PRINTED: 08/17/2021 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR BUPPLIER CENTER FOR HOSPICE AND PALLIATIVE CARE INC, THE SITECT ADDRESS, CITY, STATE, 2IP CODE 91 COMPORT PLACE MISHAWAKA, IN 46545 SIMBLAY STATE, 2IP CODE 92 COMPORT PLACE MISHAWAKA, IN 46545 DIPPERIX 1AG SIMBLAY STATE, 2IP CODE 93 COMPORT PLACE MISHAWAKA, IN 46545 DIPPERIX 1AG PREPRIX 1AG REGULATORY OR ISC IDENTIFYING INFORMATION) At this Emergency Preparadness survey, the Center for Hospice and Palliative Care Inc. was found to be in compliance with 42 CFR 4 18, 113 Emergency Preparadness requirements for Medicare participating Providers and Suppliers for Hospice agencies. Survey Dates: June 28, 29, 30 and July 1, 2, 5, 6, 7, 8, 12 and 13, 2021 Facility Number: 055934 Provider Number: 151501 Census: 321 Loo0 Initial Comments Loo0 At this Emergency Preparadness requirements for Medicare participating Providers and Suppliers for Hospice agencies. Survey Dates: June 28, 29, 30 and July 1, 2, 5, 6, 7, 8, 12 and 13, 2021 Facility Number: 055934 Provider Number: 055934 Provider Number: 151501 Current Census: 321 Unduplicated Census last 12 months: 1826 ABORATORY DIRECTORS OF PROVERSURPLES REPRESENTATIVES SIGNATURE STITLE ADDRESS, CITY, STATE, 2IP CODE MISHAWAKA, IN 46545 MISHAWAKA, IN 46545 STATE TAGOE MISHAWAKA, IN 46545 DIPPERIX TAGO PROVIDER PROVIDERS SIGNATURE STATE TAGOE MISHAWAKA, IN 46545 DIPPERIX TAGOE MISHAWAKA, IN 46545 DI		OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION		(X3) DATE COMP	SURVEY PLETED
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PREFIX TAG REGULATORY OR LSG IDENTIFYING INFORMATION) E 000 Initial Comments At this Emergency Preparedness survey, the Center for Hospice and Palliative Care Inc. was found to be in compliance with 42 CFR 418.113 Emergency Preparedness requirements for Medicare participating Providers and Suppliers for Hospice agencies. Survey Dates: June 28, 29, 30 and July 1, 2, 5, 6, 7, 8, 12 and 13, 2021 Facility Number: 005934 Provider Number: 151501 Census: 321 L 000 This visit was for a Federal hospice Recertification survey. Survey Dates: June 28, 29, and 30, and July 1, 2, 5, 6, 7, 8, 12, and 13, 2021 Facility Number: 005934 Provider Number: 151501 Current Census: 321 Unduplicated Census last 12 months: 1826			LIATIVE CARE INC, THE		501 COMFORT PLACE	/DE		
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2, 5, 6, 7, 8, 12, and 13, 2021 Facility Number: 005934 Provider Number: 151501 Current Census: 321 Unduplicated Census last 12 months: 1826 Quality Review Completed 08/17/2021 INITIAL ASSESSMENT CFR(s): 418.54(a)			The state of the s					
Provider Number: 151501 Current Census: 321 Unduplicated Census last 12 months: 1826 Quality Review Completed 08/17/2021 INITIAL ASSESSMENT CFR(s): 418.54(a)								
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Unduplicated Census last 12 months: 1826 Quality Review Completed 08/17/2021 INITIAL ASSESSMENT CFR(s): 418.54(a) L 522		Provider Number: 15	1501					
Quality Review Completed 08/17/2021 L 522 INITIAL ASSESSMENT		Current Census: 321						
L 522 INITIAL ASSESSMENT L 522 CFR(s): 418.54(a)		Unduplicated Census	a last 12 months: 1826					
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

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

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED			
		151501	B. WING _			7/13/2021		
	OR HOSPICE AND PA	LLIATIVE CARE INC, THE		STREET ADDRESS, CITY, STATE, ZIP CODE 501 COMFORT PLACE MISHAWAKA, IN 46545	·			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORR ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE		
L 522	Continued From pag	ge 1	L	522				
	initial assessment welection of hospice of §418.24 is completed patient, or represent assessment be common This STANDARD is Based on record rehospice agency failed assessment was conthe election of hospic clinical records revied Findings include: 1. Review of an age titled "Hospice Medicaid Benefit Elegiven will include" 2. Review of an age titled "Initial Assessment is done information necessarium Primary Caregiver" assessment is done information necessarium eliate needs ar hospice Registered patient election of the #2, start of care 6/26/28/21 - 9/25/21, pkidney disease stag	ency policy dated 5/2021, care Benefit & Hospice ection" stated " information effective date of the election ency policy dated 5/2021, ment of Patient, Family,						
	Hospice Benefit" da	ted 6/25/202. This agency I choose to elect the						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDI			(X3) DATE SURVEY COMPLETED		
		151501	B. WING _			07	/13/2021
	ROVIDER OR SUPPLIER FOR HOSPICE AND PAI	LIATIVE CARE INC, THE		501 C	ET ADDRESS, CITY, STATE, ZIP CODE COMFORT PLACE HAWAKA, IN 46545	,	
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L 522	Continued From page 2		L	522			
	6/25/2021"	e benefit date w evidenced an agency					
	document titled "Skil 6/28/2021 and signe This agency docume type Hospice Init visit 6/28/2021 . evidence the hospice	wevidenced an agency led Nursing Visit Note" dated ad by RN [registered nurse] T. ent stated " assessment tial Assessment date of" This document failed to e agency completed the initial 8 hours of the patient's					
	when queried why the signed and dated 6/2 (initial assessment) vice president/chief the agency would have representative or nupatient/family and has signed. The start of the signed and the signed are signed and the signed are signed.						
	#4, start of care 6/8/6/8/2021 - 9/5/2021, atherosclerosis, evic titled "Notice of Elec 6/5/2021 and signed U. This agency doc	view on 7/6/2021 for patient 2021, certification period primary diagnosis of cerebral lenced an agency document tion of Hospice Benefit" dated by admission representative ument stated I [patient #4] ne Medicare hospice 6/5/2021"					
	document titled "Skil	w evidenced an agency lled Nursing Visit Note" dated l by RN V. This agency					

l ' '		IDENTIFICATION NUMBER		PLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED	
		151501	B. WING _			07/13/2021
	ROVIDER OR SUPPLIER FOR HOSPICE AND PAL	LIATIVE CARE INC, THE		STREET ADDRESS, CITY, STATE, Z 501 COMFORT PLACE MISHAWAKA, IN 46545	IP CODE	
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L 522	Initial Assessment This document failed of the initial assessm patient's election of h	assessment type Hospice date of visit 6/8/2021" to evidence the completion ent within 48 hours of	L 5	22		
L 533	when queried why the signed and dated 6/5 (initial assessment) we president/chief operatives the agency's prehad been made on 7, with the agency.	e election of benefit was /2021 and start of care	L 5	33		
	must be accomplished interdisciplinary group individual's attending consider changes that initial assessment. It the patient's progress as well as a reassess response to care. The be accomplished as the interdisciplinary interdisciplinary group in the accomplished as the interdisciplinary group in the interdisciplinary group in the interdisciplinary group in the interdisciplinary group in the interdisciplinary group individual's attending to the interdisciplinary group gro	o (in collaboration with the physician, if any) and must at have taken place since the must include information on a toward desired outcomes,				
	Based on record rev hospice failed to ensi team) updated the co include the patient's p	not met as evidenced by: iew and interview, the ure the IDT (interdisciplinary imprehensive assessment to progress and outcomes to in 7 of 22 clinical records 9, 11, 17).				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		151501	B. WING		07/13/2021	
	ROVIDER OR SUPPLIER FOR HOSPICE AND PA	LLIATIVE CARE INC, THE		STREET ADDRESS, CITY, STATE, ZIP CODE 501 COMFORT PLACE MISHAWAKA, IN 46545		
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L 533	titled "Comprehensistated" comprehe will be conducted by collaboration/consulattending/primary plany). Updates to the will consider all chathe initial assessme outcomes, and respIDT" 2. Record review for on 6/28/21, start of	ency policy dated 5/2021, ive Assessment of the Patient" ensive assessment updates	L 53:	3		
	of Acute on chronic diastolic heart failur titled "Hospice Currbenefit period 6/23/of care stated " g patient will have infedecision making The plan of care fail progress toward the	combined systolic and e, evidenced a document ent Plan of Care - 7/1/2021" 2021 - 9/20/2021. This plan oals SN [skilled nurse]: ormation necessary for target date: 4/12/2021" led to evidence an update of				
	#3, start of care dat 6/18/2021-9/15/202 atherosclerosis, evittled "Hospice Plan signed by RN (regis director E. This agg goals chaplain spiritual needs met MSW [medical socia [caregiver] will have appropriately tar	e 3/20/2021, benefit period 11, primary diagnosis cerebral denced an agency document of Care" dated 6/16/2021 and stered nurse) W and medical ency document stated " patient and family will have target date: 6/17/2021 al worker] family/CG e mechanisms to cope get date: 6/17/2021" The co evidence an update of				

AND PLAN OF CORRECTION IDENTIFICATION N		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		151501	B. WING		07/13/2021
	ROVIDER OR SUPPLIER FOR HOSPICE AND PAI	LIATIVE CARE INC, THE		STREET ADDRESS, CITY, STATE, ZIP CODE 501 COMFORT PLACE MISHAWAKA, IN 46545	
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L 533	4. Clinical Record re #5, start of care date 5/19/2021-7/17/2021 Alzheimer's disease agency document tit dated 5/18/2021 and director E . This age goals MSW: cont maintained as approcaregiver needs 1 The plan of care faile progress toward the 5. Clinical Record re #8, start of care date 6/20/21-8/18/2021, pdisplaced cervical or an agency documend dated 6/16/2021 and medical director E. "goals aide: patient/caregiver verunderstanding/demotarget date: 6/19/2021 to evidence an updathospice aide and skill 6. Clinical Record re #9, start of care date 6/8/2021 - 8/6/2021, obstructive pulmona agency document tit Meeting" dated 6/10 This agency document care plan no chall	chaplain and MSW goals. eview on 6/30/2021 for patient a 8/19/2015, benefit period and primary diagnosis of a unspecified, evidenced and a signed by RN L and medical ancy document stated " inuity of care will be apriate to patient/primary ararget date: 1/18/2021" ed to evidence an update of MSW goal. eview on 7/7/2021 for patient a 10/23/2020, benefit period orimary diagnosis of the (spine) fracture, evidenced at titled "Hospice Plan of Care" a signed by RN W and This agency document stated ant's personal care needs will be: 6/19/2021 SN: abalized anstrate proper skin care and the of progress toward alled nursing goals. eview on 7/7/2021 for patient a 4/9/2021, benefit period primary diagnosis of chronic and a signed by RN X. and signed by RN X. and stated " changes in	L 533		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	IPLE CONSTRUCTION NG	(X	(X3) DATE SURVEY COMPLETED		
		151501	B. WING _			07/13/2021	
	ROVIDER OR SUPPLIER FOR HOSPICE AND PAL	LIATIVE CARE INC, THE	•	STREET ADDRESS, CITY, STATE, ZIP 501 COMFORT PLACE MISHAWAKA, IN 46545	CODE		
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L 533	[patient/caregiver] cameasures to improve target date: 6/7/2021 comfortable target IDT failed to indicate toward the care plan 7. Clinical Record re#11, start of care 2/1 5/16/2021 - 8/13/202 on chronic diastolic (evidenced an agency "Interdisciplinary Groand 6/24/2021, signed documents, stated "no changes since laspatient will be pain fracceptable pain leve management regime patient's personal target date: 5/15/202 indicate the updated goals. Clinical record review document titled "Interdated 6/10/2021 and agency document, sibe pain free or verba with current pain madate: 5/15/2021 pwill be met target failed to indicate the care plan goals. 8. Clinical Record reserved.	an describe/demonstrate e/maintain skin integrity patient will remain t date: 6/7/2021" The the updated progress goals. Eview on 7/6/2021 for patient 5/2021, benefit period 1, primary diagnosis of acute congestive) heart failure, y document titled pup Meeting" dated 5/27/2021 ed by RN Y. These changes in care plan st IDG meeting goals ee or verbalize an I with current pain n target date: 5/15/2021 care needs will be met 11" The IDT failed to progress toward care plan veridenced an agency redisciplinary Group Meeting" signed by RN Y. This stated " goals patient will lize an acceptable pain level magement regimen target atient's personal care needs date: 5/15/2021" The IDT updated progress toward the	L5	533			
	4/21/2021 - 6/19/202	23/2020, benefit periods 1 and 6/20/2021- 8/18/2021, cerebral atherosclerosis,					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		I ' '	PLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED	
		151501	B. WING _		07/13/2021
	ROVIDER OR SUPPLIER FOR HOSPICE AND PA	LLIATIVE CARE INC, THE		STREET ADDRESS, CITY, STATE, ZIP CODE 501 COMFORT PLACE MISHAWAKA, IN 46545	,
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT ((EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	ILD BE COMPLETION
L 533	evidenced agency of "Interdisciplinary Gr 4/20/2021, 5/4/2021 signed by RN M. Ti stated " changes since last IDG meet remains free of brea 12/21/2020" Th updated progress to Clinical record revietitled "Interdisciplina 6/1/2021 and signed stated " goals breakdown target IDT failed to indicate toward the care pland 9. During an intervithe assistant director the goals should be certification period for CONTENT OF PLA CFR(s): 418.56(c)(2) [The plan of care mancessary for the path terminal illness including the following (2) A detailed stater frequency of services specific patient and This STANDARD is Based on record residues.	documents titled oup Meeting" dated I, 5/18/2021, and 6/15/2021 hese agency documents, in plan of care no changes ing goals patient's skin akdown target date: le IDT failed to indicate the oward the care plan goals. Ew evidenced a document ary Group Meeting" dated do by RN M. This document patient's skin remains free of et date: 12/21/2020" The let the updated progress in goal. Ew on 7/8/2021 at 2:25 PM, or of nursing, RN H indicated updated at the end of the for the new certification period. IN OF CARE 2) Sust include all services alliation and management of and related conditions, ng:] ment of the scope and es necessary to meet the	L 5		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED	
		151501	B. WING _		07/13/2021
	ROVIDER OR SUPPLIER FOR HOSPICE AND PAI	LIATIVE CARE INC, THE		STREET ADDRESS, CITY, STATE, ZIP CODE 501 COMFORT PLACE MISHAWAKA, IN 46545	,
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L 547	frequency of visits to needs for 20 of 22 cd #1, 4, 5, 6, 7, 8, 9, 1 18, 19, 20, 21, 22). Findings include: 1. Review of an age titled "Plan of Care" services provided to are in accordance w plan of care establis interdisciplinary team with the patient or recaregiver patient's care and services no of the patient/caregive comprehensive and patient" 2. Clinical Record re#1, start of care 3/25/3/25/2021 - 6/22/202 titled "Hospice Plan and signed by RN Z This plan of care ind skilled nursing 1-2 til and 10 prn [as need management. Clinical record review titled "Hospice Currefor benefit period 6/26/23/2021 and signed indicated the patient a week for 13 weeks management, and management.	ende a detailed statement of a meet the patient and family inical records reviewed (Pt 0, 11, 12, 13,14, 15, 16, 17, ency policy dated 5/19/2021 stated " Hospice care and patients and their families ith an individualized, written	L 5	47	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION	(X3	(X3) DATE SURVEY COMPLETED	
		151501	B. WING _			07/13/2021	
	ROVIDER OR SUPPLIER FOR HOSPICE AND PAL	LIATIVE CARE INC, THE	•	STREET ADDRESS, CITY, STATE, ZI 501 COMFORT PLACE MISHAWAKA, IN 46545	P CODE		
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L 547	C indicated the experimental patient has used profered patient has used profered provided to staff. The individualized based of the patient and far 3. Clinical Record re #4, start of care 6/8/2 - 9/5/2021, evidenced Plan of Care" dated 6/8 BB and MD AA, which received skilled nursing weeks, and 10 provimanagement. During an interview of RN B indicated change been implemented by the most of the assessment find family's current need 4. Clinical Record re #5, start of care 8/19/5/19/2021 - 7/17/202 titled "Hospice Plan of signed by RN L and I indicated the patient a week for 1 week, to provisits for symptor chaplain 2 provisits for symptor chapter for the staff for symptor chapter for the symptom fo	ort and education. on 7/8/2021 at 2:30 PM, RN ctation was 2 prn and if visits will change the ducation will need to be efrequency failed to be on the assessment findings nily's current needs. oview on 7/6/2021 for patient 2021, benefit period 6/8/2021 da document titled "Hospice 6/11/2021 and signed by RN h indicated the patient ing 1-2 times a week for 12 sits for symptom on 7/12/2021 at 11:59 AM, ges in use of prn visits have ut not in this record. It to be individualized based ndings of the patient and s. eview on 6/30/2021 for patient /2015, benefit period 1, evidenced a document of Care" dated 5/18/2021 and MD E. This plan of care received skilled nursing once vice a week for 8 weeks, 10 m management, and	L	547			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		151501	B. WING _			7/13/2021	
	ROVIDER OR SUPPLIER FOR HOSPICE AND PAL	LIATIVE CARE INC, THE		STREET ADDRESS, CITY, STATE, ZIP CO 501 COMFORT PLACE MISHAWAKA, IN 46545			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTIVE) CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
L 547	discussed. The frequency failed on the assessment fi family's current need 5. Clinical Record re #6, start of care 6/3/2 - 8/31/2021, evidenc "Hospice Plan of Carsigned by RN W and indicated the patient a week for 13 weeks management, chaple months, 3 prn visits is support, medical soo 3 months, and 3 prn additional needs that The frequency failed on the assessment fi family's current need 6. Clinical Record re #7, start of care 5/12/5/12/2021-8/9/2021, "Hospice Plan of Carsigned by RN W, dat AA. This plan of care	to be individualized based indings of the patient and its. eview on 7/8/2021 for patient 2021, benefit period 6/3/2021 ed a document titled re" dated 6/7/2021 and IMD E. This plan of care received skilled nursing once is, 10 prn visits for symptom ain once a month for 3 for additional spiritual stal worker once a month for visits to address any traise.	L 5				
	and chaplain 3 prn v This concern was re PM, with RN B and r . The frequency failed	for symptom management, isits for spiritual support. viewed on 7/12/2021 at 12:48 no response was received to be individualized based indings of the patient and					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		151501	B. WING _			07/	13/2021
	ROVIDER OR SUPPLIER FOR HOSPICE AND PAL	LIATIVE CARE INC, THE	·	501	EET ADDRESS, CITY, STATE, ZIP CODE COMFORT PLACE SHAWAKA, IN 46545		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
L 547	#8, start of care 10/2 6/20/21 - 8/18/2021 e "Hospice Plan of Carsigned by RN W and indicated the patient twice a week for 8 w week, 10 prn visits for and chaplain 3 prn for This concern was rep PM, with RN B and row The frequency failed on the assessment of family's current need 8. Clinical Record restart of care 4/9/202 8/6/2021, evidenced Plan of Care" dated W and MD AA. This patient received skill weeks, 10 prn visits chaplain once a mor additional spiritual sured to the same and the same a	view on 7/7/2021 for patient 3/2020, benefit period evidenced a document titled re" dated 6/16/2021, and 1 MD E. This plan of care received skilled nursing eeks, once a week for a per symptom management, or spiritual support. viewed on 7/12/2021 at 1:00 no response was received to be individualized based indings of the patient and its. eview on 7/7/21 for patient #9, 1, benefit period 6/8/2021 - a document titled "Hospice 6/8/2021, and signed by RN plan of care indicated the ed nursing once a week for 9 for symptom management, ath for 2 months, 3 prn for apport, medical social worker r 3 months, and 3 prn to hal needs that arise. viewed on 7/12/2021 at 1:05 no response was received to be individualized based indings of the patient and		547			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		DNSTRUCTION	(X3) DATE COMP	SURVEY LETED
		151501	B. WING _			07/	13/2021
	ROVIDER OR SUPPLIER FOR HOSPICE AND PAL	LIATIVE CARE INC, THE		501	EET ADDRESS, CITY, STATE, ZIP CODE COMFORT PLACE HAWAKA, IN 46545		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
L 547	titled "Hospice Plan of and signed by RN Z indicated the patient twice a week for 13 v symptom manageme for 2 months, 4 prn for medical social worke months, and 3 prn to needs that arise. This concern was revered by RN B and nother assessment for family's current needs and signed by RN W indicated the patient a week for 13 weeks symptom management for the assessment for the frequency failed on the assessment for the patient and signed by RN W indicated the patient a week for 13 weeks symptom management for the assessment for the frequency failed on the assessment for the assessment for the frequency failed on the assessment for the assessment for the frequency failed on the frequen	/2021, benefit period , evidenced a document of Care" dated 4/14/2021, and MD AA. This document received skilled nursing veeks, 10 prn visits for ent, chaplain once a month or additional spiritual support, r once a month for 3 address any additional viewed on 7/12/2021 at 1:07 or response was received to be individualized based ndings of the patient and s. eview on 7/6/2021 for patient 5/2021, benefit period 1, evidenced a document of Care" dated 5/18/2021, and MD AA. This document received skilled nursing once , and 10 prn visits for ent. viewed on 7/12/2021 at 2:26 or response was received. to be individualized based ndings of the patient and		547			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		l' c		SURVEY LETED
		151501	B. WING _			07/	13/2021
	ROVIDER OR SUPPLIER FOR HOSPICE AND PAL	LIATIVE CARE INC, THE		50 ⁻	REET ADDRESS, CITY, STATE, ZIP CODE 1 COMFORT PLACE SHAWAKA, IN 46545		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
L 547	MD E. This docume received skilled nurs weeks, 5 prn visits for management. This concern was re PM, with RN B and row The frequency failed on the assessment of family's current needs 12. Clinical record row #13, start of care 6/16/14/2021 - 9/11/202 titled "Hospice Plans and signed by RN B document indicated nursing 1-2 times a wisits for symptom moved for 13 weeks, with personal groom.	ted 5/19/2021 and signed by nt indicated the patient ing 1-2 times a week for 12 or pain and symptom viewed on 7/12/2021 at 2:53 no response was received. to be individualized based indings of the patient and is. eview on 7/6/2021 for patient 4/2021, benefit period 21, evidenced a document of Care" dated 6/18/2021, B and MD AA. This the patient received skilled week for 13 weeks, 5 prn anagement, aide 1-2 times a and 5 prn visits for assistance	L	547	DEFICIENCY)		
	on the assessment f family's current need 13. Clinical record re #14, start of care 6/6 6/6/2021 - 9/3/2021, "Hospice Plan of Ca signed by RN W and indicated the patient	eview on 7/7/2021 for patient 5/2021, benefit period evidenced a document titled re" dated 6/10/2021 and I MD AA. This document received skilled nursing once and 10 prn visits for					

STATEMENT OF DEFICIENCIES (X: AND PLAN OF CORRECTION		L , IDENTIFICATION NUMBER:		MULTIPLE CONSTRUCTION ILDING			(X3) DATE SURVEY COMPLETED	
		151501	B. WING _			07/	13/2021	
	ROVIDER OR SUPPLIER FOR HOSPICE AND PAL	LIATIVE CARE INC, THE		501 C	ET ADDRESS, CITY, STATE, ZIP CODE OMFORT PLACE IAWAKA, IN 46545	,		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
L 547	Continued From page	e 14	L.5	547				
	PM, with RN B and not be frequency failed	riewed on 7/12/2021 at 3:25 o response was received. to be individualized based andings of the patient and						
	#15, start of care 4/25/2021 - 7/23/202 titled "Hospice Plan of signed by RN W, date MD F. This documer received skilled nursi weeks, 10 prn visits for chaplain 4 prn visits for the start of the start	1, evidenced a document of Care" dated 4/29/2021, ed 4/30/2021 and signed by at indicated the patient or symptom management, or spiritual support, and or 4 prn visits to assess the						
		to be individualized based ndings of the patient and s.						
	#16, start of care 5/14/5/14/2021 - 8/11/2022 titled "Hospice Plan of signed by RN WW, do by MD AA. This docureceived skilled nursi	eview on 7/6/2021 for patient 4/2021, benefit period 1, evidenced a document of Care" dated 5/18/2021 and ated 5/19/2021 and signed ument indicated the patient ng 1-2 times a week for 13 sits for pain and symptom						
	PM, with RN B and n	riewed on 7/12/2021 at 3:45 o response was received.						
		to be individualized based ndings of the patient and						

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDII		ISTRUCTION	(X3) DATE COMF	SURVEY PLETED		
		151501	B. WING _			07/	13/2021		
	ROVIDER OR SUPPLIER FOR HOSPICE AND PAL	LIATIVE CARE INC, THE		STREET ADDRESS, CITY, STATE, ZIP CODI 501 COMFORT PLACE MISHAWAKA, IN 46545			E		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE		
L 547	#17, start of care date 4/21/2021 - 6/19/202 titled "Hospice Plan or signed by RN W, date MD E. This documer received skilled nursi and 10 prn visits for second review "Hospice Plan of Care 6/20/2021 - 8/18/202 signed by RN M and received skilled nursi and 10 prn visits for second review and 10 prn visits for second received. These concerns were 3:35 PM, with RN B as received. The frequency failed on the assessment find family's current needs and 10 prn visits for second received. The frequency failed on the assessment find family's current needs and 17. Clinical record refulls, start of care 4/5, 4/5/2021 - 7/3/2021, "Hospice Plan of Care signed by RN Z and I indicated the patient twice a week for 13 wassessment and symposical worker 1-2 time and 3 prn visits to profamily and assess for	eview on 7/8/2021 for patient end 10/23/2020, benefit period 11, evidenced a document of Care" dated 4/15/2021, end 4/16/2021 and signed by the indicated the patient on gonce a week for 9 weeks, symptom management. If of another document titled end for benefit period 11, dated 6/21/2021 and 10 MD E, indicated the patient on gonce a week for 8 weeks, symptom management. If or benefit period 11, dated 6/21/2021 and 10 MD E, indicated the patient on gonce a week for 8 weeks, symptom management. If or benefit period 11/2/2021 at and no response was 11/2/2021 at and no response was 11/2/2021 at and 11/2/2021 for patient 11/2021, benefit period 11/2/2021, benefit period 11/2/2021, benefit period 11/2/2021 and	L	547					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) MULTIPLE CONSTRUCTION (X4) MULTIPLE CONSTRUCTION (X5) MULTIPLE CONSTRUCTION (X6) MULTIPLE CONSTRUCTION (X7) MULTIPLE CONSTRUCTION (X7) MULTIPLE CONSTRUCTION (X8) MULTIPLE CONSTRUCTION (X8) MULTIPLE CONSTRUCTION (X9) MULTIPLE CONSTRU		, ,	(X3) DATE SURVEY COMPLETED			
		151501	B. WING _			07/13/2021
	ROVIDER OR SUPPLIER FOR HOSPICE AND PAL	LIATIVE CARE INC, THE		STREET ADDRESS, CITY, STATE, ZIP C 501 COMFORT PLACE MISHAWAKA, IN 46545		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
L 547	Continued From pag	e 16	L 5	647		
	PM, with RN B and r	no response was received.				
		to be individualized based indings of the patient and ls.				
	#19, start of care 5/1 5/14/2021 - 8/11/202 titled "Hospice Pland signed by RN V and indicated the patient a week for 1 week, 1 weeks, once a week	eview on 7/7/2021 for patient 4/2021, benefit period 21, evidenced a document of Care" dated 5/19/2021 and MD E. This document received skilled nursing once -2 times a week for 11 for 1 week, 10 prn visits for ent, chaplain 4 prn visits, and er 4 prn visits.				
		viewed on 7/12/2021 at 3:05 no response was received.				
		to be individualized based indings of the patient and ls.				
	patient #20, start of of 6/2/2021 - 8/30/2021 titled "Hospice Plandsigned by RN W and indicated the patient times a week for 12 symptom management."	eview on 7/10/2021 for care 6/2/2021, benefit period 1, evidenced a document of Care" dated 6/7/2021 and 1 MD AA. This document received skilled nursing 1-2 weeks, and 10 prn visits for ent.				
	PM, with RN B and r	to be individualized based				
		indings of the patient and				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		151501	B. WING _			7/13/2021	
	ROVIDER OR SUPPLIER FOR HOSPICE AND PAL	LIATIVE CARE INC, THE		STREET ADDRESS, CITY, STATE, ZIP CC 501 COMFORT PLACE MISHAWAKA, IN 46545			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
L 547	patient #21, start of operiod 2/25/2021 - 5/document titled "Hos 3/1/2021 and signed document indicated in nursing once a week for symptom manage chaplain 3 prn visits support, medical soof for 3 months, and 3 padditional needs that This concern was revenue. The frequency failed on the assessment fifamily's current needs 21. Clinical record repatient #22, start of operiod 4/10/2021 - 7/document titled "Hos 4/14/2021, signed by Signed by MD AA. To patient received skills for 13 weeks, and 10 management. This concern was revenue. This concern was revenue. The frequency failed on the assessment fifamily's current needs on the assessment fifamily's current needs.	eview on 7/12/2021 for care 2/25/2021, evidenced a pice Plan of Care" dated by RN Z and MD AA. This che patient received skilled for 13 weeks, 10 prn visits ement and assessment, for additional spiritual ial worker 1-2 times a month orn visits to address any carise. Viewed on 7/12/2021 at 3:15 to response was received. Ito be individualized based ndings of the patient and s. eview on 7/10/2021 for care 4/10/2021, benefit 8/2021, evidenced a pice Plan of Care" dated of RN Z, dated 4/16/2021 and his document indicated the end nursing 1-2 times a week of prn visits for pain/symptom Viewed on 7/12/2021 at 3:53 to response was received.	L 5	47			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		151501	B. WING _		07/13/2021
	ROVIDER OR SUPPLIER FOR HOSPICE AND PA	LLIATIVE CARE INC, THE		STREET ADDRESS, CITY, STATE, ZIP CODE 501 COMFORT PLACE MISHAWAKA, IN 46545	,
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	OULD BE COMPLETION
L 548	be written, assistant indicated the nurse When queried why sprn visits with no rai operating officer A ir orders available for death. When querie would be too vague indicated an order is discipline needs to reconstruction of CONTENT OF PLA CFR(s): 418.56(c)(3) [The plan of care minecessary for the path terminal illness a including the followi (3) Measurable outcomplementing and complementing and compleme	he skilled nurse order should a director of nursing H writes a range and prn visits. Support services put in only ange, vice president/chief andicated social service want bedside presence at time of ed if prn only visit orders and director of nursing B an and a needed in case that make a visit. NOF CARE Substituted all services alliation and management of and related conditions, ang:] comes anticipated from coordinating the plan of care.	L 5		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIFICATION NUMBER:		LE CONSTRUCTION	, ,	(X3) DATE SURVEY COMPLETED		
		151501	B. WING			7/13/2021		
	ROVIDER OR SUPPLIER FOR HOSPICE AND PA	LLIATIVE CARE INC, THE		STREET ADDRESS, CITY, STATE, ZIP COL 501 COMFORT PLACE MISHAWAKA, IN 46545				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE		
L 548	#1, start of care 3/25 3/25/2021 - 6/22/20 on chronic combined failure, evidenced a Plan of Care" dated [registered nurse] Z This plan of care stapatient and family w SN [skilled nurse]: p managed SN: patient/careg measures to mainta of care failed to evidused to set measura Clinical record revietitled "Hospice Plan 6/23/2021 - 9/20/20 chaplain: patient and needs met SN: panecessary for decisifamily/caregiver will maintain skin integrit to evidence data elemeasurable goals. During an interview when queried if goad director of nursing (indicated the goals of specific, director of goals are not measurable goals. 3. Clinical review re#2, start of care 6/26/28/2021-9/25/202 kidney disease Stagestages and combined to start of care 6/26/28/2021-9/25/202 kidney disease Stagestages are	view on 7/2/2021 for patient 5/2021, benefit period 21, primary diagnosis acute d systolic and diastolic heart document titled "Hospice 3/30/2021, signed by RN and MD [medical doctor] AA. Ited " Goals chaplain: ill have spiritual needs met atient symptoms will be ient will remain comfortable iver will demonstrate in skin integrity" This plan lence data elements were able goals. We evidenced a document of Care" for benefit period 21, which stated " Goals d family will have spiritual atient will have information on making SN: demonstrate measures to ty" This plan of care failed ements were used to set On 7/8/2021 at 2:20 PM, as are measurable, assistant ADON) H shook head no and could be more patient nursing (DON) B indicated the	L 54	8				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED				
		151501	B. WING		07/13/2021
	ROVIDER OR SUPPLIER FOR HOSPICE AND PA	LLIATIVE CARE INC, THE		STREET ADDRESS, CITY, STATE, ZIP CODE 501 COMFORT PLACE MISHAWAKA, IN 46545	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE COMPLETION
L 548	AA. This plan of ca chaplain: patient accomfort MSW [mo continuity of care wito patient/primary ca of care failed to evicused to set measura. During an interview RN C indicated the 4. Clinical record re #3, start of care 3/2/6/18/2021-9/15/202 atherosclerosis (har blood vessels to the document titled "Ho 6/16/2021, signed b of care stated " Gamily will have spirifamily/CG [caregive cope appropriately evidence data elem measurable goals. During an interview RN B indicated the 9.5. Clinical record re #4, start of care 6/8/-9/5/2021, primary atherosclerosis, evic "Hospice Plan of Caby RN BB and MD A" Goals aide: pro anxiety/agitation corcare" This plan of care This plan of care	21, signed by RN BB and MD re stated " Goals hieves feelings of spiritual edical social worker]: Il be maintained appropriate aregiver needs" This plan dence data elements were able goals. on 7/12/2021 at 11:39 AM, goals are not measurable. Eview on 6/29/2021 for patient 0/2021, benefit period 1, primary diagnosis cerebral dening and thickening of brain), evidenced a spice Plan of Care" dated by RN W and MD E. This plan fooals chaplain: patient and intual needs met MSW: er will have mechanisms to" This plan of care failed to ents were used to set on 7/12/2021 at 11:50 AM, goals are not measurable Eview on 7/6/2021 for patient 2/2021, benefit period 6/8/2021	L 548		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		151501	B. WING _		07	7/13/2021	
	ROVIDER OR SUPPLIER FOR HOSPICE AND P	PALLIATIVE CARE INC, THE		STREET ADDRESS, CITY, STATE, ZIP 501 COMFORT PLACE MISHAWAKA, IN 46545	•		
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
L 548	Continued From p During an interview RN B indicated the 6. Clinical record #5, start of care 8/ 5/19/2021 - 7/17/2 Alzheimer's diseas "Hospice Plan of C by RN L and MD E Goals aide: pro hygiene aide: pro hygiene aide: pro hygiene for sta plan of care failed were used to set r During an interview when queried if go president/chief op goals should be sp 7. Clinical record r #6, start of care 6/	age 21 w on 7/12/2021 at 11:59 AM, e goals are not measurable. review on 6/30/2021 for patient f/19/2015, benefit period f/2021, primary diagnosis se evidenced a document titled Care" dated 5/18/2021, signed E. This plan of care stated " mote safe personal care and atient's personal care needs will a: patient and family will have et SN: urinary output will be age of disease process" This to evidence data elements measurable goals. w on 7/8/2021 at 3:39 PM, bals are measurable, vice erating officer A indicated the					
	of liver without asc buildup in the abd titled "Hospice Pla signed by MD W a stated " Goals feel more connect community MS\ regarding social si SN: management This plan of care f were used to set re	cites (liver disease without fluid omen), evidenced a document in of Care" dated 6/7/2021, and MD E. This plan of care chaplain: patient/caregiver will ed to the religious or spiritual W: assessment and education ituation and patient's needs and control of anxiety level"					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED				
		151501	B. WING _			07/	13/2021
	ROVIDER OR SUPPLIER FOR HOSPICE AND PAL	LIATIVE CARE INC, THE		501 C	T ADDRESS, CITY, STATE, ZIP CODE DMFORT PLACE AWAKA, IN 46545		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
L 548	the goals are not mea 8. Clinical record rev #7, start of care date 5/12/2021-8/9/2021, diastolic (congestive) document titled "Hos 5/14/2021, signed by plan of care stated " personal care needs patient achieves feeli SN: family/caregiver to maintain skin integ will be managed po comfortable" This pevidence data eleme measurable goals. During an interview of RN H indicated the goals 9. Clinical record rev #8, start of care 10/20 6/20/21 - 8/18/2021, C1 (cervical spine) fra document titled "Hos 6/16/2021, signed by of care stated " Goa care needs will be me family will have spiritt [patient] can verbalize performance of role of demonstrates knowle complications" The evidence data eleme measurable goals.	perating officer A indicated asurable. iew on 7/7/2021 for patient 5/12/2021, benefit period primary diagnosis chronic heart failure evidenced a pice Plan of Care" dated RN W and MD AA. This . Goals aide: patient's will be met chaplain: ngs of spiritual support will demonstrate measures rity SN: patient symptoms atient will remain plan of care failed to nts were used to set n 7/12/2021 at 12:48 PM, pals are not measurable. iew on 7/7/2021 for patient 3/2020, benefit period primary diagnosis displaced acture, evidenced a pice Plan of Care" dated RN W and MD E. This plan hals aide: patient's personal et chaplain: patient and ual needs met MSW: pt. er realistic expectations in SN: patient/caregiver dge of disease process and is plan of care failed to	L	548			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		151501	B. WING _		 	07/	/13/2021
	ROVIDER OR SUPPLIER FOR HOSPICE AND P	ALLIATIVE CARE INC, THE	•	501 C	TADDRESS, CITY, STATE, ZIP CODE DMFORT PLACE AWAKA, IN 46545	•	
(X4) ID PREFIX TAG	(EACH DEFICIE	' STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
L 548	10. Clinical record #9, start of care 4/- 8/6/2021, primary pulmonary disease that causes obstrue videnced a docur Care" dated 6/8/20 AA. This plan of commended in the care failed to evidence the care failed to evidence to set measurable. During an interview B indicated the good 11. Clinical record patient #10, start of 4/2/2021 - 6/30/20 myeloma (cancer of marrow), evidence Plan of Care" date and MD AA. This aide: optimal indegmaintain optimum for stage of disease evidence data elemeasurable goals. During an interview president/chief opegoals are not measurable.	d review on 7/7/2021 for patient 9/2021, benefit period 6/8/2021 diagnosis chronic obstructive e (inflammatory lung disease octed airflow from the lungs), ment titled "Hospice Plan of 1021, signed by RN W and MD are stated " Goals MSW rker]: strengthening tem SN: patient/family will ry control of symptoms SN: comfortable" This plan of ence data elements were used goals. W on 7/12/2021 at 1:05 PM, RN als are not measurable. I review on 6/30/2021 for of care 4/2/2021, benefit period 21, primary diagnosis multiple of plasma cells found in bone and a document titled "Hospice d 4/14/2021, signed by RN Z plan of care stated " Goals pendence SN: patient will level of functioning appropriate e.e" This plan of care failed to ments were used to set	L	548			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: A. BUILDING 151501 B. WING				(X3) DATE SURVEY COMPLETED	
				·	07/13/2021		
	ROVIDER OR SUPPLIER FOR HOSPICE AND PAL	LIATIVE CARE INC, THE	•	STREET ADDRESS, CITY, STATE, ZIP CO 501 COMFORT PLACE MISHAWAKA, IN 46545			
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
L 548	injuries from a motor a document titled "Ho 5/18/2021, signed by plan of care stated ". personal care needs patient and family wi SN: family/caregiver to maintain skin integfailed to evidence da measurable goals. During an interview of B indicated the goals. During an interview of B indicated the goals. 13. Clinical record re #12, start of care 5/1 5/12/2021 - 8/9/2021 chronic diastolic (corevidenced a docume Care" dated 5/17/202 E. This plan of care patient and family wi SN: patient/family wi of symptoms SN: managed SN: paticomfortable" This evidence data element measurable goals. During an interview of B indicated the goals. 14. Clinical record re #13, start of care 6/1 6/14/2021 - 9/11/202 cancer, evidenced a Plan of Care" dated of Plan of Care	21, primary diagnosis multiple -vehicle accident, evidenced ospice Plan of Care" dated of RN W and MD AA. This Goals aide: patient's will be met chaplain: Il have spiritual needs met will demonstrate measures grity" This plan of care ta elements were used to set on 7/12/2021 at 2:26 PM, RN are not measurable. eview on 7/5/2021 for patient 2/2021, benefit period , primary diagnosis acute on ngestive) heart failure, ent titled "Hospice Plan of 21, signed by RN W and MD stated " Goals chaplain: Il have spiritual needs met Il express satisfactory control patient symptoms will be ent will remain plan of care failed to	L 54	48			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		151501	B. WING		07/13/2021	
	ROVIDER OR SUPPLIER FOR HOSPICE AND PA	LLIATIVE CARE INC, THE		STREET ADDRESS, CITY, STATE, ZIP CODE 501 COMFORT PLACE MISHAWAKA, IN 46545	, 0,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE COMPLETION	ON
L 548	chaplain: patient anneeds met SN: patient symp This plan of care fai were used to set metaline be maintained as apparent symptoms with a spiritual needs metaline be maintained as apparent symptoms with patient symptoms with symptoms w	In all care needs will be met If family will have spiritual atient will remain comfortable toms will be managed" It is do evidence data elements easurable goals. It is are not measurable. It is a patient be right period primary diagnosis malignant obe right bronchus or lung need a document titled re" dated 6/10/2021, signed A. This plan of care stated "patient and family will have MSW: continuity of care will propriate to patient/primary SN: family/caregiver will res to maintain skin integrity main comfortable SN: ill be managed" This is evidence data elements	L 54	48		

STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		151501	B. WING		07/13/2021
	ROVIDER OR SUPPLIER FOR HOSPICE AND PA	LLIATIVE CARE INC, THE		STREET ADDRESS, CITY, STATE, ZIP CODE 501 COMFORT PLACE MISHAWAKA, IN 46545	·
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	OULD BE COMPLETION
L 548	comfortable SN: managed" This pattern of the concerns were 07/12/2021 at 1:35 17. Clinical record #16, start of care 5/5/14/2021 - 8/11/20 malignant neoplasm (cancer of tissues the surround other body document titled "Ho 5/18/2021, signed be plan of care stated establish/maintain repatient free of any selements were used allow" This plan of elements were used the concerns were 07/12/2021 at 3:45 18. Clinical record #17, start of care 10/4/21/2021 - 6/19/20/20 atherosclerosis, evi "Hospice Plan of Caby RN W and MD E	s SN: patient will remain patient symptoms will be plan of care failed to evidence a used to set measurable. reviewed with RN B on PM. RN B remained silent. review on 7/6/2021 for patient 1/4/2021, benefit period 21, primary diagnosis of connective and soft tissue that connect, support, and y structures), evidenced a pspice Plan of Care" dated by RN W and MD AA. The "Goals SN: normal bowel habits SN: signs/symptoms of infection ill be maintained, and as disease process will of care failed to evidence data do to set measurable goals. reviewed with RN H on PM. RN H remained silent. review on 7/8/2021 for patient 0/23/2020, benefit period 21, primary diagnosis cerebral denced a document titled are" dated 4/15/2021, signed i This plan of care stated "	L 54	8	
	Goals chaplain: pspiritual comfort to: [sic]" This pla	patient achieves feelings of MSW: patient will be oriented an of care failed to evidence used to set measurable			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			E SURVEY MPLETED	
		151501	B. WING	B. WING		07/13/2021	
	ROVIDER OR SUPPLIER FOR HOSPICE AND PA	LLIATIVE CARE INC, THE		STREET ADDRES 501 COMFORT MISHAWAKA,		•	
(X4) ID PREFIX TAG			ID PREFI TAG	(EA	PROVIDER'S PLAN OF CORRECTI ACH CORRECTIVE ACTION SHOUI SS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
L 548	document titled "Ho 6/21/2021, signed by patient will be orient activity level achieved baseline respiratory. This plan of care fair were used to set me buring an interview. Holding an interview Holding an interview Holding and interview Holding and Intervie	ew evidenced an agency spice Plan of Care" dated by RN M and MD AA. This " Goals chaplain: patient if spiritual comfort MSW: ted to: [sic] SN: optimal ed and maintained within and energy parameters" led to evidence data elements easurable goals. on 7/12/2021 at 3:30 PM, RN is are not measurable. review on 7/6/2021 for patient 5/2021, benefit period primary diagnosis alcoholic in ascites (liver disease with omen), evidenced a document of Care" dated 4/8/2021, his plan of care stated " or discuss abuse SN: mental his plan of care failed to ents were used to set on 7/12/2021 at 3:48 PM, RN is are not measurable. review on 7/7/2021 for patient 14/2021, benefit period 21, primary diagnosis e with late onset, evidenced a spice Plan of Care" dated by RN V and MD E. This plan		548			
	#19, start of care 5/ 5/14/2021 - 8/11/20 Alzheimer's disease document titled "Ho 5/19/2021, signed b of care stated "G	14/2021, benefit period 21, primary diagnosis with late onset, evidenced a spice Plan of Care" dated					

NAME OF PROVIDER OR SUPPLIER B. WING 07/13/2 STREET ADDRESS, CITY, STATE, ZIP CODE 501 COMFORT PLACE	13/2021
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
CENTER FOR HOSPICE AND PALLIATIVE CARE INC, THE MISHAWAKA, IN 46545	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
L 548 Continued From page 28 spiritual support needs met SN: patient will have information necessary for decision making" This plan of care failed to evidence data elements were used to set measurable goals. 21. Clinical record review on 7/10/2021 for patient #20, start of care 6/2/2021, benefit period 6/2/2021 - 8/30/2021, primary diagnosis malignant neoplasm of lower lobe right bronchus or lung (lung cancer), evidenced a document titled "Hospice Plan of Care" dated 6/7/2021, signed by RN W and MD AA. This plan of care stated " Goals aide: promote skin integrity SN: family/caregiver will demonstrate measures to maintain skin integrity This plan of care failed to evidence data elements were used to set measurable goals. During an interview on 7/12/2021 at 3:53 PM, RN H indicated the goals are not measurable. 22. Clinical record review on 7/12/2021 for patient #21, start of care 2/25/2021, primary diagnosis cerebral atherosclerosis, evidenced a document titled "Hospice Plan of Care" dated 3/1/2021, signed by RN Z and MD AA. This plan of care stated " Goals chaplain: patient achieves feelings of spiritual support SN: patient/caregiver verbalize understanding of s/s [signs and symptoms] of course failed to evidence data elements were used to set measurable goals. The concerns were reviewed with RN B on 07/12/2021 at 3:15 PM. RN B remained silent.	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		151501	B. WING	B. WING		07/	13/2021	
	ROVIDER OR SUPPLIER FOR HOSPICE AND PAL	LIATIVE CARE INC, THE		50	TREET ADDRESS, CITY, STATE, ZIP CODE 01 COMFORT PLACE IISHAWAKA, IN 46545			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
L 548	patient #22, start of operiod 4/10/2021 - 7/chronic diastolic (conevidenced a docume Care" dated 4/14/202 AA. This plan of care chaplain: patient and needs met SN: paticomfortable" This evidence data elemente measurable goals. The concerns were reflected to the concerns	eview on 7/10/2021 for sare 4/10/2021, benefit 8/2021, primary diagnosis gestive) heart failure, nt titled "Hospice Plan of 21, signed by RN Z and MD estated " Goals family will have spiritual tient symptoms will be ent will remain plan of care failed to nts were used to set eviewed with RN B and RN H ew on 7/12/2021 at 11:38 seeing a trend with goals not N C indicated yes and that it ove forward with review of I OF CARE st include all services liation and management of and related conditions, g:] ent necessary to meet the		548				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		151501	B. WING _			07/13/2021	
	ROVIDER OR SUPPLIER FOR HOSPICE AND PAL	LIATIVE CARE INC, THE		STREET ADDRESS, CITY, STATE, ZIP CO 501 COMFORT PLACE MISHAWAKA, IN 46545			
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
L 549	Continued From pag	e 30	L 5	49			
	the needs of the pati	reatment necessary to meet ents for 6 of 22 clinical 7, 11, 17, 19, 20, 21).					
	The findings include:						
	titled "Skin and Woul of care will be individed with the patient/family care interventions with order" 2. Review of an und "Plan of Care" stated includes, but is not lied.	ncy policy dated 5/2019, nd Care" stated " the plan lualized ensuring consistency y goals and wishes wound Il be provided per physician's ated agency policy titled I " the plan of care mited to drugs and to meet the needs of the					
	#7, start of care date period 5/12/21-8/9/20 chronic diastolic (corevidenced a docume Note" dated 6/8/2022 [registered nurse] DI clinical findings: integindex finger narratherself on left index open pill packet wo	view on 7/7/2021 for patient 5/12/2021, certification 021, primary diagnosis of agestive) heart failure ent titled "Skilled Nursing Visit 1 and signed by RN 0. This document, stated " gumentary knife cut left cive notes pt [patient] cut finger while attempting to ith a knife pt applied eant blood draining from cut dage bandage reapplied					
	dated 6/9/2021, state emergency visit triag was still bleeding	killed Nursing Visit Note" ed " narrative notes e called patient's finger this RN applied triple placed a new band-aid"					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		151501	151501 B. WING				/13/2021	
	ROVIDER OR SUPPLIER FOR HOSPICE AND PAI	LIATIVE CARE INC, THE	•	501 CC	T ADDRESS, CITY, STATE, ZIP CODE DMFORT PLACE AWAKA, IN 46545	•		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE	
L 549	Continued From pag	ge 31	L	549				
	Meeting" dated 6/10 emergency visit tr was still bleeding antibiotic cream and changes in orders A document titled "Hebenefit period 5/12/2 5/14/2021, signed by MD [medidocument stated " nurse] teach measkin breakdown" failed to evidence a antibiotic cream and Clinical record reviet document titled "Hospice benefit perioby RN W and MD Avevidence orders for finger. Clinical record agency document titl Meeting" dated 06/1 This document failed order or any wound	lospice Plan of Care" for 2021 - 8/9/2021, dated y RN W, dated 5/17/2021 and						
	when queried if an o	on 7/12/2021 at 12:48 PM, rder would be expected for t, director of nursing B						
	#11, start of care 2/1	riew on 7/6/2021 for patient 5/2021, certification period 21, primary diagnosis of acute						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
		151501	B. WING _	B. WING		07/13/2021		
	ROVIDER OR SUPPLIER FOR HOSPICE AND PAL	LIATIVE CARE INC, THE		STREET ADDRES 501 COMFORT I MISHAWAKA,		•		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE		
L 549	Continued From page	e 32	L.5	549				
	evidenced a docume Visit" dated 6/30/202 This visit note stated dressing change to le peroxide triple ABA covered with telefa supplies]". Clinical record review document titled "Hos period 5/16/2021 - 8/ and signed by RN W AA. This document s SN assess for signifection" The hoevidence a wound care	ospice plan of care failed to are order for cleansing with of antibiotic cream, and						
	when queried if there director of nursing B is entered into the ca select, to create a vergenerated. 5. Clinical record reverted with the carted and the condition of the carted and the condition of the carted and th	pice Certification of Terminal 021 and signed by MD E. d" patient with e ulcer to left heel requiring						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG	, ,	(X3) DATE SURVEY COMPLETED		
		151501	B. WING _			07/13/2021	
	ROVIDER OR SUPPLIER FOR HOSPICE AND PA	LLIATIVE CARE INC, THE		STREET ADDRESS, CITY, STATE, ZIP CODE 501 COMFORT PLACE MISHAWAKA, IN 46545	•		
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF COR ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
L 549	left foot heel pidressing wound of per care plan" An agency docume Care" for benefit pe and signed by RN Vevidence orders for Clinical record revietitled "Hospice Plan signed by RN Manstated " intervent cleanse wound with apply santyl [oint tissue from wounds hydrofera blue [foar wound cover with daily and prn [as need to comment titled "Ve and signed by MD F wound care clear cleanser apply conduring wound healing with island dressing facility [nursing hom and prn if soiled or conductive conducti	FF. This document, stated " ressure ulcer unstageable cleansing/dressing change Int titled "Hospice Plan of riod 4/21/2021 - 6/19/2021 V and MD E, failed to wound care. We of an agency document of Care" dated 6/21/2021 and d MD E. This document ions SN: wound care wound cleanser and pat dry ment that removes dead to help with healing] apply m-based dressing cut to fit in foam dressing change meded]" We evidenced an agency rbal Order" dated 6/30/2021 R. This document, stated " nese left heel with wound collagen [allows tissue growth ng] cut to fit woundcover [absorbent wound pad] me] staff to change mon/wed/fri	L 5	49			

STATEMENT OF DEFICIENCIES (AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION	' '	(X3) DATE SURVEY COMPLETED		
		151501	B. WING _		07	07/13/2021		
	ROVIDER OR SUPPLIER FOR HOSPICE AND PAL	LIATIVE CARE INC, THE	,	STREET ADDRESS, CITY, STATE, ZIP CO 501 COMFORT PLACE MISHAWAKA, IN 46545				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C ((EACH CORRECTIVE ACTIVE ACTI	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE		
L 549	covered with island decovered with island decovered with island decovered when queried for the had been documented 4/21/2021, RN C indiversed of patients we care order was in the care plan. No further received by exit of succeived by exit o	on cut to fit wound bed ressing" on 7/12/2021 at 3:05 PM, order for wound care which ad as being done since cated agency was pulling all ith wounds to see if a wound order section and in the wound care documentation	L 5					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		151501	B. WING			07/13/2021		
	ROVIDER OR SUPPLIER FOR HOSPICE AND PAI	LIATIVE CARE INC, THE	•	5	TREET ADDRESS, CITY, STATE, ZIP CODE 01 COMFORT PLACE //ISHAWAKA, IN 46545	•		
(X4) ID PREFIX TAG			ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
L 549	document titled "Inted dated 6/18/2021 and	ge 35 w evidenced an agency erdisciplinary Group Meeting" d signed by RN R. This . changes in orders no	L	549				
	changes since last li decubitus [pressure "	DG meeting prep notes sores] wounds healing well w evidenced an agency						
	document titled "Hos certification period 5	spice Plan of Care" for /14/2021 - 8/11/2021. This evidence orders for wound						
	titled "Hospice Certificated and signed by	w of an agency document fication of Terminal Illness" MD AA on 5/18/2021, stated h feet and a rash at her						
	document titled "Ver with start date 5/19/2 practitioner) GG. The care orders wash water, apply silicone prevention of further apply calazime skin wound leave open blister/wound opens	w evidenced an agency bal Order" dated 7/7/2021, 2021, signed by NP (nurse his order stated " wound sacral wounds with soap and foam dressing prn for breakdown may also protectant prn left heel in to air once wound, may apply petroleum gauze nge prn start date:						
	R was observed pro The patient was obs right side while in a observed to have re	on 7/8/2021 at 10:00 AM, RN viding care to patient #19. erved positioned on his/her nospital bed. The patient was dness and excoriation to their outer gluteal cleft (buttocks						

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED	
		151501	B. WING _			07/	13/2021	
	ROVIDER OR SUPPLIER FOR HOSPICE AND PAL	LIATIVE CARE INC, THE		STREET ADDRESS, CITY, STATE, ZIP CODE 501 COMFORT PLACE MISHAWAKA, IN 46545				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
L 549	Continued From page	∍ 36	L	549				
	was observed to left i of left heel were heali assessment. A meas redness was observe redness with scab the observed to inner left	area the size of a quarter inner gluteal cleft. Both sides ing and not boggy per RN R surement of 2 x 1.5 inched to outer left heel. Slight esize of a pencil tip was heel.						
	document titled "Skill-7/8/2021 and signed stated" inner butto groove between the bepithelializing [skin he edges macerated [sk soft, or appears white skin [tissue surroundi [erosion of top layer or cleansed with soap a silicone foam sacral of tailbone area] left in	ed Nursing Visit Note" dated by RN R. This visit note, bocks gluteal fold [deep buttocks] wound bed ealing process] wound in that looks soggy, feels er than usual] peri wound ing a wound] excoriated of skin] dressing nd water application						
	and review of the skil documentation dated the observed concern	the home visit on 7/8/2021 led nursing visit note 7/8/2021, failed to evidence ns of the patient's wounds.						
	C indicated he/she had patient #19 had a wo	ad queried RN R whether und. RN R indicated the ound and had received						
	#20, start of care date 6/2/2021-8/30/2021,	riew on 7/10/2021 for patient e 6/2/2021, benefit period primary diagnosis of lower lobe right bronchus or						

AND DLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		151501	B. WING _			07/	/13/2021
	ROVIDER OR SUPPLIER FOR HOSPICE AND PAL	LIATIVE CARE INC, THE		501 CO	TADDRESS, CITY, STATE, ZIP CODE DMFORT PLACE NWAKA, IN 46545	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
L 549	document titled "Skill 6/2/2021 and signed stated " narrative re [laxative] daily" Clinical record review titled "Hospice Plan of period 6/2/2021 - 8/3 stated " interventiod document bowel move suds enema] as direct acetaminophen [for period for peri	e 37 ung), evidenced an agency ed Nursing Visit Note" dated by RN V. This visit note, notes now takes senna v evidenced a document of Care" for certification 0/2021. This plan of care ns aide: elimination: rements give SSE [soap oted by RN medication: ain] bisacodyl [for peridol [for agitation] retions] lasix [for swelling or high blood pressure] y] melatonin [for sleep] potassium chloride [for ent] prochlorperazine [for seroquel [for sleep]" This evidence soap suds enema ne drugs and treatments. v evidenced a document y Group Meeting" dated d by RN HH. This document, n care plan no changes	L	549	DEPICIENCT)		
	since last IDG meetirelimination give so During an interview of assistant director of rorder was needed for When queried where located, no response 8. Clinical record rev #21, start of care date	or my interventions SSE as directed by RN" on 7/12/2021 at 3:53 PM, the control of the medication, senna. the order for senna was					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	FIPLE CONSTRUCTION NG		ATE SURVEY DMPLETED		
		151501	B. WING _			07/13/2021		
	ROVIDER OR SUPPLIER OR HOSPICE AND PAL	LIATIVE CARE INC, THE	•	STREET ADDRESS, CITY, STATE, ZIP C 501 COMFORT PLACE MISHAWAKA, IN 46545	CODE	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE		
L 549	document titled "Hos certification period 2 plan of care failed to care. Clinical record review titled "Skilled Nursing and signed by RN II. medial buttocks glute crack] /decubitus/prebreakdown that exteskin] dressing chaperformed not due Clinical record review	erosis, evidenced an agency pice Plan of Care" for 1/25/2021 - 5/25/2021. This evidence orders for wound of evidence orders for wound of evidenced A document graph of the state of the sta	LS	549				
	and signed by RN JJ wound measuremen 0.5 cm x depth 1.4 c cleanser application [dressing used for dressing and signed by RN KI narrative notes ca S] for pain managem nurse patient is ta acetaminophen/oxyc in the last 24 hours difficult for patient to medication receiv acetaminophen/oxyc hydromorphone [for measurement] rekennedy ulcer [dark	v evidenced a document g Visit Note" dated 3/13/2021 K. This document, stated " lled to facility [nursing facility tent spoke with facility king odone [for pain] six doses becoming increasingly take tablet form of ed orders discontinue						

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '			(X3) DATE SURVEY COMPLETED	
151501	B. WING _			07/13/2021	
LLIATIVE CARE INC, THE		STREET ADDRESS, CITY, STATE, ZIP CODE 501 COMFORT PLACE MISHAWAKA, IN 46545			
ICY MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION	SHOULD BE	(X5) COMPLETION DATE	
ew evidenced a document on the visit Note" dated 3/22/2021 J. This document stated " onse with wound cleaner, pat amount of calcium alginate 4 x 4 mepilex. Facility laily dressing changes" Jarding providing wound care reviewed on 7/12/2021 at 3:15 RN H. They remained silent. JEF SERVICES 2) develop and maintain a cation and integration, in the hospice's own policies and care and services are unce with the plan of care. So not met as evidenced by: Priview and interview, the sure physician orders were to the plan of care in 5 of 20 dis reviewed. (#7, 10, 11, 16, 16		49			
	IDENTIFICATION NUMBER:	A. BUILDIN 151501 B. WING_ STATEMENT OF DEFICIENCIES ACY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) DEVELOPMENT OF DEFICIENCIES ACY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) DEVELOPMENT OF DEFICIENCIES ACY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) DEVELOPMENT OF DEFICIENCIES ACY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) LSC IDENTIFYING INFORMATION DEVELOPMENT OF DEFICIENCIES ACY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) LSC IDENTIFYING INFORMATION DEPREFIX TAG L 5 A. BUILDIN B. WING_ PREFIX TAG L 5 L 5 L 5 L 5 L 5 L 5 L 5 L	151501 151501	ISTREET ADDRESS, CITY, STATE, ZIP CODE SOT COMPORT PLACE MISHAWAKA, IN 46545 PROVIDERS HAN DE CORRECTION PREFIX TAG GROSS-REFERENCE IT OTHE APPROPRIAT DEFICIENCY GROSS-REFERENCE IT OTHE APPROPRIAT DEFICIENCY JUNE 1549 GROSS-REFERENCE IT OTHE APPROPRIAT DEFICIENCY JUNE 1549 GROSS-REFERENCE TO THE APPROPRIAT DEFICIENCY JUNE 1549 GROSS-REFERENCE TO THE APPROPRIAT DEFICIENCY JUNE 1549 L 549 L 54	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '		ISTRUCTION	(X3) DATE	E SURVEY PLETED	
		151501	B. WING _			07/	/13/2021	
	ROVIDER OR SUPPLIER FOR HOSPICE AND PAI	LLIATIVE CARE INC, THE	·	STREET ADDRESS, CITY, STATE, ZIP CODE 501 COMFORT PLACE MISHAWAKA, IN 46545				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL RESC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE	
L 555	updated assessmen 2. Record review fo on 7/7/2021, election period 5/12/21-8/9/2 of chronic diastolic (The record failed to intervention, and goservices prior to provided and follows and titled "Stated 6/2/2021, stated 6/4/2021, and will give patient somebody" A document titled "I'm Meeting" dated 6/10 pt [patient] educated the house to help pt household help sheet the volunteer will be 3:30pm" Documents reviewed Volunteer Report and volunteers were in the 6/22/201, 6/24/2021 3. Record review for on 6/30/2021, election for 6/30/2021, election for 6/30/2021, election for 6/30/2021, election for 6/30/2021 for 6/	r patient #7 was completed and date 5/12/2021, benefit 021, and a primary diagnosis congestive) heart failure. evidence frequency, all orders for volunteer viding the services. skilled Nursing Visit Note" ed " narrative notes at ing up a volunteer service" skilled Nursing Visit Note" ed " narrative notes at ing up a volunteer service"		555				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		151501	B. WING			07/	13/2021
	ROVIDER OR SUPPLIER FOR HOSPICE AND PAL	LIATIVE CARE INC, THE	•	50	TREET ADDRESS, CITY, STATE, ZIP CODE 01 COMFORT PLACE IISHAWAKA, IN 46545		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
L 555	A document titled "In Meeting" dated 4/29pt [patient] was opstarting the process volunteer to help her other items sw pur A document titled "Mote" dated 4/21/20. the home to complet need for volunteer sevolunteer request A document titled "S dated 5/5/2021, state arrived to find patien and anticipating voluto help with organizin A document titled "S dated 5/27/2021, state arrived to find patien and anticipating voluto help with organizin A document titled "S dated 5/27/2021, stanurse will contact if something can be dentist" 4. Review record for on 7/6/2021, election period 5/16/2021 - 8 diagnosis of acute of (congestive) heart faevidence a physiciar goals for chaplain ar A document titled "H 5/16/2021 - 8/13/2021 -	services prior to providing the sterdisciplinary Group /2021, stated " prep notes en to sw [social worker] of setting her up with a go through her clothes and t in a volunteer request" Idedical Social Worker Visit 21, stated " visit with pt in e visit with pt to follow up on ervices sw put in a " killed Nursing Visit Note" ed " narrative note nurse t trying to get organized inteer to arrive someday soon ing her things" killed Nursing Visit Note" ted " narrative note this volunteer coordinator to see done to get patient to the repatient #11 was completed in date 2/15/2021, benefit /13/2021, and a primary	L	555			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDI	UCTION	(X3) DATE SURVEY COMPLETED			
		151501	B. WING			07/	13/2021
	ROVIDER OR SUPPLIER FOR HOSPICE AND PAL	LIATIVE CARE INC, THE	·	501 COMF	DDRESS, CITY, STATE, ZIP CODE FORT PLACE AKA, IN 46545		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
L 555	A document titled "In Meeting" dated 5/27/ and goals for chaplai evidence a physician Documents titled "Int Meeting" dated 6/10/ included intervention medical social worke evidence a physician medical social worke evidence a physician medical social worke Documents titled "Me Notes" dated 6/2/202 Medical Social Worke physician order. Documents titled "Ch 5/21/2021, 6/3/2021, Chaplain made patie order. 5. Record review for on 7/6/2021, election period 5/14/2021 - 8/ diagnosis of malignal tissue and soft tissue failed to evidence a pinterventions, and go	terdisciplinary Group 2021, included interventions n. The plan of care failed to order for chaplain service. erdisciplinary Group 2021 and 6/24/2021, s and goals for chaplain and r. The plan of care failed to order for chaplain and r. The plan of care failed to order for chaplain and r service. edical Social Worker Visit 21 and 6/9/2021, indicated er made patient visits with no haplain Visit Notes" dated and 6/23/2021, indicated on visits with no physician e patient #16 was completed and ate 5/14/2021, benefit 11/2021, and a primary on neoplasm of connective e unspecified. The record ohysician order, eals for social work services. Despice Plan of Care" dated 1, stated " Medical Social d evaluate 5/17/2021	L	555			
		edical Social Worker Visit 021, 5/27/2021, 6/1/2021,					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		151501	B. WING _		07	/13/2021
	ROVIDER OR SUPPLIER FOR HOSPICE AND PALI	LIATIVE CARE INC, THE	,	STREET ADDRESS, CITY, STATE, ZIP CODE 501 COMFORT PLACE MISHAWAKA, IN 46545		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
L 555	6/3/2021, 6/14/2021, 6/27/2021, indicated in patient visits with no patient diagnosis of alcoholic ascites. The record far order, interventions, a services. Documents titled "Ch 5/25/2021, 6/9/2021, Chaplain made patient order. Documents titled "Interventions" dated 5/7/20 and goals for chaplain evidence a physician LICENSED PROFES CFR(s): 418.62(c) Licensed professional hospice's quality assessimprovement program in-service training.	6/15/2021, 6/22/2021, and medical social worker made obysician order. patient #18 was completed date 4/5/2021, benefit 2021, and a primary cirrhosis of liver with ailed to evidence a physician and goals for chaplain aplain Visit Notes" dated and 6/23/2021, indicated at visits with no physician erdisciplinary Group 221, 5/20/2021, 6/3/2021, 221, included interventions and The plan of care failed to order for chaplain		586		
	professionals who pro	I to ensure hospice ded to therapy licensed ovided services to hospice rticipation in the quality				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	IPLE CONSTRUCTION NG	(X3)) DATE SURVEY COMPLETED
		151501	B. WING _			07/13/2021
	ROVIDER OR SUPPLIER FOR HOSPICE AND PA	LLIATIVE CARE INC, THE		STREET ADDRESS, CITY, STATE, ZIP CO 501 COMFORT PLACE MISHAWAKA, IN 46545	DDE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTIVE ACTIV	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
L 586	assessment and per program (QAPI). Findings include: Review of an agence "Quality Assessment Plan (QAPI) stated body will ensure that hospice services in interdisciplinary tear Review of a docume as part of the agence 4/2021, titled "Quali Improvement Guide organization, QAPI departments, and a Review of a docume as part of the agence 5/25/2021, titled "QI Meeting" stated " 1 MD [medical doctor Nursing Manager coordinator) 7 Nirmanagers] 2 Tria 1 admission 2 Cl assistants] 1 hor Services 1 socia 1 chaplain 1 vo Marketer" This d	ge 44 Informance improvement It policy dated 11/2018, titled at Performance Improvement I The hospice governing at the program involves all improvement projects in (IDT) members" I ent submitted on 6/28/2021, by's QAPI program dated at y Assessment Performance lines" stated " In our includes all employees, all all services provided" I services provided" I services provided" I ent submitted on 6/28/2021, by's QAPI program dated (quality improvement) QAPI Team Clinicians or] or 1 NP [nurse practitioner] ment1 PCC [patient care curses 2 CM [case age 2 IPU [inpatient unit] NAs [certified nursing ne care1 IPU Support a worker 1 bereavement of the corofessionals as part of the	L 5	586		
	as part of the agence agreement with Hor	ent submitted on 6/28/2021, by's contracted therapy ne Care Agency A dated emporary Personnel				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	'
		151501	B. WING _			07/13/202 ⁻	1
	ROVIDER OR SUPPLIER FOR HOSPICE AND PAL	LIATIVE CARE INC, THE		STREET ADDRESS, CITY, STATE, ZIP CO 501 COMFORT PLACE MISHAWAKA, IN 46545	ODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIA		ETION
L 586	[Home Care A] persorequirements of the policies, standards and Review of agency do "Physical Therapist", and "Speech Langua evidence the job desin QAPI and hospice Review of document agency human resoutherapists dated 7/2/Information" failed to orientation/training and During an interview of QAPI, quality assura coordinator C indicated included, but contract When queried if there hospice responsibility received no comment of the president/chief of contracted individual the same training as training is not happend.	unte orientation of Agency onnel regarding the specific position and Hospice's and procedures " ocuments dated 3/2006, titled "Occupational Therapist", age Pathologist" all failed to peription included participation in-service training. In submitted on 7/7/2021, as purce files for 5 contracted 2021, titled "Contract Staff or evidence hospice and participation in QAPI. In 7/2/2021 at 1:30 PM, disciplines participate in ance and medical records ated all disciplines are sted individuals are not. The appropriate in approximate the service orientation, and from agency. In 7/7/2021 at 3:05 PM, aracted individuals receive rientation and ongoing basis, operating officer A indicated are required to complete agency staff, but hospice		586			
L 604	PHYS, OCCUPNL T PATHOLOGY	-	L 6	504			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		NSTRUCTION		E SURVEY PLETED		
		151501	B. WING _			07	/13/2021		
	ROVIDER OR SUPPLIER FOR HOSPICE AND PAI	LIATIVE CARE INC, THE		STREET ADDRESS, CITY, STATE, ZIP CODE 501 COMFORT PLACE MISHAWAKA, IN 46545					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE		
L 604	Continued From pag	ne 46	Le	604					
	services, and speed services must be av- offered in a manner standards of practice This STANDARD is	not met as evidenced by:							
	hospice failed to ens and received the ser transfer techniques a	view and interview, the sure patients were offered vices necessary to provide and fall safety guidance in 2 ecords reviewed (#6, 19).							
	titled "Fall Prevention include safety and fawhen falls are anticipevaluation or safety therapist or physical	ency policy dated 11/2019, n" stated " care plan can all prevention interventions pated or repeated a safety teaching by an occupational therapist can be obtained by ment of the Interdisciplinary							
	titled "Plan of Care" care specifies the ca meet the needs of th	ency policy dated 5/2021, stated " patient's plan of are and services necessary to be patient/caregiver as I, comprehensive and ts of the patient"							
	#6, start of care 6/3/6/3/2021 - 8/31/2022 alcoholic cirrhosis of evidenced a docume Note" dated 6/3/202 visit note, stated " more is considered a	eview on 7/8/2021 for patient 2021, certification period I, primary diagnosis of Iliver without ascites, ent titled "Skilled Nursing Visit 1 and signed by RN CC. This fall risk a score of 4 or at risk for falling total: 6 ed unsafe ambulation							

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		151501	B. WING _		07/13/2021	
	ROVIDER OR SUPPLIER FOR HOSPICE AND PA	ALLIATIVE CARE INC, THE		STREET ADDRESS, CITY, STATE, ZIP CODE 501 COMFORT PLACE MISHAWAKA, IN 46545	,	
(X4) ID PREFIX TAG	(EACH DEFICIEI	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPE DEFICIENCY)	OULD BE COMPLETION	
L 604	walker standard Clinical record revietitled "Hospice Plane 6/3/2021 - 8/31/202 intervention SN: and/or injury SN of DME/assistive [didevices SN: assistive [didevices SN:	ation devices standard cane" Ew evidenced A document of Care" for benefit period et. This document stated " assess for history of falls assess need and proper use urable medical equipment] ess patient's risk for falls" Ew evidenced a document ess patient's risk for falls" Ew evidenced a document ess patient ess patient, stated " et [patient] states she fell last ess sleeping on the floor fell enot sustain any injuries pt es a walker or cane" Ew evidenced a document ess a walker or cane ess ess en care plan ess last IDG [interdisciplinary changes in orders no IDG meeting per patient's as fallen 5 or 6 times in the eclinical record failed to for therapy services to	L 6	04		
	#19, start of care d 8/11/2021, primary disease with late or document titled "Sk 5/14/2021 and sign	eview on 7/7/2019 for patient ate 5/14/2021, 5/14/2021 - diagnosis of alzheimer's aset, evidenced an agency cilled Nursing Visit Note" dated ed by RN V. This visit note bulatory [not able to walk] is				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE C IDENTIFICATION NUMBER: A. BUILDING			LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		151501	B. WING _			07/	13/2021	
NAME OF PROVIDER OR SUPPLIER CENTER FOR HOSPICE AND PALLIATIVE CARE INC, THE				501	EET ADDRESS, CITY, STATE, ZIP CODE COMFORT PLACE HAWAKA, IN 46545			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE	
L 604	right left" Clinical record review titled "Interdisciplinar 5/21/2021, which sta no changes since [patient's] husband is bad back patient in him both physically a clinical record failed therapy services to intechniques. Clinical record review titled "Verbal Order" by RN R and MD E. hoyer lift [mobility dedate: 6/2/2021" Clinical record review titled "Hospice Curre for benefit period 5/1 stated " goals See demonstrate safe and techniques" During an interview of when queried if this patherapy candidate, as indicated patient was would be beneficial in the hoyer lift, vice producted in the hoyer lift, vice producted would not he evaluation.	w evidenced a document y Group Meeting" dated ted " changes in careplan last IDG meeting pts primary caregiver has a leeds are overwhelming to and emotionally" The to evidence a referral for a struct caregiver in transfer w evidenced A document dated 6/2/2021 and signed This document stated " vice to lift patient] start w evidenced A document ant Plan of Care - 7/8/2021" 4/2021 - 8/11/2021, which EN: family/caregiver will deffective transfer con 7/8/2021 at 2:39 PM, postient would be a suitable essistant director of nurse so When queried if a therapist in teaching about the use of esident/chief operating officer d not be a reason to order		604				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MU IDENTIFICATION NUMBER: A. BUILI		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		151501	B. WING	····	07/13/2021
NAME OF PROVIDER OR SUPPLIER CENTER FOR HOSPICE AND PALLIATIVE CARE INC, THE			•	STREET ADDRESS, CITY, STATE, ZIP CODE 501 COMFORT PLACE MISHAWAKA, IN 46545	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE COMPLETION
L 604	7/8/2021 at 10:00 AN used the hoyer lift whand out of bed. Patic indicated he/she lifted the help of another part not know how to proper the medical equipmed demonstrated the uses. 5. During an interview when queried how the occupational and spepatients when needed operating officer A inemultiple contracts for looking for other provarea. HOSPICE AIDE ASS CFR(s): 418.76(g)(1) (1) Hospice aides are patient by a registered the interdisciplinary ginstructions for a hospy a registered nurse supervision of a hosp paragraph (h) of this This STANDARD is Based on record revagency failed to ensucompleted tasks only care plan for 2 of 12	registered nurse] R on M. RN R indicated he/she nen he/she got the patient in ent #19's caregiver then d the patient out of bed with erson, because he/she does perly use the hoyer lift and nt provider Q had e of the hoyer lift. W on 7/2/2021 at 1:30 PM, e agency ensures physical, each therapy are available for d, vice president/chief dicated the agency has entherapy providers and are eviders to cover the service AIGNMENTS AND DUTIES The assigned to a specific end nurse that is a member of group. Written patient care pice aide must be prepared to who is responsible for the pice aide as specified under section. The motimate as evidenced by: fiew and interview, the tire the hospice aide of as assigned on the aide active clinical records e aide orders, out of a total	L 62		

STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) M IDENTIFICATION NUMBER: A. BUI		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		151501	B. WING		07/13/2021		
NAME OF PROVIDER OR SUPPLIER CENTER FOR HOSPICE AND PALLIATIVE CARE INC, THE				STREET ADDRESS, CITY, STATE, ZIP CODE 501 COMFORT PLACE MISHAWAKA, IN 46545	•		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	OULD BE COMPLETION		
L 625	Continued From pa	ge 50	L 625				
	5/2021, titled "Hosp " provides care an according to the car [sic] RN [registered	-					
	#3, start of care date 6/18/2021-9/15/202 cerebral atheroscler titled "Hospice Plan 6/18/2021 - 9/15/20; interventions aide	1, primary diagnosis of cosis evidenced a document of Care" for benefit period					
	I .	o evidence specific ospice aide for visits twice a then once a week for 1 week.					
	6/21/2021, 6/24/202 interventions feed visit bath: partial bath: complete no The hospice aide in:	ide Visit Note" dated 21, and 6/28/2021 stated " I patient not applicable this not applicable this visit of applicable this visit" structions were not patient e hospice aide plan of care.					
	when queried why the interventions were in specific task is to be nursing B indicated and the home health contact the RN whe	on 7/12/2021 at 11:50 AM, the home health aide not detailed in providing a completed, the director of the agency is working on this in aides had been educated to in unable to perform a task.					
	#8, start of care date 6/20/21-8/18/2021,						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		151501	B. WING			07/	13/2021	
NAME OF PROVIDER OR SUPPLIER CENTER FOR HOSPICE AND PALLIATIVE CARE INC, THE			•	50	REET ADDRESS, CITY, STATE, ZIP CODE 11 COMFORT PLACE ISHAWAKA, IN 46545			
(X4) ID PREFIX TAG	(EACH DEFICIENCE	TATEMENT OF DEFICIENCIES DY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
L 625	Continued From pag	e 51	L	625				
	benefit period 6/20/2 stated " intervention partial bath: show evidence instructions visits twice a week for 1 week.	ospice Plan of Care" for 021 - 8/18/2021, which ons bath: complete bath: er" The record failed to s to the home health aide for or 8 weeks, then once a week						
		interventions bath: partial visit bath: complete not						
	bath: partial not shower not applica The hospice aide ins	021 stated " interventions applicable this visit bath:						
L 782	queried if the expect health aide to make provide when the capartial bath and comindicated the RN material has a satisfaction of home health aide in home or nursing faciand document the cand that documentate medical record. ORIENTATION AND CFR(s): 418.112(f)	nursing H indicated the the field [seeing patient in lity] would contact the RN are that wouldn't be given, ion would be visible in the TRAINING OF STAFF	L	782				
	ICF/IID facility staff,	rdination with SNF/NF or must assure orientation of care to hospice patients in						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		151501	B. WING		07/1	3/2021
NAME OF PROVIDER OR SUPPLIER CENTER FOR HOSPICE AND PALLIATIVE CARE INC, THE				STREET ADDRESS, CITY, STATE, ZIP CODE 501 COMFORT PLACE MISHAWAKA, IN 46545		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
L 782	and procedures regar pain control, symptom principles about death responses to death, proms, and record keet This STANDARD is an Based on record revelospice agency failed orientation had been facility (SNF) with Nu Agreements who servin 5 of 5 SNF's review. The findings include: 1. Review of agency 7/20/2016, titled "Nur Agreement" stated " orientation and ongoi Facility's personnel a provision of safe and Patients" 2. Review of agency 6/9/2010, titled "Nurs Agreement" stated " orientation and ongoi Facility's personnel a provision of safe and Patients" 3. Review of agency 11/25/2008, titled "Nurs Agreement" stated " orientation and ongoi Facility's personnel a provision of safe and Patients"	ny, including hospice policies rding methods of comfort, in management, as well as in and dying, individual patient rights, appropriate eping requirements. In an and interview, the latter to ensure hospice provided to skilled nursing racility Service viced their hospice patients, and (Entities D, E, F, G, H). I document for SNF D dated sing Facility Services Hospice shall provide ng hospice care training to a necessary to facilitate the effective care to Hospice	L 78			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MUI IDENTIFICATION NUMBER: A. BUILE		FIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		151501	B. WING _			07/13/2021	
NAME OF PROVIDER OR SUPPLIER CENTER FOR HOSPICE AND PALLIATIVE CARE INC, THE				STREET ADDRESS, CITY, STATE, ZIP COD 501 COMFORT PLACE MISHAWAKA, IN 46545		•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFII TAG		ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE	
L 782	3/1/2015, titled "Gel Services Agreemen provide orientation atraining to Facility's facilitate the provisite to Hospice Patients 5. Review of agency 11/8/2012, titled "Nu Agreement" stated orientation and ong Facility's personnel provision of safe an Patients" 6. During an interviwhen queried if hosprovided by agency director of nursing Edepartment provide pandemic some SN	by document for SNF G dated neral Inpatient Hospice t" stated " Hospice shall and ongoing hospice care personnel as necessary to on of safe and effective care	L	782			
	this was not tracked. 7. During an interviwhen queried how to providing care to he hospice orientation nursing B and vice officer A indicated that this. 8. During an intervivice president/chief copy of email with second	rector of nursing B indicated I. ew on 7/2/2021 at 1:30 PM, he nursing facility staff spice patient's receive and training, director of president/chief operating he agency was working on ew on 7/7/2021 at 9:35 AM, operating officer A provided a ubject line titled "Hospice ed 7/6/2021 at 9:49 AM, sent					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		151501	B. WING _		,	07/13/2021
NAME OF PROVIDER OR SUPPLIER CENTER FOR HOSPICE AND PALLIATIVE CARE INC, THE				STREET ADDRESS, CITY, STATE, ZIP CODE 501 COMFORT PLACE MISHAWAKA, IN 46545	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
L 782	to Employee Q whice your team contact ou contracts provide I Vice president/chief copy of documentation	ch stated " could you have r facilities where we have dospice 101 to their staff" operating officer A provided a on of education completed by a liaisons O and P, which spice orientation was	L 7	82		