STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 151516		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 12/12/2019		
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP COD 2015 JACKSON ST ANDERSON, IN 46016				
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	(X5) COMPLETION
TAG E 0000	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
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		E 00	000			
L 0000	CFR418.113.						
Bldg. 00	Recertification survey Survey Dates: Dec Facility Number: 0 Provider Number: 1	ember 2, 3, 4, 5, 6, 11, 12; 2019 005829 151516 ssions past 12 months: 471 nts: 32	L 00	000			
LABORATOR	Y DIRECTOR'S OR PRO	VIDER/SUPPLIER REPRESENTATIVE'S S	IGNATURI	'	TITLE		(X6) DATE

(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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 51N911 Facility ID: 005829 If continuation sheet Page 1 of 61

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE ((X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED
		151516	B. WING		12/12/2019
	ROVIDER OR SUPPLIER		2015	T ADDRESS, CITY, STATE, ZIP COD JACKSON ST PRSON, IN 46016	
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE	ID	BROWNERS N. IV OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	Records with home Records without home Bereavment records	me visits: 10			
	was found to be out Conditions of Partic 418.100 Organization	Ascension at Home (Hospice) of compliance with the cipation 42 CFR Sub Part D on/ Administration of Services.			
L 0521 Bldg. 00	writing a patient-spassessment that ic for hospice care a patient's need for emotional, and spassessment include care related to the	F PATIENT conduct and document in becific comprehensive dentifies the patient's need and services, and the physical, psychosocial, iritual care. This des all areas of hospice palliation and e terminal illness and			
	Based on record revenue the compreheall the patient's physrecords reviewed (#Findings include: An agency policy de "Comprehensive asse	riew, the hospice failed to ensive assessment reflected sical needs for 1 of 8 active	L 0521	Corrective Action Agency Registered Nurses we 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 1/28/20 and 1/30/20. All agence	al & of control of the control of th

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

Event ID:

51N911

Facility ID: 005829

If continuation sheet Page 2 of 61

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	LETED
		151516	B. WI	NG		12/12	/2019
NA 55 05 5	ADOLUBED OF STATE			STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	<u>t</u>			ACKSON ST		
ASCENS	ION AT HOME			ANDER	SON, IN 46016		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LISC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		aprehensive assessment			Registered Nurses education	will	
	-	the patient's physical,			include a review of policies:		
	emotional, psychosocial, spiritual and				Policy 3.003 Comprehensive		
	bereavement needs are assessed"				Assessment-Initial, policy 3.0		
	1 1 4 14/1/10 1 1/1 1				Comprehensive Assessment	: 01	
	An agency policy dated 4/1/18 and titled				the Patient, policy 3.005		
	"Comprehensive assessment content," Policy # 3.005 stated " Policy: The comprehensive				Comprehensive Assessment		
					Content and hospice process		
		es the physical, psychosocial, tual needs of the patient			guide HO Nursing Admission	1	
	^	•			Minimum Documentation		
	related to the terminal illness that must be				Requirements.		
	addressed in order to promote the well-being,				Evaluation for compliance Beginning 2/3/2020, agency		
	comfort, and dignity throughout the dying process"				Director and/or Clinical Manag	ıor	
	process				will audit 100% of admissions	•	
	The clinical record	of patient #5 was reviewed on			weeks to validate a	101 0	
		and indicated an Election date			patient-specific comprehensive	0	
		ecord contained a plan of care			assessment. If 100% complia		
		od of 11/15/19-2/12/20, which			is not achieved in 6 weeks, au		
	-	t had a left ventricular assist			will continue until 100%	uito	
	-	l a primary hospice diagnosis			compliance is achieved for 6		
	of ischemic cardion				consecutive weeks.		
	or isenemic caraton	lyopuny.			Once 100% compliance is		
	The agency initial/	comprehensive nursing			achieved for 6 consecutive we	oke	
		red on 11/15/19 stated the			25% of admissions will be aud		
	-	pressure of 98/83. The			quarterly to monitor continued		
	-	em stated the family was to			compliance that nursing needs		
		driveline dressing every other			the patient are met.	3 01	
		ailed to assess the LVAD site			and patient and mot.		
	-	mentation), and failed to					
	*	site care order was. In the					
		is it stated the patient had					
		identify the location and					
	degree of edema).	y 					
	The administrator w	vas notified of this concern on					
		M, and had nothing additional					
	to submit for review						

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 51N911 Facility ID: 005829 If continuation sheet Page 3 of 61

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 151516	A. BU	A. BUILDING <u>00</u> CO.		(X3) DATE COMPL 12/12	LETED
	PROVIDER OR SUPPLIER	2		STREET ADDRESS, CITY, STATE, ZIP COD 2015 JACKSON ST ANDERSON, IN 46016			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI. DEFICIENCY)	ATE	(X5) COMPLETION DATE
L 0523 Bldg. 00	418.54(b) TIMEFRAME FOR ASSESSMENT The hospice interconsultation with a physician (if any), comprehensive as calendar days after care in accordance. Based on record regarded to ensure a spread of the ensure as producted as part of assessment within a shopice care for 1 of (#3) Findings include: An agency policy of "Comprehensive as 3.003 stated" Base findings from the intercomprehensive assed as a soft as a series of the clinical record 12/3/19 at 11:51 All date of 11/26/19. To care for the benefit the hospice document comprehensive nurse completed on 11/26 spiritual assessment.	disciplinary group, in the individual's attending must complete the seessment no later than 5 for the election of hospice with §418.24. Wiew and interview, the hospice oritical assessment was f the comprehensive of days after the election of of 8 active records reviewed attended 4/1/18 and titled seessment - initial," Policy # seed on the patient's needs and initial assessment, the hospice see coordinates and designates st participate in the essment of the patient within 5 election of hospice care" of patient #3 was reviewed on M and indicated an Election The record contained a plan of period of 11/26/19-2/23/20. The record contained a plan of period of 11/26/19-2/23/20. The record contained a plan of period of 11/26/19-2/23/20. The record contained a plan of period of 11/26/19-2/23/20. The record contained a plan of period of 11/26/19-2/23/20. The record contained a plan of period of 11/26/19-2/23/20. The record contained a plan of period of 11/26/19-2/23/20. The record contained a plan of period of 11/26/19-2/23/20. The record contained a plan of period of 11/26/19-2/23/20. The record contained a plan of period of 11/26/19-2/23/20. The record contained a plan of period of 11/26/19-2/23/20. The record contained a plan of period of 11/26/19-2/23/20. The record contained a plan of period of 11/26/19-2/23/20. The record contained a plan of period of 11/26/19-2/23/20. The record contained a plan of period of 11/26/19-2/23/20. The record contained a plan of period of 11/26/19-2/23/20. The record contained a plan of period of 11/26/19-2/23/20. The record contained a plan of period of 11/26/19-2/23/20. The record contained a plan of period of 11/26/19-2/23/20.	L 05		Corrective Actions Agency Registered Nurses were receive education on maintain the Medication profile and performing ongoing reconcilia including a review of policy 8. Medication Profile. Training winitially completed on 12/17/1 and 12/19/19 with follow up training completed on 1/28/20/1/30/20. Agency RNs will obtain a coof all facility patient's MARs and compare and reconcile MAR to the hospice Medicate 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-4c443b07423e5e}{67}"> Evaluation for compliance Beginning 2/3/2020, Hospice Director and Clinical Manager will audit the Comprehensive Assessment 100% of admissions for 6 were	ning ation 002 was 9 0 and oppy the tion 6e-bff	01/30/2020

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 151516		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 12/12/2019		
	PROVIDER OR SUPPLIER	:	•	2015 JA	ADDRESS, CITY, STATE, ZIP COD ACKSON ST SON, IN 46016	_	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL	\prod	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	(X5) COMPLETION
L 0530 Bldg. 00	During an interview administrator stated should be completed the hospice benefit is refuses. During an interview PM-1:30 PM the addreviewing records who contact patients is can be completed who contacting the patient administrator stated anythinghe just who doesn't want to how could do is draft a learn the letter." 418.54(c)(6) CONTENT OF CONTENT (The comprehensing into consideration (6) Drug profile. A prescription and on herbal remedies a treatments that content includes, but identification of the content of the	I "I don't know if we do teeps leaving messageshe and themthe other thing he etter and put his business card DMPREHENSIVE ive assessment must take the following factors:] A review of all of the patient's ever-the-counter drugs, and other alternative build affect drug therapy. is not limited to, e following: of drug therapy cts antial drug interactions g therapy currently associated with	L 05	TAG 530	to ensure physical, spiritual an psychosocial needs are identificand documented by the Interdisciplinary team. If 100% compliance is not achieved in weeks, audits will continue unt 100% compliance is achieved consecutive weeks. Once 100% compliance achieved for 6 consecutive we 25% of admissions will be aud each quarter to monitor continue compliance.	ied 66 il for 6 is eks, ited ued	DATE 01/30/2020
	failed to ensure a re	eview and interview, the hospice eview of the patient's empleted and accurately			receive education on maintaini the Medication profile and		

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

Event ID:

51N911

Facility ID: 005829

If continuation sheet Page 5 of 61

	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED
		151516	B. WING		12/12/2019
NAME OF I	DROWNED OF CLIDITIES		STREET	ADDRESS, CITY, STATE, ZIP COD	•
NAME OF F	PROVIDER OR SUPPLIER		2015 J	IACKSON ST	
ASCENS	ION AT HOME		ANDE	RSON, IN 46016	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG		LISC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
		13 records reviewed (#2, 4, 6,		performing ongoing reconcilia	
	10).			including a review of policy 8.	
	Findings include:			Medication Profile. Training v	
				initially completed on 12/17/19	
	1 An agency police	y dated 4/1/18 and titled		and 12/19/19 with follow up	and
		y dated 4/1/18 and titled ," Policy # 8.002 stated " The		training completed on 1/28/20 1/30/20	anu
		profile review includes, but is		Agency RNs will obtain a co	nv.
	*	ermining accuracy and		of all facility patient's MARs	לא
	completeness of the	2		and compare and reconcile	·ho
	compreteness of the	prome		MAR to the hospice Medicat	
	2. The clinical reco	ord of patient #4 was reviewed		Profile prior to each IDG	
		PM and indicated an Election		meeting.	
		e record contained a plan of		Agency RNs will audit and	
		period of 10/26/19-12/24/19.		revise all active patient	
	I	ition profile stated the patient's		Medication Profiles and	
	medications were as	s followed: Acetaminophen		medication orders to ensure	
	oral 500 milligrams	(mg) 1 tablet every 6 hours as		accuracy.	
	needed (PRN) pain	or fever, and butt paste topical		p="" paraid="512391526"	
	application four tim	es per day.		paraeid="{ab8c8336-99da-4c6	Se-bff
				4-d43b07423e5e}{67}">	
		patient #4 resided (entity N)			
	1 ^	dication orders which included		Evaluation for compliance	
		owed: acetaminophen 160		Beginning 2/3/2020 the Hospi	I
		give 20 ml oral every 4 hours		Director or Clinical Manager v	
		pear butt cream small amount		perform on-site supervisory vi	I
		and groin area three times a		with each agency RN to ensu	
		otocol when no bowel		medication reconciliations are	
		ours which included natural		completed per agency Policy	
		ctive milk of magnesia, and if		8.002 Medication Profile.	
		ve dulcolax supossitory. The		Beginning 2/03/2020, Hospie	
		sure their medication profile		Director or Clinical Manager	
	and entity N were c eachother.	onsistent and mirror		will audit 100% Medication	4
	eachomer.			Profiles on all newly admitte	u
	During an interview	y on 12/11/10 at 1:17 AM the		patients to ensure that all	
	During an interview on 12/11/19 at 1:17 AM, the administrator stated the hospice and facility			physician orders are	
		ould mirror eachother.		transcribed accurately.	
	incurcation lists slic	and millor cachouler.		Once 100% compliance is achieved for 6 consecutive	
	3 The clinical reco	ord of patient #10 was reviewed		weeks. Medication Profile	
	. J. The chillen ickl			. weens, weuldaudii FidiiiA	1

AND PLAN OF CORRECTION DENTIFICATION NUMBER 151516 B. WING STREET ADDRESS, CITY, STATE, ZIP COD 2015 JACKSON ST ASCENSION AT HOME (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION 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		NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
NAME OF PROVIDER OR SUPPLIER ASCENSION AT HOME (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (DESCRIPTION OF DESCRIPTION OF	AND PLAN	OF CORRECTION				00		
ASCENSION AT HOME (X4) ID SUMMARY STATEMENT OF DEFICIENCIE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION on 12/3/19 at 2:15 PM and indicated an Election date of 6/21/19. The record contained a plan of 2015 JACKSON ST ANDERSON, IN 46016 (X5) PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) audits will decrease to 25% of all newly admitted patients.			151516	B. W	ING		12/12/	/2019
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION TAG (EACH DEFICIENCY) REGULATORY OR LSC IDENTIFYING INFORMATION TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE audits will decrease to 25% of all newly admitted patients.			ξ	2015 JACKSON ST				
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION TAG (EACH DEFICIENCY) REGULATORY OR LSC IDENTIFYING INFORMATION TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE audits will decrease to 25% of all newly admitted patients.	(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DDOUIDEDIG TV . V OT CORDE		(X5)
on 12/3/19 at 2:15 PM and indicated an Election date of 6/21/19. The record contained a plan of audits will decrease to 25% of all newly admitted patients.					PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	TE	
date of 6/21/19. The record contained a plan of all newly admitted patients.	TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	DATE
care for the benefit period of 6/21/19-9/18/19. The p="" paraid="798154408"		date of 6/21/19. Th	ne record contained a plan of			all newly admitted patients.	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				1	2 1 66	
							de-bff	
						4-043b07423e5e}{112} >		
		infection and Lamisil external 1% rub thin layer to						
affected areatwice daily for redness and irritation			-					
until healed. The record failed to evidence what		until healed. The re	cord failed to evidence what					
type of infection the Keflex was treating and what			_					
area of the body the lamisil was treating.		area of the body the	e lamisil was treating.					
During an interview on 12/11/19 at 11:22 AM, the		<u> </u>						
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		was maintained wit	h the correct regimen as					
evidenced by:		evidenced by:						
An agency document titled, "Hospice Initial		An agency docume	nt 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).		(shortness of breath	1).					
An agency document titled, "Hospice Face - to -		An agency docume	nt titled "Hospice Face - to -					
Face Documentation" dated 11/12/19 signed by			-					
Employee Z, stated, " She (patient #2) uses			0 2					
blowing respirations between every few words								
and wears O 2 (oxygen) continuously at 4 L (liters)			-					
		"						
Annual to moderate Production			and the first of the Eq. (
An agency document titled, "Physician Face to Face Encounter / Recertification of Terminal		1 0						
Illness", dated 11/21/19 and signed by Employee								

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

Event ID:

51N911

Facility ID: 005829

If continuation sheet Page 7 of 61

AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BILLIDING MANUAL MA	STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA				(X3) DATE	
ASCENSION AT HOME (X4) ID SUMMARY STATEMENT OF DEPICIENCE: PREFIX (EACH DEPICIENCY MUST BE PRECEDED BY FULL TAG EXECUTIONS (ACK SON ST AND ERSON, IN 46016) (X5) PREFIX (EACH DEPICIENCY MUST BE PRECEDED BY FULL TAG EXECUTIONS (ACK SON ST AND ERSON, IN 46016) F, MT Satied, " She (patient #2) uses blowing respirations between every few words and wears O 2 (oxygen) continuously at 4 L (liters)" An agency document (tited, "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 12/21/9 signed by Employee J, RN (Registered Nurse) stated, " Respiratory O 2 at 3.5 I (liters)" An agency document titled, "Hospice Nursing Clinical Note", dated 12/21/9 signed by Employee J, RN stated, " Respiratory O 2 at 3.5 I (liters)" During a home visit on 12/41/9 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 (pm). The hospice failed to update the Medication Profile to reflect the current toxygen rate and the RN failed to verify the correct oxygen rate and the RN failed to verify the correct oxygen rate and the RN failed to reflect the current toxygen rate and the RN failed to reflect the current toxygen rate and the RN failed to verify the correct oxygen rate and the RN failed to verify the correct oxygen rate and the RN failed to verify the correct oxygen rate and the RN failed to verify the correct oxygen rate and the RN failed to verify the correct oxygen rate and the RN failed to verify the correct oxygen rate and the RN failed to verify the correct oxygen rate and the RN failed to verify the correct oxygen rate and the RN failed to verify the correct oxygen rate and the RN failed to verify the correct oxygen rate and the RN failed to verify the correct oxygen rate and the RN failed to verify the correct oxygen rate and the RN failed to verify the cor	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER					
ASCENSION AT HOME ASCENSION AT HOME SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MIST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING DIFORMATION 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 11125/19, 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 1 (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 and Election date of 11/22/19 - 2/19/20. The hospice failed to update the Medication is was maintained with the correct regimen as evidenced by: An agency document titled, "HOSPICE MEDICATION PROFILE," dated signed by Employee L, RN (Registered Nurse) stated, " Respiratory O 2 at 3.5 1 (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 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			151516	B. W	/ING		12/12	/2019
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FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

51N911

Facility ID: 005829

If continuation sheet Page 8 of 61

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 151516		A. BU	(X2) MULTIPLE CONSTRUCTION (X3) DATE SI A. BUILDING 00 COMPLE B. WING 12/12/2			ETED	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 2015 JACKSON ST ANDERSON, IN 46016				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
L 0531 Bldg. 00	Resinol 2% to be applied and to "affected are indicate the area to applied. 418.54(c)(7) CONTENT OF COMENT OF COMEN	poplied topically 3 x (times) a a". The hospice did not which the Resinol was to be DMPREHENSIVE ive assessment must take the following factors:] An initial bereavement e needs of the patient's individuals focusing on the not cultural factors that may be to cope with the patient's in gathered from the initial	L 0.		Corrective Action Agency Registered Nurses, chaplains and social workers or receive education on the requirement to complete the Comprehensive Assessment, including the Initial Bereavement Assessment, within 5 days of patient admission. Education or 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	ent the will	02/03/2020
	date of 11/26/19. T care for the benefit	A and indicated an Election The record contained a plan of period of 11/26/19-2/23/20. A ter bereavement assessment			Nursing Admission Minimum Documentation Requirements Social Worker Minimum Documentation Requirements		

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

Event ID:

51N911

Facility ID: 005829

If continuation sheet Page 9 of 61

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

PRINTED: 02/03/2020 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 151516	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 12/12/2019		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 2015 JACKSON ST ANDERSON, IN 46016				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI 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 in completed on 12/17/19 and 12/19/19 with follow up training to the complete on 2/3/2020 Evaluatetion for compliance Beginning 2/03/2020, Hospical Director and Clinical Manage audit the Comprehensive Assessment on 100% of admissions for 6 weeks to en an Initial Bereavement Assessment was completed a documented by the Interdisciplinary team. Once 100% compliance is achieved for 6 consecutive wilnitial Bereavement Assessment additional Bereavement Assessment was completed and the complete of the Interdisciplinary team. Once 100% compliance is achieved for 6 consecutive wilnitial Bereavement Assessment additional Bereavement Assessment As	eeks,		
L 0543 Bldg. 00	patients and their individualized writt by the hospice into collaboration with any), the patient o primary caregiver patient's needs if a Based on record rev	and services furnished to families must follow an iten plan of care established erdisciplinary group in the attending physician (if it representative, and the in accordance with the any of them so desire. The wand interview, the hospice of followed the plan of care for its reviewed (#3, 4)	L 0543	Corrective Action Agency Nurses, Social Worke Chaplains, Volunteer Coordinators, and Hospice Ai will receive education on the requirement for an individual	des		

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

Event ID:

51N911

Facility ID: 005829

If continuation sheet

Page 10 of 61

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUI		00	COMPLETED	
		151516	B. WIN	IG		12/12/	/2019
			'	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIER	t .			ACKSON ST		
ASCENS	ION AT HOME			ANDER	RSON, IN 46016		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL	P	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		1 . 14/4/40 . 13/1 1			of care that includes the scope	Э	
	1. An agency policy dated 4/1/18 and titled				and frequency of visits by		
	"Comprehensive assessment of the patient,"				discipline. Education will inclu		
	Policy # 3.004 stated "				documentation requirements f		
	2. The clinical record of patient #3 was reviewed				Visit Frequency and Missed V		
		-			and include a review of proces		
		AM and indicated an Election			guides HO Visit Frequency Or	uers	
		the record contained a plan of			and HH/HO Missed Visit		
		period of 11/26/19-2/23/20 ospice initial order that stated			Process. Training was initially	у	
		frequency 3 x [times] week			completed on 12/17/19 and	a on	
		11/26/2019 (week 1)"			12/19/19 with follow up training	_	
	101 1 week starting	11/20/2019 (week 1)			1/28/20 and 1/30/20. Training	WIII	
	On week 1 visits we	ere made by the SN on 11/26/19			be complete on 2/3/2020 Effective 2/3/2020, Hospice		
		Skilled nursing failed to follow			•	,iII	
	the plan of care.	Skilled lidising laned to follow			Director or Clinical Manager w attend 100% of IDG meetings		
	the plan of care.				ensuring that each patient is		
	3 The clinical reco	ord of patient #4 was reviewed			assessed appropriately for		
		PM and indicated an Election			planned scope and frequency	of	
		e record contained a plan of			visits including a review of all	OI .	
		period of 10/26/19-12/24/19			missed or additional visits that	1	
		N frequency of 1 x per week.			occurred outside of the plan o		
	William moradou u Si	in inequality of the per week.			care.	•	
	On week 3 (11/3/19	1-11/9/19) a missed visit was			Evaluation for compliance		
	,	ated "pt [patient] was on a			Beginning 2/3/2020, each wee	ek	
		omen and the staff from the			the Hospice Director and Clini		
	_	N waited and saw all the other			Manager will utilize the Dever		
		ll did not return talked with the			visit compliance report to valid		
	_	nurse] stated there were no			frequency of visits are made in		
		t need anything this visit, and			accordance to plan of care. Al		
		all if they needed anything or			inconsistencies noted will be		
	_	ecord failed to evidence an			addressed with the hospice		
	attempted visit later	in the week to make up for the			clinician and documented in the	ne	
	missed visit.	-			medical record.		
					If 100% compliance is not		
	4. During an interview on 12/11/19 at 11:07 AM,				achieved in 4 weeks, a		
	_	ated staff should be following			performance development pla	n will	
	the ordered frequen	cy, and if a missed visit			be initiated for clinicians not		
		aff should attempt to make the			following policies/processes.		
	visit up later in the	-]		

02/03/2020 PRINTED: FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 12/12/2019 151516 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 2015 JACKSON ST ASCENSION AT HOME ANDERSON, IN 46016 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE L 0544 418.56(b) PLAN OF CARE Bldg. 00 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. L 0544 **Corrective Action** 01/30/2020 Based on record review and interview, the hospice Staff who provide direct patient failed to ensure the patient and caregiver received contact will be on providing education on admission regarding smoking with education to patients and oxygen for 1 of 1 records reviewed of patients on caregivers regarding the use of oxygen who smoked (#8). Oxygen in the home. Education will include a review of Section IV Findings include: of Patient & Family Training Guide for Hospice Care and its use in The clinical record of patient #8 was reviewed on patient education. Training was 12/3/19 at 3:35 PM and indicated an Election date initially completed on 12/17/19 of 3/29/19. The record contained a plan of care for and 12/19/19 with additional the benefit period of 3/29/19-6/26/19. training completed on 1/28/20 and 1/30/20. An agency document titled "Hospice additional Agency RNs, under the admission page," dated 3/29/19 indicated under supervision of the Hospice Director section IV: oxygen safety and that instruction was and Clinical Manager, will audit provided to the caregiver. Education that could medical record documentation for have been provided was: 6 inch clearance around all active patients with oxygen, concentrator, Back-up O2 (oxygen) supply, provide and document Oxygen change connecting tubing at least every 3 education by 1/31/2020 months, change O2 cannula every other week when using O2 continuously, clean filer at least Evaluation for compliance weekly, Do not use electrical appliance while Beginning 2/03/2020, all using O2, ear care/ nasal care, keep concentrator admission plans of care will be cord away from wet/ damp areas, keep flammable audited to validate education on materials away from O2, keep O2 tubing at least 6 oxygen safety has been provided feet away from heat/ flame, no smoking sign to patient and/or caregiver. If 90% posted, preventative maintenance, secure O2 compliance is not achieved in 4 cylinders on cart or laying down, soak O2 weeks, 100% admissions will be humidifier weekly for 30 minutes in 1:2 audited until compliance is vinegar/water solution, and wash humidifier jar/lid achieved for 4 consecutive weeks.

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

Event ID:

51N911

Facility ID: 005829

If continuation sheet

Page 12 of 61

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 151516			ILDING	onstruction 00	(X3) DATE SURVEY COMPLETED 12/12/2019		
	PROVIDER OR SUPPLIER	:		2015 JA	ADDRESS, CITY, STATE, ZIP COD ACKSON ST SON, IN 46016		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	ΓE	(X5) COMPLETION
TAG	daily with warm wadocument failed to of the oxygen safety. An agency complainthe HHA called the was smoking with 4 She instructed paties oxygen and notified During an interview administrator stated smoking with oxygen During an interview AM-1:30 PM, empl document for patier admission page," w	ov on 12/11/19 at 11:20 AM, the I nurses always discuss not en on admission. ov on 12/12/19 between 11:05 loyee D stated the agency at #8 titled "Hospice additional as completed by social worker buld be completed by nurse		TAG	Once 90% compliance is achie for 4 consecutive weeks, 25% admissions will be audited monthly to monitor continued compliance with Oxygen safety education.	of	DATE
L 0545	418.56(c) CONTENT OF PL	AN OF CARE					
Bldg. 00	written plan of car of care must reflect and interventions identified in the initial updated comprehe plan of care must necessary for the	develop an individualized be for each patient. The plan ct patient and family goals based on the problems itial, comprehensive, and ensive assessments. The include all services palliation and management ess and related conditions, wing:					
	Based on record rev	view and interview, the hospice plan of care contained wound 3 records reviewed of patients	L 05	545	Corrective Action Agency Registered Nurses we receive education on the Initial Comprehensive Assessment of Patient with emphasis on obtaining and documentation of accurate Wound Care Orders.	& of	01/30/2020

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

Event ID:

51N911

Facility ID: 005829

If continuation sheet Page 13 of 61

02/03/2020 PRINTED: FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 12/12/2019 151516 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 2015 JACKSON ST ASCENSION AT HOME ANDERSON, IN 46016 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE Education will include review of The clinical record of patient #5 was reviewed on policy 3.003 Comprehensive 12/4/19 at 8:00 AM and indicated an Election date Assessment-Initial, policy 3.004 of 11/15/19. The record contained a plan of care Comprehensive Assessment of for the benefit period of 11/15/19-2/12/20 which the Patient, policy 3.005 indicated the patient had a left ventricular assist Comprehensive Assessment device (LVAD) and a primary hospice diagnosis Content, 3.006 Comprehensive of ischemic cardiomyopathy. Assessment Updates, policy 7.002 Plan of Care, hospice The agency initial/ comprehensive nursing process guide HO Nursing assessment completed on 11/15/19 in the Admission Minimum integumentary system stated the family was to Documentation Requirements, and care for the LVAD driveline dressing every other hospice process guide HO day. The plan of care failed to evidence what the Nursing Minimum Documentation wound care/ site care order was to be performed. Requirements. raining was initially completed on 12/17/19 and During an interview on 12/11/19 at 11:26 AM, the 12/19/19 with additional administrator stated there should be a written training completed on 1/28/20 and order for wound/ dressing treatments. 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

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

Event ID:

51N911

Facility ID: 005829

If continuation sheet

Page 14 of 61

02/03/2020 PRINTED: FORM APPROVED

CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES			OM	IB NO. 0938-039		
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	î î	LE CONSTRUCTION	(X3) DATE			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 151516	A. BUILDING B. WING	G <u>00</u>	COMPI 12/12			
	PROVIDER OR SUPPLIEF	<u>. </u>	201	STREET ADDRESS, CITY, STATE, ZIP COD 2015 JACKSON ST ANDERSON, IN 46016				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	CROSS-REFERENCED TO THE APPRI	LD BE	(X5) COMPLETION DATE		
				100% compliance is not a in 6 weeks, audits will con until 100% compliance is a for 6 consecutive weeks. Once 100% compliance is achieved for 6 consecutive 25% of patients with wour be audited quarterly to mocontinued compliance.	ntinue achieved is e weeks, nds will			
L 0552 Bldg. 00	collaboration with physician, (if any) document the indi frequently as the p	PLAN OF CARE disciplinary group (in the individual's attending must review, revise and vidualized plan as patient's condition requires, ently than every 15 calendar						
	Based on observation interview, the hospital interview, the hospital IDG (Interdisciplinary problems identified progress toward the observations during Findings include: 1. An agency policititled "comprehensive stated "Policy: The comprehensive assepatient's response to patient's progress to	the IDG meeting (#3, 4).	L 0552	Corrective Action Agency Nurses, Social Wo Chaplains, Volunteer Coo and BereavementCoordin receive education on the U the Comprehensive Asses with emphasis on docume of the patient's progress to goals and desired outcom response to care reassess often as required by the patient of the IDG review of the ongoing reassessment of the patie caregiver's status. • Education will include a life	ordinators nators will Update of essment entation oward nes and sed as natient's is meeting	02/03/2020		

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

required by the patient's condition but no less

the updated comprehensive assessment is

frequently than every 15 days. Information from

Event ID:

51N911

Facility ID: 005829

policy 3.006 Comprehensive

Assessment Updates, policy

3.015 Interdisciplinary Group,

If continuation sheet

Page 15 of 61

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 151516		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 12/12/2019	
	PROVIDER OR SUPPLIER		STREET 2015 J ANDEI		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LEG IDENTIFYING INFORMATION	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION
TAG	reviewed by the IDG and is used to revise needed. Documents planning meetings reassessment of the and needs. 2. The clinical record on 12/3/19 at 11:51 date of 11/26/19. To care for the benefit included a hospice of orders for discipline care impending of death assess not need for caregiver rof the patient and care interventions pt [falls ADL [activity interventions pt [falls ADL [activity interventions pt status O2 [oxyger medications and treatment assess fluid retention and nausea/vomiting patients swallowing verbalize understant assess level of consinterventions equal to the patient swallowing were the patient swallowing were the patient swallowing were assessed to consinterventions equal to coordinator, registered nurse (LPN), chapt coordinator, volunted manager, and admin patient #3 the nurse	rd of patient #3 was reviewed AM and indicated an Election he record contained a plan of period of 11/26/19-2/23/20 that nitial order which stated e and treatments of "terminal eath interventions/imminence eed for volunteer asses elief assess spiritual needs aregiver mobility patient] will remain free from	TAG	hospice process guide HO ID Process, and hospice process guides HO Nursing Minimum Documentation Requirements Social Worker Minimum Documentation Requirements HO Chaplain Minimum Documentation Requirements. Training was initially completed on 12/17/1 and 12/19/19 with additional training completed on 1/28/20 1/30/20 Training will be compon 2/3/2020 Evaluation for compliance Beginning 2/03/2020, Hospic Director or Clinical Manager audit 100% of all updated comprehensive assessments weeks to ensure the interdisciplinary documents a changes that have occurred sinitial 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 weeks, audits will continue for additional 6 weeks or later un compliance is achieved. Once 100% compliance is achieved. Once 100% compliance is achieved for 6 consecutive w 25% of updated comprehens assessments will be audited quarter to monitor continued compliance with updating comprehensive assessment.	DATE OG S S, HO S, and 9 D and olete e will s for 6 Ill since S A 6 A 7 A man ntill eeeks, ive

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

Event ID:

51N911

Facility ID: 005829

If continuation sheet

Page 16 of 61

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

PRINTED: 02/03/2020 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER 151516		A. BUILDING 00 COMPLETE B. WING 12/12/20			ETED		
NAME C	F PROVIDER OR SUPPLIE	₹			DDRESS, CITY, STATE, ZIP COD CKSON ST		
ASCE	ISION AT HOME				SON, IN 46016		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREF		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
TAG	at home. Patient wolder than 63, signed was weak and frail. 3 times per week, so the stated patient work and in a diversion. Patient I longer refilling Normand new orders from discontinue premaruse with smoking). Patient was on spir. She stated this coult patient runs out of worker stated they daughter had significated addiction in past. To were writing down being given and contain all are accounted for review, and update spiritual needs, fall nausea, vomiting, a progress towards go 3. The clinical recontain 12/3/19 at 1:57 date of 4/29/19. The care for the benefit that indicated needs "terminal care in anticipatory grief pain management assess urinary states will be met	ord of patient #4 was reviewed PM and indicated an Election are record contained a plan of period of 10/26/19-12/24/19 sof the patient which included apending death interventions assess need for volunteer assess cardiovascular status atus nutrition/hydration assess patients swallowing needs status social/emotional	TA	G .	DEFICIENCY		DATE

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

Event ID:

51N911

Facility ID: 005829

If continuation sheet

Page 17 of 61

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 151516		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION OO	(X3) DATE SURVEY COMPLETED 12/12/2019		
	PROVIDER OR SUPPLIER SION AT HOME	STREET ADDRESS, CITY, STATE, ZIP COD 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 APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE		
L 0565	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.					
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 Hospic Director, revised the Ascensi at Home QAPI Program for Hospice. Revised QAPI program includes the			

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

Event ID:

51N911

Facility ID: 005829

) I:

If continuation sheet Page 18 of 61

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 151516		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00			(X3) DATE SURVEY COMPLETED	
		151516	B. WI	NG		12/12/	2019
	PROVIDER OR SUPPLIER		•	2015 J	ADDRESS, CITY, STATE, ZIP COD ACKSON ST RSON, IN 46016		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID			(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE			COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	AIE	DATE
	Findings include:				identification of Quality		
	An agency policy dated 4/1/18 titled "Quality assessment and performance improvement,"				Indicators for the improving		
					palliative outcomes,		
					requirement of Performance	,	
	Policy # 3.018 state	d "Policy: The hospice			Improvement Projects (PIPs) for	
	program is committ	ed to the highest level of			demonstrating improved		
	quality ns safe care	for its hospice service			performance, oversight of		
	recipients. The hos	pice's governing body must			contracted services, QAPI		
		ram: reflects the complexity of			Meeting documentation		
	its organization and services, involves all hospice				standards to ensure agency	,	
	services (including those services provided under				analyzes and tracks quality		
	contract or arrangement) focuses on indicators				indicator data, QAPI Meeting	9	
	related to improved palliative outcomes and takes				schedule for quarterly		
		ate improvement in hospice			meetings with timeline for		
	-	OCEDURE: The governing			Hospice Director to submit		
		sible to ensure that an			meeting minutes and PIPs		
		or quality improvement and			summary to the Governing		
		ined, maintained and			Body. QAPI Quality Indicato	rs	
	_	and that the hospice wide			include required data		
		and improvement efforts			collection determined to		
	_	or improved quality of care and			provide the Governing Body		
		ning body will assure that one			and Hospice Director with a		
		are designated to operate the			overall evaluation of patient		
	QAPI program."				care and safety.		
					Policy 3.018: Quality		
		body minutes dated 10/12/18			Assessment and Performan		
		" The governing board			Improvement Program-Hosp		
		the following items prior to the			Service Line (revised 1/17/20	020)	
		Assessment Performance			revised in collaboration		
		ency QAPI summaries			with the Governing Body to		
		ing body members. No			accurately reflect the new		
		e T will review AAH			QAPI program for Hospice		
		hospice QAPI program behalf ard and approve" The			Service Line.¿ ¿¿ Director		
					received training on revised		
	1	ed to approve the hospice's			QAPI program from member	T OT	
	data collection.				the governing body on	oioo	
	During an interview	on 12/11/10 at 12:54 DM			1/22/2020. The revised Hosp	JICE	
	_	on 12/11/19 at 12:54 PM, ked if the governing body			Quality Assessment		
		nat was collected. She stated			Performance Improvement (QAPI) Program and Hospic		

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

Event ID:

51N911 Facility ID: 005829 If continuation sheet Page 19 of 61

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

PRINTED: 02/03/2020 FORM APPROVED OMB NO. 0938-039

	OF CORRECTION	IDENTIFICATION NUMBER 151516	A. BUILDING B. WING	00	COMPLETED 12/12/2019
	PROVIDER OR SUPPLIEF	2	2015 J	ADDRESS, CITY, STATE, ZIP COD ACKSON ST RSON, IN 46016	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	TION (X5) D BE OPRIATE COMPLETION DATE
	QAPI is given to er QAPI) and she was that. When asked i	that all information regarding nployee W (national director of not sure what happened after f the governing body was elopment and ongoing		Operations Policy Manua approved by the governi body on 01/28/2019.	
	evaluation of QAPI had had the greater would be ran throug who the QAPI team employee D, admin	she stated she thought they oversight, but everything gh employee W. When asked is she stated herself, istrator, medical director, and a ual care, social work,		Evaluation for compliant of Hospice Operations, appointee to Governing will attend and audit the agency QAPI Committee Meeting on 2/04/2020. Ag QAPI Meeting Minutes (Clindicators), PIPS and Qu Director Summary documentation reviewed the VP of Hospice Operatin collaboration with Hospice for accuracy. Review included recommendations for additional PIPs and/or dacollection to ensure a the evaluation of patient carsafety was conducted by QAPI Committee the QAI Meeting Minutes (Quality Indicators), PIPS and Qu Director Summary documentation will be reviewed by the VP of Hoppications, appointed mof the Governing Body, i collaboration with Hospi Director and Regional Director and	Body, gency Quality earterly by tions, spice rector ata orough e and y the PI y arterly ospice nember n ce rector ata orough

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

Event ID:

51N911

Facility ID: 005829

If continuation sheet

Page 20 of 61

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 151516		li i		(X3) DATE SURVEY COMPLETED 12/12/2019		
		STREET ADDRESS, CITY, STATE, ZIP COD 2015 JACKSON ST ANDERSON, IN 46016				
(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	(X5) E COMPLETION DATE		
418 58(o)(2)			safety was conducted by the QAPI Committee. Beginning 1 2020, VP of Hospice Operations will present QAC Committee summary and F to the Governing Body for review and approval.	g Q API		
EXECUTIVE RES [The hospice's gov for ensuring the fo (3) That one or mo responsible for op assessment and p	verning body is responsible llowing:] ore individual(s) who are erating the quality erformance improvement					
Based on record rev failed to follow thei individual (s) were for operating the Qarindra Findings include: An agency policy drassessment and perf Policy # 3.018 state governing body will individuals are designogram." Governing body me at 9:30 AM, failed to operate the QAPI puring this survey, meeting 12/9/19 wh and V attended. Re	riew, the governing body r policy to ensure that designated to be responsible API program for 1 of 1 agency. ated 4/1/18 titled "Quality formance improvement," d " PROCEDURE: The I assure that one or more gnated to operate the QAPI setting minutes dated 10/12/18 to designate individual(s) to rogram. the Governing body held a gree employees Q, R, S, T, U, view of the minutes reflected	L 0576	Corrective Action Governing Body met on 12/s and appointed an agency director to oversee the QAP program. The revised Hospice Qualit 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 Committee. Evaluation for compliance VP of Hospice Operations, appointee to Governing Bod attend and audit the agency Committee Meeting on 2/03/2020, Agency QAPI Me	ty cy QAPI ly, will QAPI		
(PROVIDER OR SUPPLIER SION AT HOME SUMMARY S (EACH DEFICIEN REGULATORY OR 418.58(e)(3) EXECUTIVE RES [The hospice's governing the form of the company of t	DENTIFICATION NUMBER 151516 PROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION 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	A BUILDING B. WING PROVIDER OR SUPPLIER JON AT HOME SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION 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	DENTIFICATION NUMBER 151516 ROVIDER OR SUPPLIER RON AT HOME SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR I.SC IDENTIFYING INFORMATION 418.58(e)(3) EXECUTIVE RESPONSIBILITIES [The hospice's governing body is responsible for operating the following.] (3) That one or more individual(s) who are responsible for operating the equality assessment and performance improvement program are designated to be responsible for operating the QAPI program. Findings include: Findings include: Findings include: Findings include: Governing body will assure that one or more individuals are designated to operate the QAPI program. 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 STREET ADDRESS, CITY, STATE, AIP COD 2015 JACKSON ST ANDERSON, IN 46016 STREET ADDRESS, CITY, STATE, AIP COD 2015 JACKSON ST ANDERSON, IN 46016 STREET ADDRESS, CITY, STATE, AIP COD 2015 JACKSON ST ANDERSON, IN 46016 STREET ADDRESS, CITY, STATE, AIP COD 2015 JACKSON ST ANDERSON, IN 46016 ID 2016 JACKSON STANDERSON, IN 46016 ID 2016 JACKSON STANDERSO		

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

Event ID:

51N911

Facility ID: 005829

If continuation sheet

Page 21 of 61

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

PRINTED: 02/03/2020 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER 151516		A. BUILDING B. WING	00 00	COMPLETED 12/12/2019					
	ROVIDER OR SUPPLIER		2015 J	STREET ADDRESS, CITY, STATE, ZIP COD 2015 JACKSON ST ANDERSON, IN 46016					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE				
	hospice agencies in Oklahoma, Texas, a approved during the reflective of this age	oup (IDG) members for all Indiana, Alabama, Michigan, and Wisconsin that were meeting and not just		and Quarterly Director Summa documentation reviewed by the of Hospice Operations, in collaboration with Hospice Director of Hospice and Regional Director of Hospice recommendations for addition PIPs and/or data collection to ensure a thorough evaluation patient care and safety was conducted by the QAPI Committee the QAPI Meeting Minutes (Quality Indicators), Fand Quarterly Director Summa documentation will be reviewed the VP of Hospice Operations appointed member of the Governing Body, in collaborat with Hospice Director and Regional Director of Hospice. Review recommendations for additional PIPs and/or data collection to ensure a thoroug 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 an approval.	e VP ector sice al on of PIPS ary d by , ion				
L 0579	418.60(a) PREVENTION								
Bldg. 00	of practice to previ	follow accepted standards ent the transmission of nmunicable diseases, of standard precautions.	L 0579	Corrective Action ·	01/30/2020				

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

Event ID:

51N911

Facility ID: 005829

If continuation sheet

Page 22 of 61

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			VEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETE	D
		151516	B. W	ING		12/12/201	9
		<u> </u>		STREET /	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	8			ACKSON ST		
ASCENS	SION AT HOME				RSON, IN 46016		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE CO	OMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG			DATE
	Based on observation, record review, and				Hospice Director will ensure t		
	interview, the agency failed to ensure that hospice				Interdisciplinary Team member		
		tion control policies for 3 of 3			will receive training on standa	rds	
	home visits observe	ed (#1, 2, 4).			of practice to prevent the		
					transmission of infections,		
	Findings include:				including the use of standard		
					precautions, proper bag techr	ique.	
		y dated 3/18 titled "clinical bag			All members of The		
		3.019 attachement C stated "			Interdisciplinary Team will rev		
	-	designated clean area(the			the Hand Hygiene Policy and	Bag	
	inside of the bag), aand a dirty area (the pockets				Technique. All Hospice Nurse	s	
	on the outside of the bag). The clean area contais				and Hospice Aides will review		
	unused or cleaned supplies/equipment and the				Relias checklists Bathing-Peri	neal	
	dirty is designated for frequently used materials				Care Female and Bathing -		
	(i.e., soap, paper towels, waterless hand cleanser,				Perineal Care Male. Training	was	
	bag barriers, ectc.)	Hand hygiene must always			given on 12/17/19, 12/19/19 w	vith	
	be performed using	alcohol based hand cleanser			follow up training completed o	n	
	or soap and water b	efore reaching into the ag for			1/28/2020 and 1/30/2020.		
	supplies/equipment	"			Hospice Director will provide		
					education to all nursing staff of	n	
	2. An agency polic	y dated 4/1/18 and titled			infection control standards wh	en	
	"Infection control p	rogram," stated " The			performing wound dressing		
		or or designee is responsible			changes including proper han	d	
	for ensuring all clin	ical staff receive instruction			hygiene intervals, utilization o	and	
	regading identificat	ion, transmission, prevention,			changing gloves between task	is,	
	and control of infec	tion as well as communicable			cleansing of equipment to pre	vent	
	disease sources	These prevention and / or			potential transmission of disea	ise	
		may include, nut are not			from a patient with weeping,		
		wing: Appropriate use of			draining wounds. Training was	3	
	aseptic techniques	during dressing changes as			given on 12/17/19, 12/19/19 w	vith	
	defined in standard	precautions"			follow up training completed o	n	
					1/28/2020 and 1/30/2020.		
	_	visit on 12/4/19 at 12:35 PM,			Evaluation for compliance ·		
		nealth aide (HHA), was			Beginning 2/3/2020, Hospice		
		personal care to patient #4			Director or Clinical Manager w	rill	
	(hospice election da	ate of 4/29/19). Employee I			perform at least 1 onsite		
	transfered patient to	shower chair and into the			supervisory home visit with ea	ch	
	shower. While in the	he shower the patient had a			clinical staff member to observ		
	bowel movement or	n the shower floor. Employee I			staff for competency in the		
	washed body and ri	nsed, then washed the			standards of practice to preve	nt	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		151516	B. W	ING		12/12/	2019
		L		OTD DET	ADDRESS CITY STATE ZIR COR		
NAME OF F	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD		
ASCENIO	ION AT HOME		2015 JACKSON ST ANDERSON, IN 46016				
ASCENS	ION AT HOME			ANDER			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	_	area last. After washing the			the transmission of infections	,	
	anal area (which had stool on washcloth),				including the use of standard		
		tely rinsed patient, wrapped a			precautions, proper bag techr	nique.	
	_	atient and then moved the			Any staff who does not		
		f the shower before removing			demonstrate compliance with		
		I failed to remove gloves			standards of practice for hand		
	I	washing anal area and before			washing and perineal care wil		
		ntamination to the patient and			reeducated and scheduled for	r an	
	patient's belonging	S.			additional onsite managerial		
					supervisory visit.		
	4. During an interview on 12/11/19 at 11:30 AM,				Beginning 2/3/2020, Hospice		
	the administrator stated after using vital sign				Director or Clinical Manager v	vill	
	equipment all equipment should be placed on a				perform at least 1 onsite		
	_	down together, then placed			supervisory home visit with ea		
	back in bag.				nursing staff member to obse	rve	
	_	visit on 12/4/19 at 11:10 AM			staff for competency in the		
		ner home, Employee K,			standards of practice to stand		
		RN), was observed providing			when performing wound dress	-	
	_	oyee K began the visit with			changes including proper han		
		hand gel and applied			hygiene intervals, utilization o		
	_	Employee K followed by			changing gloves between task		
	_	al dressing, then gloves and			cleansing of equipment to pre		
	_	Patient #1's abdomen revealed a			potential transmission of dise	ase	
	_	e right middle-upper quadrant			from a patient with weeping,		
	_	ce. The drainage tube			draining wounds.		
		risibly leaking fluid onto the and the bed. The employee			· Any staff who does not		
		(fluid draining system) drainage			demonstrate compliance with		
		laced beside the patient on the			standards of practice for hand washing and perineal care will		
		e followed by opening sterile			reeducated and scheduled for		
		placed on the patient's bed,			additional onsite managerial	ı alı	
		s, picked up the plurex drain			supervisory visit.		
		on the sterile barrier beside			· Each staff member will be gi	iven	
	_				a maximum of 3 retraining	14611	
	the patient. Employee K then donned sterile gloves and contaminated the fingers of the gloves				sessions and subsequent ons	site	
	_	iile pulling on the right hand			supervisory visits to demonstr		
		nployee followed by opening 3			competency. If competency is		
		placed on the barrier.			achieved after 3 attempts, the		
		the drainage tube cap exterior,			member will be terminated from		
		nd attached to the plurex drain			employment.	7111	
I	I removed the cap an	ia attached to the plutes utani			Cimpioyinicii.		

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

PRINTED: 02/03/2020 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SU			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETED	
		151516	B. W	ING		12/12/2019	
NAME OF F	DOLUBED OF GUIDNIE			STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF E	PROVIDER OR SUPPLIER	· ·		2015 JA	ACKSON ST		
ASCENS	SION AT HOME			ANDER	SON, IN 46016		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY		DATE
	-	rex drain evacuated 1/2 bottle					
		uid, the employee verbalized					
		d was approximately 300 ml					
	,	ne placed the drainage and					
		The employee then clamped the					
		en and plurex drainage bottle,					
		ction between the tubing's and					
		o the end of the abdominal employee then continued by					
	_						
	_	ol swab left on the barrier and the drainage tube insertion					
	-	by rubbing the wipe					
		ngerbreadth's from the insertion					
		ed to the insertion site and					
		ore discarding the wipe in a bag					
		employee then applied a split					
		omen and curled the excess					
	_	e dressing and then covered					
		x 4 gauze. The employee					
	_	s and immediately placed her					
	_	dressing while she began to					
	_	clusive dressing to the					
		and held in place for 5					
	_	e employee held the dressing in					
		t, ungloved hand, she reached					
		e left side of her head,					
	_	the abdomen, placing the right					
		en and removed the remaining					
		ion of the dressing. The					
	employee then disc	arded the trash in a bag,					
	placed both hands of	on her hips, observed the					
	dressing. She then						
	incontinence brief f	from across the room and					
	placed it in her lap	as she applied hand gel. The					
		hed into her bag that had been					
	placed on the patier	nts floor to retrieve scissors					
	and paper tape and	placed on the patient's					
	dresser. The emplo	yee cut the adult incontinence					
	brief ends to cover	the abdominal dressing and					
	placed scissors in h	er pocket. The employee					

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

Event ID:

51N911

Facility ID: 005829

If continuation sheet Page 25 of 61

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

PRINTED: 02/03/2020 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER 151516		A. BUILDING B. WING	00 00		LETED 2/2019	
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD		
ASCENS	ION AT HOME			RSON, IN 46016		
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTIV (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPRO	BE	(X5) COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	O MATE	DATE
		pe to secure the brief over the				
	_	and followed by placing the				
		The employee reached again				
	_	ed hand gel and performed				
		laced wrist blood pressure				
	_	left wrist, and the pulse				
	_	ent's right index finger. The eved her phone from her				
		time for respiratory rate and				
		aced it back in her pocket.				
		ere complete, the employee				
	_	documentation partly on her				
	*	the bed. The employee then				
		sessment with bare hands.				
		erved to exhibit swollen lower				
	-	en, weeping sores and scabs.				
	_	ormed an assessment of the				
	lower extremities by	y both observation and				
	palpation without gl	loves. After the physical				
	assessment, the emp	ployee began to document on				
	her tablet without po	erforming hand hygiene and				
	_	issors and paper tape back				
		byee K failed to perform proper				
		propriate intervals, failed to				
		gloves between tasks, and				
		aipment to prevent potential				
		ease from a patient with				
	weeping, draining w	vounds.				
	6 During a hamay	risit on 12/4/19 at 11:10 AM				
		n assisted living facility,				
		ered Nurse (RN), was observed				
		re. Employee J began the visit				
		directly on the patient's chair				
		ean, non-sterile gloves. The				
		nto her bag, removed a				
		cleansed the assisted living's				
		pment and stethoscope, then				
		her paper tablet on the				
	patient's dining table	e. After the employee				
			1	i .		1

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

Event ID:

51N911

Facility ID: 005829

If continuation sheet

Page 26 of 61

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

PRINTED: 02/03/2020 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER 151516		JILDING	00	COMPL 12/12/	ETED	
	ROVIDER OR SUPPLIER		2015 JA	DDRESS, CITY, STATE, ZIP COD CKSON ST SON, IN 46016		
AGOLING	ION AT HOWL		 ANDLIN	3011, 111 40010		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL 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 0590	cleansed the equipment and proceeded to obvital signs she place blood pressure cuff employee began the then the employee ir running. She reached tissue and blew her went into the patient water and rinsed her used) for 3 seconds towel. She immediated and palpated the pation of the patient's discussion of the patient's discussion of the patient's discussion of the patient's oxygen container and CPAF pressure) reservoir of employee then obtained when she finish stethoscope from her previously used cleatable from the begin the agency equipment hand hygiene utilizities equipment with previously and face appropriately and face equipment in a man	nent, she removed her gloves tain vital signs. After taking and the assisted living agency in her nursing bag. The apatient physical assessment, andicated her nose was and into her pocket, retrieved a nose. The employee then it's restroom, turned on the re hands in water (no soap was and dried hands with a paper ately went back to the patient itent's lower legs and feet and ing a pen from her pocket and ing a pen from her pocket and ing table. After the indicated the documentation, she filled concentrator humidifier of (continuous positive airway with distilled water. The ined a repeat blood pressure ined, she retrieved the er nursing bag and the ansing wipe from the dining ining of the visit to wipe down int. The employee performed ing hand gel after wiping off viously used cleansing wipe. To perform proper hand hygiene wals, failed to utilize gloves inted to cleanse multi-use iner to prevent potential in to and from patients in an try.	IAU			DATE
Bldg. 00	The hospice medicemployees, and co	cal director, physician ontracted physician(s) of njunction with the patient's				

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

Event ID:

51N911

Facility ID: 005829

If continuation sheet Page 27 of 61

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING 00 COMPLE			ETED
		151516	B. Wl	ING		12/12/	/2019
NAME OF I	PROVIDER OR SUPPLIER)		STREET A	ADDRESS, CITY, STATE, ZIP COD		
		\			ACKSON ST		
ASCENS	SION AT HOME			ANDER	SON, IN 46016		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		an, are responsible for the					
		nagement of the terminal					
		ions related to the terminal					
	illness.	manifest and the action does					
		mployees and those under action under the supervision					
	of the hospice me	· · · · · · · · · · · · · · · · · · ·					
	· ·	mployees and those under					
		et 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,						
		ysician employee is					
	responsible for me	eeting the medical needs of					
	the patient.						
			L 0:	590	Corrective Action ·		02/03/2020
		view and interview, the agency			Hospice Director		
		hospice physician was			educated Medical Director and	t	
		s job title and that he was to			Hospice Physician on job		
	_	al director for 1 of 1 physician			description and delineation of	-	
	designee interviewe	ed (F).			responsibilities using the NHP	CO	
	F: 1: : 1 1				Physician compliance training		
	Findings include:				guide. Training was provided of 1/29/2020 and will be complet		
	An agency policy d	ated 4/1/18 titled "Medical			on 2/3/2020 and will be completed on 2/3/2020.	cu	
		" Policy # 4.001 stated " Policy			The Hospice Director will		
	· ·	lical Director assumes the			collaborate with contracting		
	_	ty for the medical component			services and legal departmen	nt	
	_	program When the Medical			to revise Medical Director an		
		able, a physician designated			hospice physician employme		
		mes the same responsibilities			contracts to include delineat		
		he Medical Director"			of job responsibilities of		
					each position, including		
	The agency hospic	e physician agreement was			organizational reporting		
	reviewed on 12/12/	19 and stated "This agreement			structure. Medical Director a	nd	
		e 15 th day of August, 2018, by			hospice physician will sign		
		K], an Indiana limited liability			revised and compliant		
	company, hereinaft	er referred to as [entity L] and			employment contract no late	r	

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

Event ID:

51N911

Facility ID: 005829

If continuation sheet Page 28 of 61

PRINTED: 02/03/2020

EPARTMENT OF HEALTH AND HUN	FORM APPROVED			
ENTERS FOR MEDICARE & MEDIC	OMB NO. 0938-039			
STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CONSTRUCTION	(X3) DATE SURVEY
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING <u>00</u>	COMPLETED
	151516	B. WI	ING	12/12/2019
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	
While of TROVIDER OR SOLTELEN			2015 JACKSON ST	
ASCENSION AT HOME			ANDERSON, IN 46016	

ASCENS	SION AT HOME	ANDER	ANDERSON, IN 46016				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION [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	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) than 2/3/2020. Review Employment Agreement and Physician Onboarding Process including Clinical Onboarding	(X5) COMPLETION DATE			
	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,		Competency Checklist with any new physician during the onboarding process. Evaluation for compliance · Beginning 2/3/2020, Hospice Director and Regional Director of				
	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.		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			

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

Event ID:

51N911

Facility ID: 005829

If continuation sheet

Page 29 of 61

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 00 COMPLETE			ETED	
		151516	B. WING 12/12/2019			/2019	
				STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	ROVIDER OR SUPPLIER	L Company of the Comp			ACKSON ST		
ASCENS	ION AT HOME				RSON, IN 46016		
			1				ı
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LISC IDENTIFYING INFORMATION		TAG			DATE
	Findings include:				emphasis on documentation of	of the	
					integumentary, wound care,		
		y dated 4/1/18 and titled			gastrointestinal, and pulmonal		
	_	Policy # 4.005 stated "			Education will include a revie	w of	
	_	e provided in accordance with			policies: Policy 3.003		
	accepted standards	of practice"			Comprehensive		
		MON DN G FND (2004)			Assessment-Initial, policy 3.00		
		MSN, RN, C-FNP. (2004, June			Comprehensive Assessment	ot .	
	· ·	ursing Health Assessment.			the Patient, policy 3.005		
		r 12, 2019, from rn.com			Comprehensive Assessment		
		ASSESSMENT: When			Content; policy 3.006		
		nonary system Inspect the			Comprehensive Assessment		
		te the thoracic cage,			Updates, policy 4.005 Nursing		
		rior and posterior chest: Have			Services, policy 7.001 Clinical		
		ly deeper than normal through			Record Content, and hospice		
		tate from C-7 to approximately			process guide HO Nursing		
	_	t comparative sequence. You			Minimum Documentation		
		etween every rib Identify			Requirements; Relias training	_	
	-	eath sounds Assessing the testinal System: When			physical assessment. Training	9	
		men/gastrointestinal system,			was initially completed on 12/17/19 and 12/19/19 with		
	_	owing Any abdominal pain,			additional training completed	nn.	
		el habits Auscultate for			1/28/20 and 1/30/20	JII	
		ruits. Begin by dividing the			1/28/20 and 1/30/20		
		drants, by drawing an			Evaluation for compliance		
	_	cally and horizontally across			Beginning 2/3/2020, Hospice		
		rsect the umbilicus. Right			Director and Clinical Manager	will	
		eft Upper Quadrant, Right		identify active patients with wour			
	* *	eft Lower Quadrant.			care interventions and audit 1		
		I begin in the right lower		of medical records for wound care			
		sounds are not heard, in order		physician orders, with nursing			
	_	el sounds are truly absent,			documentation evident of		
	listen for a total of t				compliance with plan of care.	If	
					100% compliance is not achie		
	3. During a home v	risit on 12/4/19 at 11:10 AM			in 6 weeks, audits will continue		
	with patient #1 in h	er home, Employee K,			until 100% compliance is achi-		
	Registered Nurse (F	RN), was observed providing			for 6 consecutive weeks.		
	skilled care. Emplo	yee K obtained the patient's			Beginning 2/3/2020, Hospice		
	blood pressure, oxy	gen saturation, pulse,			Director and Clinical Manager	will	
	temporal temperatu	re and respiratory rate. During			perform at least 1 onsite		
1							I

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			VEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING 00 COMPLETED B. WING 12/12/2019			
		151516	B. W	NG	_	12/12/201	9
NAME OF P	DDOMNED OD GUDDU TED			STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	C			ACKSON ST		
ASCENS	ION AT HOME			ANDER	RSON, IN 46016		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE CO	MPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		nent, the employee utilized her ultate right upper and middle,			supervisory home visit with ea		
		middle anterior lung sounds			registered nurse to observe fo competency in performing a		
		ely by auscultation of the right			complete physical assessmen	t	
		and left lower abdominal bowel			per professional standards. Ar		
		K remarked, bowel sounds			staff who does not demonstrate	-	
		he employee failed to			competence will be reeducate		
		ields posteriorly and failed to			and scheduled for an additional		
		bdominal quadrants for bowel			onsite managerial supervisory		
	sounds.				visit.		
	_	visit on 12/4/19 at 11:10 AM					
	with patient #2 in an assisted living facility, Employee J, Registered Nurse (RN), was observed						
		are. Employee J obtained the					
		sure, oxygen saturation, pulse,					
		d respiratory rate. During the					
		t, the employee utilized the					
		and auscultated patient's					
		upper anterior breath sounds					
	followed by auscult	ating right lower and left lower					
		ounds. The employee remarked					
		ly has no breath sounds."					
		d to auscultate all lung fields					
		eriorly and failed to auscultate					
		quadrants for bowel sounds					
		visit on 12/4/19 at 11:06 AM, stered nurse (RN), was					
		skilled care to patient #4					
		ate of 4/29/19). Employee AA					
	1	ook at edema (patient had					
), auscultated anterior lung					
		nd one time on each side.					
	Employee AA faile	d to assess feet for edema or					
		to auscultate posterior lung					
	fields.						
	6 The clinical reserve	ard of nations #11 was reviewed					
		ord of patient #11 was reviewed PM and indicated an Election					
		he record contained a plan of					
	auto 01 2/13/17. 111	e record comunica a pian or	1		l	I	

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

Event ID:

51N911

Facility ID: 005829

If continuation sheet Page 31 of 61

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING 00 COMPLETI			
		151516	B. W	ING	_	12/12/2019	
NAME OF T	DOUDED OF CURRY			STREET A	ADDRESS, CITY, STATE, ZIP COD	1	
NAME OF P	PROVIDER OR SUPPLIER	t .		2015 JA	ACKSON ST		
ASCENS	ION AT HOME			ANDER	RSON, IN 46016		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION period of 10/11/19-12/9/19.	<u> </u>	TAG	DEFICIENCE!		DATE
		sure that wound assessment					
		was thorough and consistent					
		type of wound being treated.					
	, ,						
		nursing clinical note					
		and documentation which					
		e wound was a Stage I buttock					
	wound.						
	On 11/13/19 the wo	ounds were documented as a					
		uttock with one extension.					
	On 11/21/19 the wo	ound was described as a coccyx					
	wound.						
	On 12/4/10 the						
	buttock/coccyx wou	and was described as a					
	buttock/coccyx wot	and.					
	7. During an interv	iew on 12/11/19 at 11:23 AM,					
	the administrator sta	ated if the same nurse is					
		en the wound documentation					
		t, nurses should listen					
		eriorly to lungs fields during					
	•	l four bowel sounds should be					
	auscultated during a	a nursing assessment.					
L 0596	418.64(d)(1)						
	COUNSELING SE	ERVICES					
Bldg. 00		es must include, but are not					
	limited to, the follo						
	(1) Bereavement	counseling. The hospice					
	must:						
		zed program for the					
	•	vement services furnished					
	under the supervis						
	· ·	experience or education in					
	grief or loss couns	ment services available to					
	* *	er individuals in the					

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

Event ID:

51N911

Facility ID: 005829

If continuation sheet

Page 32 of 61

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 151516		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING (X3) DATE SURVEY COMPLETED 12/12/2019				LETED	
	PROVIDER OR SUPPLIER			2015 JA	ADDRESS, CITY, STATE, ZIP COD ACKSON ST SON, IN 46016		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
	following the death Bereavement couresidents of a SNF appropriate and idplan of care. (iii) Ensure that be the needs of the be (iv) Develop a bernotes the kind of be offered and the free A special coverage counseling is special coverage counseling is special coverage. Based on record rever failed to ensure bere individualized, special services that would they would be deliverecords reviewed (#Findings include: 1. An agency police "Bereavement assess"The bereavement assessed needs of the kind of bereavement the frequency of death in the frequency of death of 3/29/19 and bereavement intervelobereavement prograde death in complete because of the complete because of t	riseling also extends to F/NF or ICF/MR when lentified in the bereavement ereavement services reflect rereaved. eavement plan of care that bereavement services to be equency of service delivery. The provision for bereavement cified in §418.204(c). Friew and interview the hospice reavement careplans delineated cific, types of bereavement be offered with the frequency rered for 3 of 3 bereaved (8, 14, 15). Friew and interview the hospice reavement careplans delineated cific, types of bereavement be offered with the frequency rered for 3 of 3 bereaved (8, 14, 15).	L 05	596	Corrective Action Hospice Director will ensure to interdisciplinary team received education on assessing bereavement needs and developing a bereavement placare that notes the kind of bereavement services to be conditional training and the frequency of service delivery. Education will include review of policy 3.014 Bereavement Assessment and policy 4.007 Bereavement Counseling. Training was initic completed on 12/17/19 and 12/19/19 with additional training 1/28/20 and 1/30/20. Training be complete on 2/3/2020 Bereavement Counselor will develop the bereavement car and obtain Interdisciplinary teinput on the development of the bereavement care plan at the IDG meeting post death. Evaluation for compliance Beginning 2/03/2020, Hospice	an of offered de ad ially ng on p will e plan am he offirst	02/03/2020

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

Event ID:

51N911

Facility ID: 005829

If continuation sheet Page 33 of 61

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

PRINTED: 02/03/2020 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 151516		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE COMPI 12/12		
	PROVIDER OR SUPPLIER	3	2015 J	ADDRESS, CITY, STATE, ZIP C IACKSON ST RSON, IN 46016	OD	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SE CROSS-REFERENCED TO THE A DEFICIENCY)	RECTION HOULD BE PPROPRIATE	(X5) COMPLETION DATE
	education packet, 5 survey, holiday grid bereavement team of the bereaved" A bereaved the date, to with what was mail failed to evidence so bereavement care of the bereaved on the survey and the bereavement progradeath complete to Care plan within 28 Other: Provide grie through bereavement service education packet, 5 survey, holiday grid bereavement team of the bereaved" A bereaved the date, to with what was mail failed to evidence so bereavement care of the bereaved on the survey bereavement transparent to the bereaved on the survey. A complete the bereaved on the survey bereavement progradeath complete the care plan within 28 Other: Provide grie through bereavement the progradeath complete the Care plan within 28 Other: Provide grie through bereavement	es and benefits, grief months needs & issues ef support; closure letter; may place 'Ambassador Call' to s contact is made with the ype of contact and initials ed was filled out. The record pecific types and duration of nat was also individualized for bereavement plan of care. ord of patient #14 was reviewed ed a death date of 9/11/19. The entions were "duration of am 13 months after patient's ereavement initial assessment / 8 days of patient's death f education and support ent correspondence program for ence letter, information on es and benefits, grief months needs & issues ef support; closure letter; may place 'Ambassador Call' to s contact was made with the ype of contact and initials ed was filled out. The record pecific types and duration of nat was also individualized for bereavement plan of care. ord of patient #15 was reviewed ed a death date of 8/5/19. The entions were "duration of am 13 months after patient's ereavement initial assessment / 6 days of patient's death f education and support ent correspondence program for ence letter, information on		Director and Clinical M audit 100% of deaths for to validate bereavement assessment and plan of contain individualized a goals and interventions the types of bereavement offered and the frequencompleted at the first II post death. If 100% contour achieved in 4 week deaths will be audited a compliance is achieved consecutive weeks.	or 4 weeks int of care and specific is including ent services incy were DG meeting impliance is is, 100% until	

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

Event ID:

51N911

Facility ID: 005829

If continuation sheet

Page 34 of 61

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 151516		(X2) MULTIPLI A. BUILDING B. WING	E CONSTRUCTION G 00	(X3) DATE SURVEY COMPLETED 12/12/2019			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 2015 JACKSON ST ANDERSON, IN 46016				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP	BE COMPLETION		
L 0602 Bldg. 00	education packet, 5 survey, holiday grie bereavement team r the bereaved" As bereaved the date, t; with what was mail- failed to evidence s; bereavement care the the bereaved on the 5. During an interv administrator stated should have specific bereavement service 418.70 FURNISHING OF A hospice must er described in §418 provided directly be arrangements mas specified in §418. be provided in a r current standards Based on record rev failed to ensure the measurements upon with wounds (#6). Findings include: The clinical record of 12/5/19 and indicate The record containe period of 11/15/19	NON-CORE SERVICES name that the services .72 through §418.78 are by the hospice or under de by the hospice as 100. These services must nanner consistent with	L 0602	Corrective Actions Hospice Director will ensur the agency provides quality nursing services as directed patient's individualized plan care. All agency Registered Nurses will receive education accurate and complete documentation of wound calincluding obtaining wound measurements on every phassessment, per current standards of practice. Train was initially completed on 12/17/19 and 12/19/19 with	d in the of on on one, ysical ing		

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

Event ID:

51N911

Facility ID: 005829

If continuation sheet

Page 35 of 61

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 151516		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 12/12/2019	
	ROVIDER OR SUPPLIER		2015 J	ADDRESS, CITY, STATE, ZIP COD ACKSON ST RSON, IN 46016	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	Comprehensive Nur 11/15/19 signed by following: " Co- of sacral region, sta; 1 pressure ulcer to t no open areas. Writ and will instruct pt's layer to the area" An agency documer Interdisciplinary Ca signed by Employee " Integumentary S Assess characteristis size, (length, width, During an interview administrator stated	ant titled, "Hospice Initial / rsing Assessment" dated Employee K evidenced the Morbiditiesh. Pressure Ulcer ge 1 Pt (patient) has a stage the coccyx. There are currently ter will order magic butt paste to daughter to apply a think ant titled, "Hospice the Plan" dated 11/15/19 and the K, evidenced the following, teatusIntervention #2: the cost of wound including color, depth), drainage and odor" To on 12/11/19 at 11:23 AM, the the nurses should be weekly at the first visit of the		additional training on 1/28/20 at 1/30/20. Post education, Registered Nurses will demonstrate wound care competency, including the measurement of the wound, purent standards of practice, through teach back to the Clin Manager. Evaluation for compliance Beginning 2/3/2020, Hospice Director and Clinical Manager audit 100% of medical records with wound care interventions weeks for nursing documental that includes wound measurements and interventioner current standard practice. 100% compliance is not achie in 4 weeks, 100% deaths will be audited until compliance is achieved for 4 consecutive weeks.	d e er ical will s for 4 cion ons If ved oe
L 0625		SSIGNMENTS AND			
Bldg. 00	patient by a registe member of the inte Written patient car aide must be prep who is responsible	are assigned to a specific ered nurse that is a erdisciplinary group. The instructions for a hospice ared by a registered nurse a for the supervision of a pecified under paragraph (h)			
	registered nurse fail instructions on the a	riew and interview, the hospice ed to complete written care tide care plan to include the are to be completed for 4 of 13 2, 5, 7, 12).	L 0625	Corrective Action ·Hospice Director will ensure a Registered Nurses receive education and training on completing written patient care instructions for a hospice aide	9

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

Event ID:

51N911

Facility ID: 005829

If continuation sheet

Page 36 of 61

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	LETED
		151516	B. WI	ING		12/12	/2019
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIEF	8			ACKSON ST		
ASCENS	ION AT HOME				SON, IN 46016		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	Findings include:				include frequency and type of		
	Findings include:				tasks to be performed and any specific safety precautions.	/	
	1 An agency polic	y dated 4/1/18 and titled			Education will include a review	v of	
		sessment of the patient,"			policy 5.002 Hospice Aide	V OI	
	_	ed " The hospice RN			Services and policy 5.003 Hos	spice	
	-	evelops and maintains a			Aide Assignments &		
	hospice aide plan or	-			Duties. Training was initially		
	instructions to the h	-			completed on 12/17/19 and		
	patient-specific care	e to be provided"			12/19/19 with additional trainir	ng on	
					1/28/20 and 1/30/20.		
		ord of patient #5 was reviewed			Under the direction of the Clin	ical	
		AM and indicated an Election			Manager, Registered Nurses	will	
		he record contained a plan of			audit and revise 100% of curre	ent	
	care for the benefit	period of 11/15/19-2/12/20.			patients with hospice aide writ	ten	
					instructions to ensure type,		
		de (HHA) careplan dated			frequency of tasks and specifi		
		tasks the aide was to complete:			safety precautions are include	d.	
		e, make bed, mouth care, clean					
		stance with dressing, all which					
		frequency of how often the			Evaluation for compliance		
	tasks were to be con	mpietea.			Beginning 2/03/2020, Hospic		
	2 The climical race	ord of patient #12 was reviewed			Director and Clinical Manager		
		PM and indicated an Election			audit 100% of hospice aide wi		
		ne record contained a plan of			patient care instructions for all new admissions for 4 weeks to		
		period of 9/1/19-12/8/19.			ensure that patient safety	J	
	care for the benefit	period 01 9/1/19-12/0/19.			precautions, type and frequen	cv of	
	The agency docume	ent titled "hospice			tasks are present. If 100%	Oy Oi	
		ve nursing assessment," stated			compliance is not achieved in	4	
	•	theter which required			weeks, 100% admissions will		
		nth and as needed with a 16			audited until compliance is		
		balloon. The home health aide			achieved for 4 consecutive we	eks.	
		ted 9/23/19 indicated the					
		catheter, but failed to evidence					
	tasks for the aide to	complete catheter care or					
	empty the catheter l	bag (which is required for					
	anyone with a cathe	eter).					
	1 1 During an interv	riew on 12/11/19 at 11:34 AM	I				I

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 151516	A. BUILDING <u>00</u> CO		(X3) DATE COMPL 12/12/	ETED	
	PROVIDER OR SUPPLIEF		2	015 JA	DDRESS, CITY, STATE, ZIP COD CKSON ST SON, IN 46016		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PR	D EFIX AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	·ΤΕ	(X5) COMPLETION DATE
L 0626	contain the frequency completed. 5. The clinical record on 12/5/19 and indi 3/29/19. The record the benefit period of the completed Nurse), indicating suring each visit will instruction: Refer the safety precautions and indicate the specific aide care plan to increquired to provide to the benefit period of the p	ated the aide care plan should by that tasks are to be ord of patient #2 was reviewed cated an Election date of discontained a plan of care for f 9/25/19 - 11/23/19. If an "HHA Care Plan" dated by Employee J, RN (Registered ervices the Aide is to provide nich included " Special to patient POC (plan of care) for" the care plan failed to be safety precautions on the discate supplies or equipment this care and prevent harm. For different #7 was reviewed cated an Election date of red contained a plan of care for f 11/22/19 - 2/19/20. If an "HHA Care Plan" dated do by Employee AA, RN, the Aide is to provide during bluded tasks to be performed oral care, lotion, 'clean nails' supper and lower dressing so, and commode. Further, the senced the following: " Refer to patient POC (plan of cautions" the aide care plan the frequency of the specified sety precautions to indicate ent required to provide this rm.					
L 0020		SSIGNMENTS AND					

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

Event ID:

51N911

Facility ID: 005829

9

If continuation sheet Page

Page 38 of 61

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 151516	(X2) MULTIPLE (A. BUILDING B. WING	CONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 12/12/2019	
	PROVIDER OR SUPPLIER		2015 .	ADDRESS, CITY, STATE, ZIP COD JACKSON ST RSON, IN 46016		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
Bldg. 00	(i) Ordered by the (ii) Included in the (iii) Permitted to be law by such hospic (iv) Consistent with Based on observation interview, the hospic services in accordance of 9 records reviewed. An agency policy de "Hospice aide assig 5.003 stated " A hathat are: a. ordered be included in the plant of 4/29/19. The recent the benefit period of care plan contained shampoo to be computing a home visit 12:35 PM, employed personal care to pat shampoo patient's haduring visit. During an interview.	e performed under State ce aide. In the hospice aide training. In the hospice aide provide are for 1 aide with aide services (#4). In the hospice aide plan of care for the hospice aide provides services are the interdisciplinary group an of care" In the hospice aide provides services are the interdisciplinary group an of care and plan of care for the hospice aide plan of care for the hospice aide plan of care and plated at each visit. In the hospice aide training. In the hospice aide aide training. In the hospice aide aide training. In the hospice aide aide aide aide aide aide aide aid	L 0626	Corrective Action Hospice Director will ensure to all hospice aides receive education and training on following the hospice aide written patiencare instructions prepared by RN. Included in the training we education clarifying that the hospice aide provides service that are: (i) Ordered by the interdiscipling group. (ii) Included in the plan of care (iii) Permitted to be performed under State law by such hospicate. (iv) Consistent with the hospication will include a review policy 5.002 Hospice Aide Services and policy 5.003 Hospice Aide Services and policy 5.003 Hospices. Training was initially completed on 12/17/19 and 12/19/19 with additional training 1/28/20 and 1/30/20. Evaluation for compliance Beginning 2/03/2020, Clinica Manager or designee will aud 100% of hospice Aide visit documentation for 4 weeks to validate hospice aide only pro-	owing nt the ill be s nary e l ice ce w of spice Ing on	

PRINTED: 02/03/2020 FORM APPROVED OMB NO. 0938-039

	OF CORRECTION	IDENTIFICATION NUMBER 151516	A. BUILDING B. WING	00	COMPLETED 12/12/2019
	PROVIDER OR SUPPLIER		2015 J	ADDRESS, CITY, STATE, ZIP COD ACKSON ST RSON, IN 46016	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				care as directed in the written patient care instructions prepare by the RN. If 100% compliance not achieved in 4 weeks, audit will continue until compliance achieved for 4 consecutive were Beginning 2/03/2020, Register nurses will perform at least 1 onsite supervisory home visit each hospice aide to observe is following written patient care instructions. Any hospice aided who does not demonstrate compliance with providing care patient care instructions will be reeducated and scheduled for additional onsite RN supervisor visit. Each staff member will be given a maximum of 3 retraining sessions and subsequent ons supervisory visits to demonstrate competency. If competency is achieved after 3 attempts, the hospice aide will be terminate from employment.	e is ts is eeks. ered with aide e e e per e an ory ven ite atte not
L 0648					
Bldg. 00	agency failed to ensure reflected the hospic orientation, coding, quality assurance p (QAPI) was not del contracts were in plutilized to assist the	view and interview, the hospice sure; all contracts in place e's legal name, all staff human resources (HR); erformance improvement egated to another entity; ace if outside sources were e hospice; employee files were spice (See Tag L649); the	L 0648	Corrective Action Hospice Director, in collaborate with a representative of the Governing Body, completed a 100% audit of the agency contracts to ensure vendor contracts for DME, pharmacy, medical reflected the hospice agency's legal name. Audit was completed on 1/16/2020.	and

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

Event ID:

51N911

Facility ID: 005829

If continuation sheet

Page 40 of 61

	VT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 151516	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV A. BUILDING 00 COMPLETED B. WING 12/12/2019		
	PROVIDER OR SUPPLIER		2015 J	ADDRESS, CITY, STATE, ZIP COD IACKSON ST RSON, IN 46016	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	administrator report governing body ass the management of body provided manahospice's quality assimprovement (QAP body appointed the administrator into the proper chain of comorganizational chart control of staff who and over the multip the administrator we received orientation Tag L662). These pemployee files, and the hospice. The cursystemic problem reof compliance with	ted to the governing body; the turned full responsibility for the hospice; the governing agement and oversight of the sessment performance. I) program; the governing administrator and alternate heir positions (See Tag L651); amand on the agency to delineate administrative worked daily in the hospice de site location; staff knew who has (See Tag L658); and staff for specific job duties (See bractices impacted contracts, the day to day functions of amulative effect of this resulted in the agency being out the Condition of Participation reganization/Administration of		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 th governing body on 12/9/19. Governing Body, in collaboration with the Hospi Director, revised the Ascens 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 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 Indicato 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).	ce sion

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

Event ID:

51N911

Facility ID: 005829

If continuation sheet

Page 41 of 61

PRINTED: 02/03/2020 FORM APPROVED OMB NO. 0938-039

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 151516	(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 12/12/2019
	ROVIDER OR SUPPLIE	ER .	2015 J	ADDRESS, CITY, STATE, ZIP C ACKSON ST RSON, IN 46016	COD
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	RECTION (X5) HOULD BE APPROPRIATE COMPLETION DATE
				PIPS and Quarterly Disummary documentate reviewed by the Vishospice Operations, a member of the Govern Body, in collaboration Hospice Director and Director of Hospice. For recommendations for additional PIPs and/o collection to ensure a evaluation of patient of safety was conducted QAPI Committee. Beg 1 2020, VP of Hospice Operations will prese QAPI Committee sum PIPs to the Governing review and approval. 12/9/2019: Governing appointed Administrat QAPI Core group mer the Organizational cobe reviewed and revisaccurately reflect repistructure of Anderson location in Kokomo we completed on 12/17/1 12/19/19 with addition training on 1/28/20 an 1/30/20. Training will complete on 2/3/2020 Effective 12 St. Vincent Hospice-ALC entered into an a with Ascension Health Home, LLC to include	irector ition will P of appointed ning n with Regional Review r data a thorough care and d by the ginning Q ent agency mary and g Body for On Body ator, for, and mbers for tharts will sed to orting n branch vith as initially 9 and hal id be 2/6/2019, Anderson, igreement h at

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

Event ID:

51N911

Facility ID: 005829

If continuation sheet Page 42 of 61

PRINTED: 02/03/2020 FORM APPROVED OMB NO. 0938-039

	OT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 151516	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 12/12/2019
	PROVIDER OR SUPPLIER	?	2015 J	ADDRESS, CITY, STATE, ZIP COD ACKSON ST RSON, IN 46016	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				QA auditing, and education. Hospice Direct with assistance from administrative assistant will audit 100% of employee human resource files for evidence of documentation 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 6.0° Orientation and collaborated and revised the agency process of the ensuring every employeer receives a complete orientation and onboarding upon hire. Regional Director of Hospice and Hospice Director reviewed the agency 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, Hospid Director of Operations will review any new contract's content to ensure the hospid agency legal name is accurately documented prior	or t of r io ess r d ce

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

Event ID:

51N911

Facility ID: 005829

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If continuation sheet

Page 43 of 61

PRINTED: 02/03/2020 FORM APPROVED OMB NO. 0938-039

	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 151516	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 12/12/2019
	ROVIDER OR SUPPLIER	₹	2015 J	ADDRESS, CITY, STATE, ZIP COD ACKSON ST RSON, IN 46016	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	D BE COMPLETION DATE
IAU	REGULATORY OF	X LOC IDENTIFITING INFURMIATION	TAU	Hospice Operations, apple to Governing Body, will a and audit the agency QAC Committee Meeting on 2/4/2020 Agency QAPI Minutes (Quality Indicate PIPS and Quarterly Direct Summary documentation reviewed by the VP of Hooperations, in collaborate with Hospice Director and Regional Director of Hosfor accuracy. Review increcommendations for additional PIPs and/or dacollection to ensure a three valuation of patient care safety was conducted by QAPI Committee the QAI Meeting Minutes (Quality Indicators), PIPS and Quality Indicators), PIPS and Quality Indicators, appointed mof the Governing Body, i collaboration with Hospi Director and Regional PIPs and/or dacollection to ensure a threvaluation of patient care safety was conducted by QAPI Committee Beginn 2020, VP of Hospice Operations and PIPs to the Governing Body for review approval Regional Director and Regional Director and Regional Director and Regional Director API Committee Beginn 2020, VP of Hospice Operations Body for review approval Regional Director approval	deeting ors), etor or ospice etion of ospice etiuded et ata orough er and et arterly ospice etember or oce irector et ata orough er and er ata orough
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FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

51N911

Facility ID: 005829

If continuation sheet Page 44 of 61

PRINTED: 02/03/2020 FORM APPROVED OMB NO. 0938-039

	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 151516	A. BUI B. WIN	LDING	00	COMPL 12/12/	
		131310	B. WIN			12/12/	2019
NAME OF F	ROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD ACKSON ST		
ASCENS	ION AT HOME				RSON, IN 46016		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL	F	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	Hospice, as appointee of		DATE
					governing body, will conduc	t a	
					quarterly review of agency		
					organizational charts with th	е	
					Hospice Director to ensure		
					timely revisions occur to		
					maintain accuracy. Beginnin 2/03/2020, 100% of all new	g	
					employee files will be audite	d	
					after completion of orientation		
					for 3 months to validate that		
					the orientation addressed the	е	
					employee's specific job dution	es.	
					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	í	
					consecutive months, quarter	·ly	
					audits of 25% of all new		
					employee files will be audite	d	
					to monitor continued compliance		
					Compliance		
L 0649	418.100						
Bldg. 00	ORGANIZATION SERVICES	I AND ADMINISTRATION OF					
		t organize, manage, and					
		ources to provide the					
		services to patients,					
	_	milies necessary for the					
	illness and relate	nagement of the terminal					
	miless and relate	a conditions.	L 06	49	Corrective Action		01/16/2020
	Based on record re	view and interview, the hospice	L 00.	7.7	Hospice Director, in		01/10/2020
		contracts in place reflected the			collaboration with a		
		ne and not the corporation for 4			representative of the		
		ewed, all staff orientation,			Governing Body, will comple	te	
	coding, human reso	ources (HR) and quality			a 100% audit of the agency		

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

Event ID:

51N911

Facility ID: 005829

If continuation sheet

Page 45 of 61

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 151516		A. BUILDING <u>00</u> COMPL		(X3) DATE SURVEY COMPLETED 12/12/2019	
	PROVIDER OR SUPPLIEF	2	2015 J	ADDRESS, CITY, STATE, ZIP COD JACKSON ST RSON, IN 46016	_
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR	
	assurance performanot delegated to and were in place if out assist in the hospice managed by the hospital in the forman and were in place if out assist in the hospice managed by the hospital in the durable metal in the	R LSC IDENTIFYING INFORMATION Ince improvement (QAPI) was other entity and contracts side sources were utilized to equipment (page 2). I was reviewed on 12/12/19 edical equipment (DME) I "This vendor agreement is between [entity A] and [entity which were Ascension at Home). I was reviewed on 12/12/19 eand stated "This pharmacy (the "Agreement") is entered in 1, 2015 ("Effective date") by edical entity C]" I was reviewed on 12/12/19 eard stated "This pharmacy (the "Agreement") is entered in 1, 2015 ("Effective date") by edical entity C]" I was reviewed on 12/12/19 eare and lospice agencies in the agreement was between the (Neither of which were the entity and contracts the entity of th	PREFIX TAG	contracts to ensure vendor contracts for DME, pharmac medical supplies and accurately reflected the hospice agency's legal name. Audit was completed 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-28b6-4440-051516ebb384}{60}"> Evidence of compliance Effective immediately, Hospid Director or the Regional Director of Coperations will review any new contract's content to ensiste hospice agency legal nar accurately documented prior obtaining signature.	COMPLETION DATE Cy, i on 624-a8 ce ctor csure me is
		she did quality assurance for			

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

Event ID:

51N911

Facility ID: 005829

If continuation sheet

Page 46 of 61

PRINTED: 02/03/2020 FORM APPROVED OMB NO. 0938-039

		IDENTIFICATION NUMBER 151516	A. BU	a. BUILDING 00 COMPLETED b. WING 12/12/2019			ETED
	ROVIDER OR SUPPLIER			2015 JA	DDRESS, CITY, STATE, ZIP COD CKSON ST		
(X4) ID	ION AT HOME SUMMARY S	STATEMENT OF DEFICIENCIE		ID	SON, IN 46016		(X5)
PREFIX TAG	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION DATE
	Indiana, and was a remployed by the hos	national employee not spice.					
	administrator stated educator, coders, an employees and not of the administrator was were that signed the assessments and pla coders and quality a sign the documents employees. She also contract was in place educator and HR was she stated that new orientation, home he there for 1-2 days and days. They complete contains HR docume equipment, and come	on 12/3/19 at 4:17 PM, the that all QAPI staff, the d HR are all national on the hospice's employee list. The sa asked who the employees bottom of the comprehensive in of care. She stated the surance team review and and are all corporate of stated she did not know if a see. She stated that the ere located in Indianapolis. The hires go to Indianapolis for ealth aides (HHA) are typically and skilled nurses usually 2-3 are a general orientation that ents, computer system, obtain uplete relias training. She contract in place with					
	employee D stated s	on 12/3/19 at 4:56 PM, he was part of the national employed by the hospice.					
L 0651 Bldg. 00	A governing body functioning) assum responsibility for the hospice, the provisits fiscal operations assessment and page 4 qualified administrations to the go	DY AND ADMINISTRATOR (or designated persons so nes full legal authority and ne management of the sion of all hospice services, s, and continuous quality erformance improvement. strator appointed by and verning body is responsible operation of the hospice.					

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

Event ID:

51N911

Facility ID: 005829

If continuation sheet

Page 47 of 61

PRINTED: 02/03/2020 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES						OM	B NO. 0938-039
	ENT OF DEFICIENCIES IN OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 151516	A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 12/12/2019	
	F PROVIDER OR SUPPLIER			2015 J	ADDRESS, CITY, STATE, ZIP COD ACKSON ST RSON, IN 46016		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
	employee and pose experience require governing body. Based on record reversal failed to ensure the governing body, the responsibility for the the governing body oversight of the host performance improve the governing body and alternate adminal of 1 agency. Findings include: During review of a PM titled "hospice chart," updated 11/document was a concontain any staff entorganizational chart top to bottom: "SVI Chief operating offit operations which be regional director (for Alabama, Michigand directors. Also brain regional director was assurance, administ assurance nurses, coordinators (all froeducation, and cliniform different states.) The agency provide revised 12/2019 for	seess education and ed by the hospice's view and interview, the hospice administrator reported to the e governing body assumed full the management of the hospice, provided management and spice's quality assessment extraction (QAPI) program, and appointed the administrator istrator into their positions for document on 12/2/19 at 12:48 service line organization 19/19, it was noted the reporate structure and did not apployed by the hospice. The tadelineated the structure from P'' [sic] Home care services, iteer, vice president hospice aranched to the hospice or Indiana, Texas, Oklahoma, a, and Wisconsin) then agency inched from the hospice as the director of quality rative assistant, quality or ders, and quality of the different states), manager of called aducation specialists (all	L 06		Corrective Action Administrator for agency was appointed by the governing be on 12/9/19. Governing Body, in collaboration with the Hospi Director, revised the Ascens 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) demonstrating improved performance, oversight of contracted services, QAPI Meeting documentation standards to ensure agency analyzes and tracks quality indicator data, QAPI Meetings with timeline for Hospice Director to submit meeting minutes and PIPs summary to the Governing Body. QAPI Quality Indicator 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	ce sion	01/28/2020

[Indiana] Hospice." The organizational chart

Program-Hospice Service Line

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 12/12/2019 151516 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 2015 JACKSON ST ANDERSON, IN 46016 ASCENSION AT HOME (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE delineated the structure from top to bottom: Vice (revised 1/17/2020) revised in President of hospice operations, regional director collaboration with the of operations (whom marketers and administrator Governing Body to accurately answer to), and director of hospice (administrator) reflect the new QAPI program who all remaining staff report to. The organziation for Hospice Service Line.; ; chart failed to indicate the Administrator reports ¿ Director received training on to the Governing Body of this agency. revised QAPI program from member of the governing body Pre-survey information from the Indiana State on 1/22/2020. The revised Department of Health (ISDH) indicated the **Hospice Quality Assessment** administrator effective date of position was **Performance Improvement** 3/12/19. (QAPI) Program and Hospice **Operations Policy Manual were** Governing body meeting minutes from 12/9/19 approved by the governing (during survey) employees Q, R, S, T, U, and V body on 01/28/2020. The attended. The minutes reflected "... Appointment governing body also appointed of new board members [employees Q, R, V] the Regional Director of Approval of additional board members was Operations, to whom the unanimous ... appointment of hospice agency Administrator reports, to the directors, medical directors, supervising nurses governing body on 01/28/2020. including alternates, as well as interdisciplinary **Evaluation for compliance** core groups. A listing of these positions at each VP of Hospice Operations, location was provided and reviewed. ... The 2020 appointee to Governing Body, will quality assessment and performance improvement attend and audit the agency QAPI plan (QAPI) for hospice was presented and Committee Meeting, including the reviewed " Attached to the minutes of the Hospice Director performance as meeting were the leadership and interdisciplinary the QAPI chairperson. Agency group (IDG) members for all hospice agencies in QAPI Meeting Minutes (Quality Indiana, Alabama, Michigan, Oklahoma, Texas, Indicators), PIPS and Quarterly and Wisconsin that were approved during the Director Summary documentation meeting. The Governing Body failed to ensure the reviewed by the VP of Hospice appointment of the administrator was prior to the Operations, in collaboration with administrator starting in the position, failed to Hospice Director and Regional ensure the appointments of agency directors, Director of Hospice for accuracy. supervising nurses/ alternates, and Review inclusive of interdisciplinary core groups were completed prior recommendations for Performance to survey and prior to starting positions, and the Improvement Project revisions Governing Body minutes failed to delineated from where indicated. other agencies and states and failed to exclusive Beginning Q 1 2020, VP of to this agency. Hospice Operations will present

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

Event ID:

51N911

Facility ID: 005829

If continuation sheet

Page 49 of 61

EPARTMENT OF HEALTH AND HUMAN SERVICES							
CENTERS FOR MEDICARE & MEDICA	AID SERVICES						
STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION					

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 151516	(X2) MULTIPLE A. BUILDING B. WING	OO OO	(X3) DATE COMPI 12/12	LETED
	PROVIDER OR SUPPLIEF	2	2015	T ADDRESS, CITY, STATE, ZIP COD JACKSON ST ERSON, IN 46016		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPI DEFICIENCY)	TION LD BE ROPRIATE	(X5) COMPLETION DATE
	_	on 12/2/19 at 3:50 PM, the I she reported to employee H		agency QAPI Committee summary and PIPs to the Governing Body for revie approval	;	
	employee C stated so Indiana, was a national employees employee list. During an interviewe employee D stated team, not employee C was as approved the data to "I'm guessing yes," QAPI is given to employeed in the development of QAPI had had the greater would be ran throug who the QAPI team	ov on 12/3/19 at 4:17 PM, the I that all QAPI staff, the and human resources are all and not on the hospice's ov on 12/3/19 at 4:56 PM, she was part of the national				

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

Event ID:

51N911

Facility ID: 005829

If continuation sheet

Page 50 of 61

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 151516		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 12/12/2019	
	ROVIDER OR SUPPLIER		-	2015 J	ADDRESS, CITY, STATE, ZIP COD ACKSON ST RSON, IN 46016		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
L 0658 Bldg. 00	member from spiritive bereavement, and voluming an interview administrator was a appointed into her purchought she was a contained in the high structure and in purchought she was a contained in the hospice and over and failed to delineate purche agency organizary administrative control the hospice and over and failed to ensure administrator was for the purchought she purchought she was a contained in the purchought she purchou	ual care, social work, olunteer. y on 12/11/19 at 1:20 PM the sked if she had been position. She stated that she pointed locally by employees not find it. She also stated pody just appointed all the meeting on 12/9/19 PLE LOCATIONS athority, and professional econtrol must be clearly prospice's organizational fractice, and must be traced to issued the certification The wand interview, the agency proper chain of command on attional chart to delineate tool of staff who worked daily in the multiple site location, staff knew who the	LO		Corrective Action: On 12/9/2019: Governing Body appointed Administrator Alternate Administrator, and O 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. Tra was initially completed on 12/17/19 and 12/19/19 with additional training on 1/28/20 1/30/20. Training will be complete on 2/3/2020 Effective 12/6/2019, St. Vince Hospice-Anderson, LLC enter into an agreement with Ascen Health at Home, LLC to include	ining and ent red ision	02/03/2020
	-	or Indiana Texas Oklahoma			coding OA auditing and		

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

Event ID:

51N911

Facility ID: 005829

If continuation sheet

Page 51 of 61

PRINTED: 02/03/2020 FORM APPROVED OMB NO. 0938-039

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 151516		(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 12/12/2019
	PROVIDER OR SUPPLIER		2015 .	ADDRESS, CITY, STATE, ZIP COD JACKSON ST RSON, IN 46016	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROI DEFICIENCY)	(X5) BE COMPLETION DATE
TAG	Alabama, Michigan directors. Also brai regional director wa assurance, administ assurance nurses, or coordinators (all froeducation, and clini from different states). The agency then prochart revised 12/20/12/2/19 at 3:50 PM [Indiana] Hospice." delineated the struct President of hospice of operations (whor answer to), and dire who all remaining sorganizational chart site location and the within it, and failed performance improvitraining staff. During an interview employee P stated thospice was employ administrator of the employee F did not was. During an interview employee F did not was.	, and Wisconsin) then agency nehed from the hospice as the director of quality rative assistant, quality oders, and quality of ders, and quality of derivative and administrator ctor of hospice (administrator)	TAG	education. Evidence of compliance Regional Director of Hospi appointee of governing bod conduct a quarterly review agency organizational char the Hospice Director to ens timely revisions occur to ma accuracy.	ce, as ly, will of ts with ure
	educator, coders, an	d human resources are all and not on the hospice's			
L 0662 Bldg. 00	418.100(g)(2) TRAINING (2) A hospice mus	t provide an initial			

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

Event ID:

51N911

Facility ID: 005829

If continuation sheet

Page 52 of 61

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u>			COMPLETED	
		151516	B. WING 12/12/2019			/2019		
				STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>		
NAME OF F	PROVIDER OR SUPPLIEF	8			ACKSON ST			
ASCENS	ION AT HOME				RSON, IN 46016			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
		ch employee that addresses						
	the employee's sp	ecific job duties.						
			L 00	662	Corrective Action		02/03/2020	
		view and interview, the hospice			Hospice Director with assista			
	_	initial orientation for each			from administrative assistant v			
		job duties for 3 of 4 employee			audit 100% of employee huma	an		
	files reviewed (A, F	3, N).			resource files for evidence of			
					documentation of orientation.			
	Findings include:				Incomplete orientation records			
	1.5.	6 1 61 104140			be updated to ensure accurate			
	_	f employee files on 12/11/19,			record of training and education	on to		
		mployees included employee			job.			
		ate of hire 6/28/10. The			Director of Hospice and Hospi			
		to evidence an orientation to			Director reviewed policy 6.010)		
	the role of administ	rator.			Regional Orientation and			
	D	dian Carry day In Italiana Charles			collaborated and revised the			
		tion from the Indiana State			agency process for ensuring e			
		Ith (ISDH) indicated the			employee receives a complet			
	3/12/19.	tive date in that position was			orientation and onboarding up	on		
	3/12/19.				hire.	d		
	An orientation as st	aff registered nurse was			Regional Director of Hospice			
	signed completed o	_			Hospice Director reviewed the			
	aigneu compicieu o	11 // 2J/ 1U.			agency Director job specific responsibilities and provided			
	A general orientation	on containing policy review			training on QAPI, budgeting,			
		e items checklist was signed			overseeing hospice multiple			
	by the administrator				locations, emergency			
	of the administrator	- 011 10/0/10.			preparedness. Corrective			
	2. During review o	f employee files on 12/11/19,			Action			
	_	nployees included employee B,			Evaluation for compliance			
		ator, date of hire 10/22/18. The			Beginning 2/03/2020, 100% or	f all		
		I to evidence an orientation to			new employee files will be aud			
	her job duties.				after completion of orientation			
	. J				months to validate that the			
	A hospice orientation	on was partially completed and			orientation addressed the			
		ipline specific checklist," it			employee's specific job duties	. If		
		" The orientation form failed to			100% compliance is not achie			
	1	yee B or the human resources			in 3 months, audits will continu			
	representative.				until compliance is achieved for			
	P				consecutive months	-	1	

AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER 151516		ľ	JILDING	onstruction 00	(X3) DATE COMPL 12/12 /	ETED	
NAME OF PROVIDER OR SUPPLIER ASCENSION AT HOME		STREET ADDRESS, CITY, STATE, ZIP COD 2015 JACKSON ST ANDERSON, IN 46016					
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	the list of current er N, registered nurse, employee file failed her job duties.	f employee files on 12/11/19, mployees included employee date of hire 10/15/18. The I to evidence an orientation to on containing policy review			Once 100% compliance is achieved for 3 consecutive months, quarterly audits of 25 all new employee files will be audited to monitor continued compliance.	% of	
	-	e items checklist was signed					
	~	iew on 12/11/19 at 4:27 PM, the she never had an orientation histrator.					
L 0666	418.102(a) MEDICAL DIREC	TOR CONTRACT					
Bldg. 00	(1) A hospice may following- (i) A self-employed (ii) A physician em entity or physician When contracting services, the contraction	d physician; or apployed by a professional so group. for medical director ract must specify the sumes the medical director					
	Based on record reversal failed to ensure one the hospice medical responsibility for the hospice, that the medical designee contracts of designee to act as the event of the medical all physician contra	view and interview, the hospice physician was contracted as director to assume to medical component of the edical director and physician specified the physician are medical director in the directors absence, and that cets reflected the legal name of 3 physician contracts	L 00	666	Corrective Action Hospice Director educated Medical Director and Hospice Physician on job description and delineation of responsibilities using the NHP Physician compliance training guide, completed on 1/30/2020 The Hospice Director will collaborate with contracting services and legal department revise Medical Director and hospice physician employmen contracts to include delineation job responsibilities of each	job CO 0. to	02/03/2020

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

Event ID:

51N911

Facility ID: 005829

If continuation sheet Page 54 of 61

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u>			ETED	
		151516	B. WING			12/12/2019		
				CTREET A	ADDRESS CITY STATE ZID COD	<u> </u>		
NAME OF P	ROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD			
ACCENIC	ION AT LIONE							
ASCENS	ION AT HOME			ANDER	SON, IN 46016			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	The agency medical	l director contract was			position, including organization	nal		
	reviewed on 12/12/2	19 and stated "this medical			reporting structure. Medical			
	director agreement	for hospice services			Director and hospice physicial	n will		
	("Agreement") is en	ntered into by and between			sign revised and compliant			
	[entity I] and emplo	oyee E 3.1 On an as needed			employment contract no later			
	basis physician sl	hall provide medical direction			than 02/03/2020.			
		I serve as the medical director			Evaluation for compliance			
		us name of multiple site			Beginning 2/03/2020, Hospic	e l		
	. , , .,	term of this agreement shall			Director and Regional Director			
	_	2, 2012. This agreement shall			Hospice will audit 100% of all			
		ntil terminated upon thirty (30)			medical director and hospice			
	days written notice	by either [entity I] or			physician files to validate			
	physician, or as other	erwise terminated as provided			presence of signed employme	ent		
		ospice medical director is			agreement which includes			
		overall medical direction of the			description of duties and repo	rting		
	-	"The contract failed to be			structure. Audits will continue	_		
		gal name of the hospice, reflect			until 100% compliance.			
		the hospice as a whole and not			Hospice Director will meet at I	_{east}		
		e, and designate the physician			monthly with Medical Director			
		nedical director in the even of			review agency clinical outcom			
	the medical director				physician service needs,			
					physician scheduling and staff	f		
	The agency hospice	e physician agreement was			education needs.	.		
		19 and stated "This agreement						
		e 15 th day of August, 2018, by						
		K], an Indiana limited liability						
		er referred to as [entity L] and						
		nedule 2.01A Designated						
		mployee F] Responsibilities						
	-	e responsibility for the medical						
		rogram, oversee the palliation						
		the terminal illness and						
	-	o the terminal illness of						
		id ensure that the medical						
		atients are being met" The						
		e updated with the legal name						
		· -						
	-	d to ensure the duties were						
		cal director, and failed to						
		ian as the physician designee						
	to act as medical dii	rector if the medical director						

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

Event ID:

51N911

Facility ID: 005829

If continuation sheet

Page 55 of 61

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 151516		(X2) MUL A. BUIL B. WINC	DING	nstruction 00	(X3) DATE S COMPL 12/12/	ETED	
	ROVIDER OR SUPPLIER			2015 JA	DDRESS, CITY, STATE, ZIP COD CKSON ST SON, IN 46016		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	PR	ID REFIX FAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION DATE
IAG	was unavailable. The agency hospice reviewed on 12/12/is effective as of the and between [entity company, hereinafte [employee G]Sch medical director [er Direct and assum component of the program patients an needs of program patients an needs of program patients and not that of the medical director [er Direct and assum component of the program patients and management of conditions related to program patients and needs of program patients and needs of program patients and the hospice and for the hospice and for the hospice and for the medical directory in the program patients are contract failed to be of the hospice and for the hospice and for the hospice and for the medical directory in the program patients are contract failed to be of the hospice and for the medical directory in the program patients are contract failed to be of the hospice and for the medical directory in the program patients are contract failed to be of the hospice and for the medical directory in the program patients are contract failed to be of the hospice and for the medical directory in the program patients are contracted as a program patients are contrac	physician agreement was 19 and stated "This agreement 24 th day of July, 2018, by K], an Indiana limited liability er referred to as [entity L] and redule 2.01A designated apployee G] Responsibilities e responsibility for the medical rogram, oversee the palliation of the terminal illness and to the terminal illness of densure that the medical ratients are being met" The regulated with the legal name railed to ensure the duties were		IAG	BACEACT		DATE
L 0668 Bldg. 00	ILLNESS Before the recertif patient, as describ medical director or review the patient	DN OF THE TERMINAL ication period for each sed in §418.21(a), the r physician designee must s clinical information.	L 066	8	Corrective Action		02/03/2020
	Based on record rev	view and interview, the hopice			Hospice Director, Clinical Man	ager	

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

Event ID:

51N911 Facility ID: 005829

If continuation sheet Page 56 of 61

X3) DATE SURVEY STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 12/12/2019 151516 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 2015 JACKSON ST ANDERSON, IN 46016 ASCENSION AT HOME (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE failed to follow their policy to ensure that a verbal and Medical Director to review the recertification of terminal illness (RTI) was IDG process for obtaining timely obtained within 2 calendar days of the new benefit written recertifications, including period for 1 of 4 recertification records reviewed the regulations for obtaining a (#11).verbal certification if needed. Education to include process Findings include: guide HO IDG Process. Training was initially completed on An agency policy dated 4/01/18 and titled 12/17/19 and 12/19/19 with "Recertification of terminal illness,"Policy# 2.004 additional training on 1/28/20 and stated "... If the hospice medical director or 1/30/20. Training will hospice physician does not sign and date the be complete on 2/3/2020 recertification of terminal illness form within two days of the start of the new benefit period (by the **Evaluation for compliance** end of the third day), a verbal recertification is Beginning 2/03/2020, Hospice obtained from the hospice physician which may Director and Clinical Manager will be obtained up to 15 days prior to the start of the audit 100% of recertifications for 6 new benefit or within two daysof the start of the weeks to validate that the medical new benefit period and is documented in the director or physician designee patient's clinical record" have reviewed the patient's clinical information and a verbal The clinical record of patient #11 was reviewed on recertification was obtained within 12/10/19 at 1:16 PM and indicated an Election date the timeframe of 15 days prior or 2 of 2/13/19. The record contained a plan of care for day before the start of the new the benefit period of 10/11/19-12/9/19. The benefit period. If 100% agency document titled "Physician face to face compliance is not achieved in 8 encounter/ recertification of terminal illness weeks, audits will continue until 60-day periods," for the benefit period compliance is achieved for 6 10/11/19-12/9/19 stated the nurse practitioner consecutive weeks. completed the face to face on patient #11 on Once 100% compliance is 9/17/19. The document was signed by the medical achieved for 8 consecutive weeks, director on 11/2/19 (22 days after the start of the 25% of recertifications will be benefit period). The record failed to evidence a audited quarterly to monitor verbal recertification of terminal illness. continued compliance. 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.

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

Event ID:

51N911

Facility ID: 005829

If continuation sheet

Page 57 of 61

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 12/12/2019 151516 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 2015 JACKSON ST ASCENSION AT HOME ANDERSON, IN 46016 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE L 0687 418.106 DRUGS BIOLOGICALS MEDICAL Bldg. 00 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. L 0687 **Corrective Action** 01/30/2020 Based on record review and interview, the hospice Registered Nurses will be failed to ensure drugs and medical supplies educated on compliant related to the terminal illness was covered under documentation of hospice covered the hospice benefit for 3 of 13 records reviewed DME, medications, supplies and (#3, 9, 12).biologicals on the plan of care to ensure services are identified as Findings include: being covered by the hospice benefit. Education will include: 1. The clinical record of patient #3 was reviewed review policy 6.007 Scope of on 12/3/19 at 11:51 AM and indicated an Election Services, policy 7.002 Plan of date of 11/26/19. The record contained a plan of Care, 8.002 Medication Profile and care for the benefit period of 11/26/19-2/23/20 hospice process guide HO which indicated a primary hospice diagnosis of Nursing Minimum Documentation chronic obstructive pulmonary disease (COPD). Requirements. Training was An agency document titled "hospice medication initially completed on 12/17/19 profile," listed spiriva handihaler and symbicort and 12/19/19 with additional inhalation (both respiratory inhalers). The training completed on 1/28/20 and document failed to evidence that the spiriva and 1/30/20 symbicort were covered under the hospice benefit Under the direction of the Clinical as they were related to the hospice diagnosis. Manager, Registered Nurses will audit and revise 100% of current During an interview on 12/12/19 between 11:30 patient plan of care to ensure that AM-1:35 PM, the administrator stated the spiriva DME, supplies, medications and and symbicort should be marked as covered. biologicals are accurately identified as being covered by the 2. The clinical record of patient #9 was reviewed hospice. on 12/3/19 at 12:30 PM and indicated an Election

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

Event ID:

51N911

Facility ID: 005829

If continuation sheet

Page 58 of 61

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED	
151516		B. WING		12/12/2019		
NAME OF P	PROVIDER OR SUPPLIEF	3		F ADDRESS, CITY, STATE, ZIP COD JACKSON ST		
ASCENS	ION AT HOME			ERSON, IN 46016		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION	TAG		DATE	
		record contained a plan of		Evaluation for compliance		
		period of 1/14/19-4/13/19 rimary hospice diagnosis of		Beginning 2/3/2020, 100% of		
	-	gency document titled		admissions will be audited for 8 weeks to validate that		
		n profile," listed zofran as a		medications and supplies rela	ated	
	_	sea/vomiting). The document		to hospice diagnosis are cover		
	· ·	hat the zofran was covered		If 100% compliance is not	Sicu.	
		enefit as it was related to the		achieved in 8 weeks, audits v	vill	
	hospice diagnosis.			continue until compliance is		
				achieved for 8 consecutive w	eeks.	
	During an interview	v on 12/12/19 between 11:30		Once 100% compliance is		
	AM-1:35 PM, the a	dministrator stated "Zofran		achieved for 8 consecutive w	eeks,	
	should be covered."	•		25% of admissions will be au	dited	
				quarterly to monitor continued	d	
		ord of patient #12 was reviewed		compliance.		
		PM and indicated an Election		br>		
		ne record contained a plan of				
		period of 9/1/19-12/8/19 which				
		the skilled nurse to complete				
		ery month and as needed with liliter balloon. The hospice				
		/10/19 failed to evidence any				
		e would be covering for				
	patient #12.	e would be covering for				
	-	riew on 12/12/19 between 11:30				
		dministrator stated patient #12				
		admission but it was				
		ne point, but while in the				
		ould have been listed on the				
	plan of care and wo	ouid de covered.				
L 0781	418.112(e)(3)					
	COORDINATION	OF SERVICES				
Bldg. 00	The hospice must					
	•	NF/NF or ICF/MR with the				
	following informati	ion:				
		nt hospice plan of care				
	specific to each pa					
	(ii) Hospice election	on form and any advance				

02/03/2020 PRINTED: FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 12/12/2019 151516 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 2015 JACKSON ST ASCENSION AT HOME ANDERSON, IN 46016 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE directives specific to each patient; (iii) Physician certification and recertification of the terminal illness specific to each (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. L 0781 02/03/2020 Corrective action Based on record review and interview, the hospice Under the direction of the Hospice failed to ensure skilled nursing facility (SNF) Director and Clinical Manager, binders contained the most recent hospice plan of Registered Nurses will audit and care and medication list for 1 of 2 SNF binders update as needed 100% of LTC observed (#4). patient forms binders to ensure that each contains the following: Findings include: (i) The most recent hospice plan of care specific to each patient; (ii) The clinical record of patient #4 was reviewed on Hospice election form and any 12/3/19 at 1:57 PM and indicated an Election date advance directives specific to each of 4/29/19. The record contained a plan of care for patient; (iii) Physician certification the benefit period of 10/26/19-12/24/19. and recertification of the terminal Interdisciplinary group (IDG) meetings were held illness specific to each patient; (iv) on 10/31/19, 11/14/19, 11/21/19, and 12/5/19 in Names and contact information for which careplan updates were completed. The SNF hospice personnel involved in binder contained the last plan of care dated hospice care of each patient; (v) 11/1/19. The binder failed to evidence the care Instructions on how to access the plan from the 11/21/19 IDG meeting. hospice's 24-hour on-call system; (vi) Hospice medication During an interview on 12/11/19 at 11:17 AM, the information specific to each administrator stated the hospice binders in the patient; an (vii) Hospice physician facilities are updated every 2 weeks and contain and attending physician. the most recent careplan, medication list and the LTC patient forms will be updated recent notes for the disciplines. following IDG meetings and at least every 14 days or more

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

Event ID:

51N911

Facility ID: 005829

If continuation sheet

Page 60 of 61

PRINTED: 02/03/2020 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 151516	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 12/12/2019	
	PROVIDER OR SUPPLIE	R	2015 J	ADDRESS, CITY, STATE, ZIP COD ACKSON ST RSON, IN 46016		
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(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 mont 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.	on by hly ided	

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 51N911 Facility ID: 005829 If continuation sheet Page 61 of 61