staff, the educator, coders, and HR are all national employees and not on the hospice's employee list. The administrator was asked who the employees were that signed the bottom of the comprehensive assessments and plan of care. She stated the coders and quality assurance team review and sign the documents and are all corporate employees. She also stated she did not know if a contract was in place. She stated that the educator and HR were located in Indianapolis. She stated that new hires go to Indianapolis for orientation, home health aides (HHA) are typically there for 1-2 days and skilled nurses usually 2-3 days. They complete a general orientation that contains HR documents, computer system, obtain equipment, and complete relias training. She stated there was no contract in place with Indianapolis. During an interview on 12/3/19 at 4:56 PM, employee D stated she was part of the national QAPI team and not employed by the hospice.			
L 0651 Bldg. 00	418.100(b) GOVERNING BODY AND ADMINISTRATOR A governing body (or designated persons so functioning) assumes full legal authority and responsibility for the management of the hospice, the provision of all hospice services, its fiscal operations, and continuous quality assessment and performance improvement. A qualified administrator appointed by and reporting to the governing body is responsible for the day-to-day operation of the hospice. The administrator must be a hospice			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	151516	A. BUILDING 00 B. WING	12/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ASCENSION AT HOME	2015 JACKSON ST ANDERSON, IN 46016

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	employee and possess education and experience required by the hospice's governing body. Based on record review and interview, the hospice failed to ensure the administrator reported to the governing body, the governing body assumed full responsibility for the management of the hospice, the governing body provided management and oversight of the hospice's quality assessment performance improvement (QAPI) program, and the governing body appointed the administrator and alternate administrator into their positions for 1 of 1 agency. Findings include: During review of a document on 12/2/19 at 12:48 PM titled "hospice service line organization chart," updated 11/19/19, it was noted the document was a corporate structure and did not contain any staff employed by the hospice. The organizational chart delineated the structure from top to bottom: "SVP" [sic] Home care services, Chief operating officer, vice president hospice operations which branched to the hospice regional director (for Indiana, Texas, Oklahoma, Alabama, Michigan, and Wisconsin) then agency directors. Also branched from the hospice regional director was the director of quality assurance, administrative assistant, quality assurance nurses, coders, and quality coordinators (all from different states), manager of education, and clinical education specialists (all from different states). The agency provided another organizational chart revised 12/2019 for the surveyed hospice on 12/2/19 at 3:50 PM titled "Anderson/ Kokomo, IN [Indiana] Hospice." The organizational chart	L 0651	**Corrective Action** Administrator for agency was appointed by the governing body on 12/9/19. **Governing Body, in collaboration with the Hospice Director, revised the Ascension at Home QAPI Program for Hospice. Revised QAPI program includes the identification of Quality Indicators for the improving palliative outcomes, requirement of Performance Improvement Projects (PIPs) for demonstrating improved performance, oversight of contracted services, QAPI Meeting documentation standards to ensure agency analyzes and tracks quality indicator data, QAPI Meeting schedule for quarterly meetings with timeline for Hospice Director to submit meeting minutes and PIPs summary to the Governing Body. QAPI Quality Indicators include required data collection determined to provide the Governing Body and Hospice Director with an overall evaluation of patient care and safety. Policy 3.018: Quality Assessment and Performance Improvement Program-Hospice Service Line**	01/28/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	151516	A. BUILDING 00 B. WING	12/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ASCENSION AT HOME	2015 JACKSON ST ANDERSON, IN 46016

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	delineated the structure from top to bottom: Vice President of hospice operations, regional director of operations (whom marketers and administrator answer to), and director of hospice (administrator) who all remaining staff report to. The organziation chart failed to indicate the Administrator reports to the Governing Body of this agency. Pre-survey information from the Indiana State Department of Health (ISDH) indicated the administrator effective date of position was 3/12/19. Governing body meeting minutes from 12/9/19 (during survey) employees Q, R, S, T, U, and V attended. The minutes reflected "... Appointment of new board members [employees Q, R, V] Approval of additional board members was unanimous ... appointment of hospice agency directors, medical directors, supervising nurses including alternates, as well as interdisciplinary core groups. A listing of these positions at each location was provided and reviewed. ... The 2020 quality assessment and performance improvement plan (QAPI) for hospice was presented and reviewed .... " Attached to the minutes of the meeting were the leadership and interdisciplinary group (IDG) members for all hospice agencies in Indiana, Alabama, Michigan, Oklahoma, Texas, and Wisconsin that were approved during the meeting. The Governing Body failed to ensure the appointment of the administrator was prior to the administrator starting in the position, failed to ensure the appointments of agency directors, supervising nurses/ alternates, and interdisciplinary core groups were completed prior to survey and prior to starting positions, and the Governing Body minutes failed to delineated from other agencies and states and failed to exclusive to this agency.		**(revised 1/17/2020) revised in collaboration with the Governing Body to accurately reflect the new QAPI program for Hospice Service Line.¿ ¿ ¿ Director received training on revised QAPI program from member of the governing body on 1/22/2020. The revised Hospice Quality Assessment Performance Improvement (QAPI) Program and Hospice Operations Policy Manual were approved by the governing body on 01/28/2020. The governing body also appointed the Regional Director of Operations, to whom the Administrator reports, to the governing body on 01/28/2020.** **Evaluation for compliance** VP of Hospice Operations, appointee to Governing Body, will attend and audit the agency QAPI Committee Meeting, including the Hospice Director performance as the QAPI chairperson. Agency QAPI Meeting Minutes (Quality Indicators), PIPS and Quarterly Director Summary documentation reviewed by the VP of Hospice Operations, in collaboration with Hospice Director and Regional Director of Hospice for accuracy. Review inclusive of recommendations for Performance Improvement Project revisions where indicated. Beginning Q 1 2020, VP of Hospice Operations will present	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	151516	A. BUILDING 00 B. WING	12/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ASCENSION AT HOME	2015 JACKSON ST ANDERSON, IN 46016

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	During an interview on 12/2/19 at 3:50 PM, the administrator stated she reported to employee H (regional director). During an interview on 12/3/19 at 3:30 PM, employee C stated she did quality assurance for Indiana, was a national employee not employed by the hospice. She asked what was needed about Governing body. Requested minutes, approvals for policies, appointments of staff, QAPI, or any information the governing body discussed, or approved. She stated she would look in her stuff and see what she had been sent. The administrator stated she knew the governing body had sent information previously. During an interview on 12/3/19 at 4:17 PM, the administrator stated that all QAPI staff, the educator, coders, and human resources are all national employees and not on the hospice's employee list. During an interview on 12/3/19 at 4:56 PM, employee D stated she was part of the national team, not employed by the hospice. During an interview on 12/11/19 at 12:54 PM, employee C was asked if the governing body approved the data that was collected. She stated "I'm guessing yes," that all information regarding QAPI is given to employee W (national director of QAPI) and she was not sure what happened after that. When asked if the governing body was involved in the development and ongoing evaluation of QAPI she stated she thought they had had the greater oversight, but everything would be ran through employee W. When asked who the QAPI team is she stated herself, employee D, administrator, medical director, and a		agency QAPI Committee summary and PIPs to the Governing Body for review and approval	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	151516	A. BUILDING 00 B. WING	12/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ASCENSION AT HOME	2015 JACKSON ST ANDERSON, IN 46016

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	member from spiritual care, social work, bereavement, and volunteer. During an interview on 12/11/19 at 1:20 PM the administrator was asked if she had been appointed into her position. She stated that she thought she was appointed locally by employees T and X , but could not find it. She also stated that the governing body just appointed all management staff at the meeting on 12/9/19			
L 0658 Bldg. 00	418.100(f)(1)(iii) HOSPICE MULTIPLE LOCATIONS (iii) The lines of authority, and professional and administrative control must be clearly delineated in the hospice's organizational structure and in practice, and must be traced to the location that issued the certification number. Based on record review and interview, the agency failed to delineate proper chain of command on the agency organizational chart to delineate administrative control of staff who worked daily in the hospice and over the multiple site location, and failed to ensure staff knew who the administrator was for 1 of 1 agency. Findings include: During review of a document on 12/2/19 at 12:48 PM titled "hospice service line organization chart," updated 11/19/19, it was noted the document was a corporate structure and did not contain any staff employed by the hospice. The organizational chart delineated the structure from top to bottom: "SVP" [sic] Home care services, Chief operating officer, vice president hospice operations which branched to the hospice regional director (for Indiana, Texas, Oklahoma,	L 0658	**Corrective Action:** On 12/9/2019: Governing Body appointed Administrator, Alternate Administrator, and QAPI Core group members for the Organizational charts will be reviewed and revised to accurately reflect reporting structure of Anderson branch location in Kokomo with completion on 1/30/2020. Training was initially completed on 12/17/19 and 12/19/19 with additional training on 1/28/20 and 1/30/20. Training will be complete on 2/3/2020 Effective 12/6/2019, St. Vincent Hospice-Anderson, LLC entered into an agreement with Ascension Health at Home, LLC to include: coding, QA auditing, and	02/03/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	151516	A. BUILDING 00 B. WING	12/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ASCENSION AT HOME	2015 JACKSON ST ANDERSON, IN 46016

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Alabama, Michigan, and Wisconsin) then agency directors. Also branched from the hospice regional director was the director of quality assurance, administrative assistant, quality assurance nurses, coders, and quality coordinators (all from different states), manager of education, and clinical education specialists (all from different states). The agency then provided another organizational chart revised 12/2019 for the surveyed hospice on 12/2/19 at 3:50 PM titled "Anderson/Kokomo, IN [Indiana] Hospice." The organizational chart delineated the structure from top to bottom: Vice President of hospice operations, regional director of operations (whom marketers and administrator answer to), and director of hospice (administrator) who all remaining staff report to. The organizational chart failed to identify the multiple site location and the employees who worked within it, and failed to include quality assurance performance improvement (QAPI), coders, and training staff. During an interview on 12/3/19 at 10:00 AM, employee P stated the administrator of the hospice was employee Q, employee M stated the administrator of the hospice was employee L, and employee F did not know who the administrator was. During an interview on 12/3/19 at 4:17 PM, the administrator stated that all QAPI staff, the educator, coders, and human resources are all national employees and not on the hospice's employee list.		education. **Evidence of compliance** Regional Director of Hospice, as appointee of governing body, will conduct a quarterly review of agency organizational charts with the Hospice Director to ensure timely revisions occur to maintain accuracy.	
L 0662 Bldg. 00	418.100(g)(2) TRAINING (2) A hospice must provide an initial			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	151516	A. BUILDING 00 B. WING	12/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ASCENSION AT HOME	2015 JACKSON ST ANDERSON, IN 46016

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	orientation for each employee that addresses the employee's specific job duties. Based on record review and interview, the hospice failed to provide an initial orientation for each employees specific job duties for 3 of 4 employee files reviewed (A, B, N). Findings include: 1. During review of employee files on 12/11/19, the list of current employees included employee A, administrator, date of hire 6/28/10. The employee file failed to evidence an orientation to the role of administrator. Pre-survey information from the Indiana State Department of Health (ISDH) indicated the administrator effective date in that position was 3/12/19. An orientation as staff registered nurse was signed completed on 9/25/10. A general orientation containing policy review and human resource items checklist was signed by the administrator on 10/5/18. 2. During review of employee files on 12/11/19, the list of current employees included employee B, family care coordinator, date of hire 10/22/18. The employee file failed to evidence an orientation to her job duties. A hospice orientation was partially completed and under section "discipline specific checklist," it stated "incomplete." The orientation form failed to be signed by employee B or the human resources representative.	L 0662	Corrective Action Hospice Director with assistance from administrative assistant will audit 100% of employee human resource files for evidence of documentation of orientation. Incomplete orientation records will be updated to ensure accurate record of training and education to job. Director of Hospice and Hospice Director reviewed policy 6.010 Regional Orientation and collaborated and revised the agency process for ensuring every employee receives a complete orientation and onboarding upon hire. Regional Director of Hospice and Hospice Director reviewed the agency Director job specific responsibilities and provided training on QAPI, budgeting, overseeing hospice multiple locations, emergency preparedness. **Corrective Action** **Evaluation for compliance** Beginning 2/03/2020, 100% of all new employee files will be audited after completion of orientation for 3 months to validate that the orientation addressed the employee's specific job duties. If 100% compliance is not achieved in 3 months, audits will continue until compliance is achieved for 3 consecutive months.	02/03/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	151516	A. BUILDING 00 B. WING	12/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ASCENSION AT HOME	2015 JACKSON ST ANDERSON, IN 46016

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	3. During review of employee files on 12/11/19, the list of current employees included employee N, registered nurse, date of hire 10/15/18. The employee file failed to evidence an orientation to her job duties. A general orientation containing policy review and human resource items checklist was signed by employee N on 10/22/18. 4. During an interview on 12/11/19 at 4:27 PM, the administrator stated she never had an orientation to her role as administrator.		Once 100% compliance is achieved for 3 consecutive months, quarterly audits of 25% of all new employee files will be audited to monitor continued compliance.	
L 0666 Bldg. 00	418.102(a) MEDICAL DIRECTOR CONTRACT (1) A hospice may contract with either of the following- (i) A self-employed physician; or (ii) A physician employed by a professional entity or physicians group. When contracting for medical director services, the contract must specify the physician who assumes the medical director responsibilities and obligations. Based on record review and interview, the hospice failed to ensure one physician was contracted as the hospice medical director to assume responsibility for the medical component of the hospice, that the medical director and physician designee contracts specified the physician designee to act as the medical director in the event of the medical directors absence, and that all physician contracts reflected the legal name of the hospice for 3 of 3 physician contracts reviewed (E, F, G). Findings include:	L 0666	**Corrective Action** Hospice Director educated Medical Director and Hospice Physician on job description and delineation of job responsibilities using the NHPCO Physician compliance training guide, completed on 1/30/2020. The Hospice Director will collaborate with contracting services and legal department to revise Medical Director and hospice physician employment contracts to include delineation of job responsibilities of each	02/03/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	151516	A. BUILDING 00 B. WING	12/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ASCENSION AT HOME	2015 JACKSON ST ANDERSON, IN 46016

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	The agency medical director contract was reviewed on 12/12/19 and stated "this medical director agreement for hospice services ("Agreement") is entered into by and between [entity I] and employee E ... 3.1 On an as needed basis ... physician shall provide medical direction and supervision and serve as the medical director of [entity J] [previous name of multiple site location] ... 7.1 The term of this agreement shall commence on 6/6/12, 2012. This agreement shall continue in effect until terminated upon thirty (30) days written notice by either [entity I] or physician, or as otherwise terminated as provided hereinafter ... The hospice medical director is responsible for the overall medical direction of the hospice program ...." The contract failed to be updated with the legal name of the hospice, reflect medical director of the hospice as a whole and not just the multiple site, and designate the physician who would act as medical director in the even of the medical director's absence. The agency hospice physician agreement was reviewed on 12/12/19 and stated "This agreement is effective as of the 15 th day of August, 2018, by and between [entity K], an Indiana limited liability company, hereinafter referred to as [entity L] and [employee F] ... Schedule 2.01A Designated Medical director [employee F] ... Responsibilities ...Direct and assume responsibility for the medical component of the program, oversee the palliation and management of the terminal illness and conditions related to the terminal illness of program patients and ensure that the medical needs of program patients are being met ...." The contract failed to be updated with the legal name of the hospice, failed to ensure the duties were not that of the medical director, and failed to identify this physician as the physician designee to act as medical director if the medical director		position, including organizational reporting structure. Medical Director and hospice physician will sign revised and compliant employment contract no later than 02/03/2020. **Evaluation for compliance** Beginning 2/03/2020, Hospice Director and Regional Director of Hospice will audit 100% of all medical director and hospice physician files to validate presence of signed employment agreement which includes description of duties and reporting structure. Audits will continue until 100% compliance. Hospice Director will meet at least monthly with Medical Director to review agency clinical outcomes, physician service needs, physician scheduling and staff education needs.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	151516	A. BUILDING 00 B. WING	12/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ASCENSION AT HOME	2015 JACKSON ST ANDERSON, IN 46016

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	was unavailable. The agency hospice physician agreement was reviewed on 12/12/19 and stated "This agreement is effective as of the 24 th day of July, 2018, by and between [entity K], an Indiana limited liability company, hereinafter referred to as [entity L] and [employee G] ...Schedule 2.01A designated medical director [employee G] ... Responsibilities ... Direct and assume responsibility for the medical component of the program, oversee the palliation and management of the terminal illness and conditions related to the terminal illness of program patients and ensure that the medical needs of program patients are being met ...." The contract failed to be updated with the legal name of the hospice and failed to ensure the duties were not that of the medical director. During an interview on 12/11/19 at 3:55 PM, the administrator stated the contracts she had for the physicians were all old and she reached out to employee Y to see if they had an updated version. She stated employee Y was the person from corporate designated to review and scan contracts. During an interview on 12/12/19 at 10:45 AM, the administrator stated that employee E's contract was never updated.			
L 0668 Bldg. 00	418.102(c) RECERTIFICATION OF THE TERMINAL ILLNESS Before the recertification period for each patient, as described in §418.21(a), the medical director or physician designee must review the patient's clinical information. Based on record review and interview, the hopice	L 0668	**Corrective Action** Hospice Director, Clinical Manager	02/03/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	151516	A. BUILDING 00 B. WING	12/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ASCENSION AT HOME	2015 JACKSON ST ANDERSON, IN 46016

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	failed to follow their policy to ensure that a verbal recertification of terminal illness (RTI) was obtained within 2 calendar days of the new benefit period for 1 of 4 recertification records reviewed (#11). Findings include: An agency policy dated 4/01/18 and titled "Recertification of terminal illness,"Policy# 2.004 stated "... If the hospice medical director or hospice physician does not sign and date the recertification of terminal illness form within two days of the start of the new benefit period (by the end of the third day), a verbal recertification is obtained from the hospice physician which may be obtained up to 15 days prior to the start of the new benefit or within two daysof the start of the new benefit period and is documented in the patient's clinical record ...." The clinical record of patient #11 was reviewed on 12/10/19 at 1:16 PM and indicated an Election date of 2/13/19. The record contained a plan of care for the benefit period of 10/11/19-12/9/19. The agency document titled "Physician face to face encounter/ recertification of terminal illness 60-day periods," for the benefit period 10/11/19-12/9/19 stated the nurse practitioner completed the face to face on patient #11 on 9/17/19. The document was signed by the medical director on 11/2/19 (22 days after the start of the benefit period). The record failed to evidence a verbal recertification of terminal illness. During an interview on 12/12/19 at 2:00 PM, the administrator stated she could not find a verbal RTI (recertification of terminal illness) for patient #11.		and Medical Director to review the IDG process for obtaining timely written recertifications, including the regulations for obtaining a verbal certification if needed. Education to include process guide HO IDG Process. Training was initially completed on 12/17/19 and 12/19/19 with additional training on 1/28/20 and 1/30/20. Training will be complete on 2/3/2020 **Evaluation for compliance** Beginning 2/03/2020, Hospice Director and Clinical Manager will audit 100% of recertifications for 6 weeks to validate that the medical director or physician designee have reviewed the patient's clinical information and a verbal recertification was obtained within the timeframe of 15 days prior or 2 day before the start of the new benefit period. If 100% compliance is not achieved in 8 weeks, audits will continue until compliance is achieved for 6 consecutive weeks. Once 100% compliance is achieved for 8 consecutive weeks, 25% of recertifications will be audited quarterly to monitor continued compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	151516	A. BUILDING 00 B. WING	12/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ASCENSION AT HOME	2015 JACKSON ST ANDERSON, IN 46016

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
L 0687 Bldg. 00	418.106 DRUGS BIOLOGICALS MEDICAL SUPPLIES & DME Medical supplies and appliances, as described in §410.36 of this chapter; durable medical equipment, as described in §410.38 of this chapter; and drugs and biologicals related to the palliation and management of the terminal illness and related conditions, as identified in the hospice plan of care, must be provided by the hospice while the patient is under hospice care. Based on record review and interview, the hospice failed to ensure drugs and medical supplies related to the terminal illness was covered under the hospice benefit for 3 of 13 records reviewed (#3, 9, 12). Findings include: 1. The clinical record of patient #3 was reviewed on 12/3/19 at 11:51 AM and indicated an Election date of 11/26/19. The record contained a plan of care for the benefit period of 11/26/19-2/23/20 which indicated a primary hospice diagnosis of chronic obstructive pulmonary disease (COPD). An agency document titled "hospice medication profile," listed spiriva handihaler and symbicort inhalation (both respiratory inhalers). The document failed to evidence that the spiriva and symbicort were covered under the hospice benefit as they were related to the hospice diagnosis. During an interview on 12/12/19 between 11:30 AM-1:35 PM, the administrator stated the spiriva and symbicort should be marked as covered. 2. The clinical record of patient #9 was reviewed on 12/3/19 at 12:30 PM and indicated an Election	L 0687	**Corrective Action** Registered Nurses will be educated on compliant documentation of hospice covered DME, medications, supplies and biologicals on the plan of care to ensure services are identified as being covered by the hospice benefit. Education will include: review policy 6.007 Scope of Services, policy 7.002 Plan of Care, 8.002 Medication Profile and hospice process guide HO Nursing Minimum Documentation Requirements. Training was initially completed on 12/17/19 and 12/19/19 with additional training completed on 1/28/20 and 1/30/20 Under the direction of the Clinical Manager, Registered Nurses will audit and revise 100% of current patient plan of care to ensure that DME, supplies, medications and biologicals are accurately identified as being covered by the hospice.	01/30/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	151516	A. BUILDING 00 B. WING	12/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ASCENSION AT HOME	2015 JACKSON ST ANDERSON, IN 46016

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	date of 1/14/19. The record contained a plan of care for the benefit period of 1/14/19-4/13/19 which indicated a primary hospice diagnosis of brain cancer. An agency document titled "hospice medication profile," listed zofran as a medication (for nausea/vomiting). The document failed to evidence that the zofran was covered under the hospice benefit as it was related to the hospice diagnosis. During an interview on 12/12/19 between 11:30 AM-1:35 PM, the administrator stated "Zofran should be covered." 3. The clinical record of patient #12 was reviewed on 12/10/19 at 4:01 PM and indicated an Election date of 9/10/19. The record contained a plan of care for the benefit period of 9/1/19-12/8/19 which indicated orders for the skilled nurse to complete catheter changes every month and as needed with a 16 french/ 10 milliliter balloon. The hospice initial order dated 9/10/19 failed to evidence any supplies the hospice would be covering for patient #12. 4. During an interview on 12/12/19 between 11:30 AM-1:35 PM, the administrator stated patient #12 had a catheter upon admission but it was discontinued at some point, but while in the catheter supplies should have been listed on the plan of care and would be covered.		**Evaluation for compliance** Beginning 2/3/2020, 100% of admissions will be audited for 8 weeks to validate that medications and supplies related to hospice diagnosis are covered. If 100% compliance is not achieved in 8 weeks, audits will continue until compliance is achieved for 8 consecutive weeks. Once 100% compliance is achieved for 8 consecutive weeks, 25% of admissions will be audited quarterly to monitor continued compliance. br>	
L 0781 Bldg. 00	418.112(e)(3) COORDINATION OF SERVICES The hospice must:] (3) Provide the SNF/NF or ICF/MR with the following information: (i) The most recent hospice plan of care specific to each patient; (ii) Hospice election form and any advance			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	151516	A. BUILDING 00 B. WING	12/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ASCENSION AT HOME	2015 JACKSON ST ANDERSON, IN 46016

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	directives specific to each patient; (iii) Physician certification and recertification of the terminal illness specific to each patient; (iv) Names and contact information for hospice personnel involved in hospice care of each patient; (v) Instructions on how to access the hospice's 24-hour on-call system; (vi) Hospice medication information specific to each patient; and (vii) Hospice physician and attending physician (if any) orders specific to each patient. Based on record review and interview, the hospice failed to ensure skilled nursing facility (SNF) binders contained the most recent hospice plan of care and medication list for 1 of 2 SNF binders observed (#4). Findings include: The clinical record of patient #4 was reviewed on 12/3/19 at 1:57 PM and indicated an Election date of 4/29/19. The record contained a plan of care for the benefit period of 10/26/19-12/24/19. Interdisciplinary group (IDG) meetings were held on 10/31/19, 11/14/19, 11/21/19, and 12/5/19 in which careplan updates were completed. The SNF binder contained the last plan of care dated 11/1/19. The binder failed to evidence the care plan from the 11/21/19 IDG meeting. During an interview on 12/11/19 at 11:17 AM, the administrator stated the hospice binders in the facilities are updated every 2 weeks and contain the most recent careplan, medication list and the recent notes for the disciplines.	L 0781	**Corrective action** Under the direction of the Hospice Director and Clinical Manager, Registered Nurses will audit and update as needed 100% of LTC patient forms binders to ensure that each contains the following: (i) The most recent hospice plan of care specific to each patient; (ii) Hospice election form and any advance directives specific to each patient; (iii) Physician certification and recertification of the terminal illness specific to each patient; (iv) Names and contact information for hospice personnel involved in hospice care of each patient; (v) Instructions on how to access the hospice's 24-hour on-call system; (vi) Hospice medication information specific to each patient; an (vii) Hospice physician and attending physician. LTC patient forms will be updated following IDG meetings and at least every 14 days or more	02/03/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	151516	A. BUILDING 00 B. WING	12/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ASCENSION AT HOME	2015 JACKSON ST ANDERSON, IN 46016

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			frequent when needed to ensure the most current documentation has been provided to the LTC facility. **Evaluation for compliance** Effective 2/3/2020, LTC facility forms binders will be audited by the RN case manager or designated hospice staff monthly to ensure the most current documentation has been provided to the LTC facility. Hospice Director or Clinical Manager will conduct random audits of at least 25% of LTC facility binders each quarter to ensure compliance with documentation requirements.	