PRINTED: 06/28/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
151577 B. WING					C 05/11/2021	
	ROVIDER OR SUPPLIER N ANGEL HOSPICE INC			STREET ADDRESS, CITY, STATE, ZIP COI 513 W LINCOLN RD KOKOMO, IN 46902	DE	1 03/11/2021
(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 CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BI E APPROPRIA	
E 000	Initial Comments		EC	000		
L 000	conducted by the Ind Health in accordance Survey Date: 5/11/21 Facility Number: 003 Provider Number: 15 Census: 948 At this Emergency Proguardian Angel Hosp with Emergency Proguedicare and Medicare and Medicare and Suppliers, 42 CF INITIAL COMMENTS This was a federal histate licensure surve Survey Dates: 4/27/5	reparedness survey, pice was found in compliance paredness Requirements for aid Participating Providers R 418.113. cospice recertification and y. 21, 4/28/21, 4/29/21, 5/3/21, , 5/7/21, 5/10/21, 5/11/21 3385 1577 00406660 5: 756	LC	000		
L 509	Assisted living patien Skilled nursing facility Total Current Census EXERCISE OF RIGH PROPRTY/PERSON	t census: 22 / patient census: 87 :: 948 ITS/RESPECT FOR		509		(YS) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATI

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

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		I ` ′	PLE CONSTRUCTION G	, ,	(X3) DATE SURVEY COMPLETED		
		151577	B. WING _			C 05/11/2021	
	ROVIDER OR SUPPLIER	3		STREET ADDRESS, CITY, STATE, ZIP CODE 513 W LINCOLN RD KOKOMO, IN 46902		1 03/11/2021	
(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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
L 509	involving anyone fur the hospice and imm prevent further poter alleged violation is b	stigate all alleged violations nishing services on behalf of nediately take action to ntial violations while the eing verified. Investigations on of all alleged violations n accordance with	L 5	09			
	Based on record rev hospice failed to ens	not met as evidenced by: view and interview, the sure all complaints were ted for 4 of 4 complaints					
	A policy dated 3/30/2 nurse C on 4/4/27/2 "Complaint Resolution personnel conduct a of all written or verbal are tracked and regulaterns or trends are opportunities"	on," stated "Appropriate nd document an investigation al complaints Complaints ularly reviewed to identify nd performance improvement					
	complaint, as no call patients/families LPN patients were not dis evidenced by:	fully investigate each is were made to any other N D cared for, to ensure other estatisfied with care as					
		ne agency complaint log, a 9/2020 was reviewed. The					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		151577	B. WING		C 05/11/2021	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 513 W LINCOLN RD KOKOMO, IN 46902	, 00.1.112021	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDENCY)	D BE COMPLETION	
L 509	that Licensed Practi provided to her father rushed, as she liked wasn't as gentle as documented resultsInvestigator apoloshe would like a differequests [LPN D] no registered nurse cas coaching session wi [LPN D] voiced under A complaint dated 1 A nurse from Skilled stated she requeste told she couldn't cor A felt LPN D was rur of the complaint were on making a visit an voiced understandin A complaint dated 1 A nurse from SNF B requested a visit from breath. When she signed to make the document of the patient of tumor ground return to their how visits. The document of the document of tumor ground return to their how visits. The document were the state of the patient of tumor ground return to their how visits. The document of the patient of tumor ground return to their how visits. The document of the patient of tumor ground return to their how visits. The document of the patient of tumor ground return to their how visits. The document of the patient of tumor ground return to their how visits. The document of the patient of tumor ground return to their how visits. The document of the patient of tumor ground return to their how visits. The document of the patient of tumor ground return to their how visits. The document of the patient of tumor ground return to their how visits. The document of the patient of the patient of tumor ground return to their how visits.	coiced concern over the care cal Nurse (LPN) D had er. She stated that she felt to help with his care. LPN D she would have liked. The of the complaint were "gized to daughter asked if erent nurse daughter it return informed se manager of request th [LPN D] on 10/14/2020 erstanding" 2/24/2021 was also reviewed. Nursing Facility (SNF) A d a visit from LPN D, and was ne now. The nurse from SNF de. The documented results er [LPN D] was coached by time requested [LPN D] g" 2/25/2021 was also reviewed. stated the family of a patient on LPN D for shortness of coke with LPN D, she felt she cake the visit, but that she coumented results of the ituation was discussed with form was completed" Idated 2/24/2021 was not she felt d when she informed the with and requested that she come for visits, including on call ted results of the complaint or discussed empathy during	L 509			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
			7 11 201231			(c
		151577	B. WING			05/	11/2021
	OVIDER OR SUPPLIER			51	TREET ADDRESS, CITY, STATE, ZIP CODE 3 W LINCOLN RD OKOMO, IN 46902		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC 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 509	Continued From page	3	L	509			
L 522	asked how the agence not a systemic proble administrator, indicate responses, patient and quality assessment profeedback from field st INITIAL ASSESSMEN CFR(s): 418.54(a) The hospice registere initial assessment with election of hospice cas §418.24 is complete (patient, or represental assessment be compound that the patient's immediate pregarding wound care initial assessment for reviewed of patients where the patient's immediate pregarding wound care initial assessment for reviewed of patients where the patient's immediate pregarding wound care initial assessment for reviewed of patients where the patient's immediate pregarding wound care initial assessment for reviewed of patients where the patient's immediate policy title Comprehensive Assessment visit to the determine the patient's support needs"	ed through patient survey vocate calls, tracking in erformance indicators, and aff. IT ed nurse must complete an hin 48 hours after the are in accordance with funless the physician, tive requests that the initial leted in less than 48 hours.) not met as evidenced by: ew and interview, the N failed to assess the hysical care needs e physical status upon the 1 of 6 (#13) records with wounds. ed "Assessment - ssment of the Patient," en urse makes an initial epatient/caregiver to is immediate care and	L	522			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		151577	B. WING		C 05/11/2021
	ROVIDER OR SUPPLIER	3	5	TREET ADDRESS, CITY, STATE, ZIP CODE 13 W LINCOLN RD COKOMO, IN 46902	1 03/11/2021
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETION
L 522	physical needs of addressed in order to well-being, comfort, dying process" A policy titled "Regis Manager," dated 6/6"Demonstrates co for the agency Eventhe patient" An undated policy ti Services," stated " [Registered Nurse] of the ongoing sharing contracted facilities to the terminal illness. The clinical record of on 5/4/21 at 2:16 PN election date of 11/2 illness was identified unspecified [brain diwith memory, thinking the record included 11/22/2019, titled "Stated"Description Visit Wound Asse Posterior Buttocks/E Other: Wound care wound" The record also included "Wound Flows [Patient #13] Bilat Coccyx/Decubitus/F	the patient that must be to promote the patient's and dignity throughout the stered Nurse - Case 5/2017, stated, impetency in all skills required faluates nursing needs of the "Coordination of An assigned hospice RN coordinates and facilitates of information with furnishing services related is" If patient #13 was reviewed M and indicated an initial the 2/2/2019. The patient's terminal dias "Alzheimer's Disease isorder that causes problems ing and behavior]." a document dated skilled Nursing Visit Note," in: RN/SOC [Start of Care] issment and Care: Right Decubitus/Pressure Ulcer by facility Unable to assessible uded an undated document theet," which stated "	L 522		

(X1) PROVIDER/SUPPLIER/CLIA

PRINTED: 06/28/2021 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		151577	B. WING _			C 5/11/2021	
	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP CO 513 W LINCOLN RD KOKOMO, IN 46902		<u> </u>	
(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 ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
L 522	Wound Edges: WN Peri Wound Skin: WN The record failed to e comprehensive asses hospice benefit. During an interview o when asked if a facilit patient and managed would the nurse obtai initial assessment. Th indicated they would the facility. CONTENT OF COMF ASSESSMENT CFR(s): 418.54(c)(6) [The comprehensive consideration the folic (6) Drug profile. A re- prescription and over- remedies and other a could affect drug ther not limited to, identific (i) Effectiveness of dr (ii) Drug side effects (iii) Actual or potentia (iv) Duplicate drug the (v) Drug therapy curre laboratory monitoring This STANDARD is r Based on record rev hospice failed to ensu	Clean Bed Color/%: Pink JL [within normal limits] JL [within normal limits]" evidence a thorough initial assment upon election of the In 5/10/2021 at 4:45 PM, ty is taking care of a hospice of their wound as well, how in measurements upon an ine Family Care Coordinator request documentation from PREHENSIVE assessment must take into powing factors: I view of all of the patient's enthe-counter drugs, herbal alternative treatments that apy. This includes, but is cation of the following: The drug interactions derapy ently associated with		530			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		151577	B. WING		C 05/11/2021	
	ROVIDER OR SUPPLIER		51	TREET ADDRESS, CITY, STATE, ZIP CODE 13 W LINCOLN RD OKOMO, IN 46902	1 03/11/2021	
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD & CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETION	
L 530	records reviewed (2) Findings include: 1. An undated policy Content," stated " includes all services and management of related conditions interventions to man detailed statement of services necessary and family needs necessary to meet to 2. An undated policy Management," state maintained for every of the current medic the medication primedications and 3. An undated policy Administration, " state Nurse) or designee proper administration instruction includes administer medications administer medication the safe administrate 4. The clinical record on 4/29/2021 at 9:00 election date of 4/1/of congestive heart	r use, in 10 of 17 active 2, 3, 4, 5, 8, 11, 14, 16, 21, 24). y titled "Plan of CareThe patient's plan of care 3 necessary for the palliation 6 the terminal illness and its . the plan of care includes nage pain and symptoms a of the scope and frequency of to meet the specific patient drugs and treatments he needs of the patient" y titled "Medications - ed " A medication profile is y patient and includes a listing cation orders for each patient rofile includes all prescriptions, alternative supplements" y titled "Medications - ted " The RN (Registered provides instructions on the on of medications	L 530			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE COMP	SURVEY LETED
		151577	B. WING				C 11/2021
	ROVIDER OR SUPPLIER N ANGEL HOSPICE INC			5	TREET ADDRESS, CITY, STATE, ZIP CODE 13 W LINCOLN RD KOKOMO, IN 46902		
(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 BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
L 530	plan of care failed to a goal oxygen saturation notify the physician. 5. The clinical record on 5/3/2021 at 11:47 election date of 12/17 diagnosis of syringom within the spinal cord of care, with benefit p that indicated an order medication list failed and ComfortPak was, who information, instruction effects, and possible medications. 6. The clinical record on 4/28/2021 at 3:41 election date of 10/13 diagnosis of congestic contained a plan of care on a pla	r "oxygen 2l aerosol; r minute intranasally [shortness of breath]." The specify titration orders, a on percentage, or when to of patient #3 was reviewed AM and indicated a hospice 7/2018 and a primary nyelia (a fluid-filled cyst). The record contains a plan period of 2/1/21 to 4/1/21, er for "ComfortPak." The to specify what the lat it contained, dosage ons for use, possible side interactions with other of patient #4 was reviewed PM and indicated a hospice 8/2017 with a primary we heart failure. The record lare, with a benefit period of lat indicated orders for, but buterol [prevent and treat theezing, shortness of dichest tightness caused by s asthma and chronic y disease] Aldactone ssure and heart failure] in blood pressure and heart lats diabetes] Lasix	L	530			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDI	FIPLE CONSTRUCTION NG	, ,	(X3) DATE SURVEY COMPLETED	
		151577	B. WING _			C 05/11/2021
	ROVIDER OR SUPPLIER N ANGEL HOSPICE INC		,	STREET ADDRESS, CITY, STATE, ZIP CO 513 W LINCOLN RD KOKOMO, IN 46902	DE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
L 530	Reglan [treats gastrom Spiriva [treats sympulmonary disease] and chronic obstruct Tamsulosin [treats the prostate] Trazodo Xarelto [treats and period plan of care failed to oxygen being used coxygen. On 4/29/2021, during the medications that the patient were obstincluded Aldactone, Xarelto, Aspirin, and Loratadine failed to be care/medication list. 7. The clinical record on 5/3/2021 at 1:25 lelection date of 7/6/2 of ischemic cardiomy coronary arteries). To care, with a benefit pheriod plan of the medication list for ComfortPak was, whinformation, instructive effects, and possible medications. 8. The clinical record on 5/3/21 at 2:45 PM election date of 3/6/2 of atherosclerotic hecoronary artery (programs).	chloride [supplement] desophageal reflux disease] aptoms of chronic obstructive Symbicort [treats asthma we pulmonary disease] de symptoms of an enlarged ane [treats insomnia] revents blood clots]" The specify when to titrate the ar how much to increase the ga home visit with patient #4, were reported to be taken by derved. The medications Reglan, Spiriva, Symbicort, Loratadine. Aspirin and the evidenced on the plan of and findicated a hospice and of 2/25/2021 to an order for "ComfortPak". Tailed to specify what the at it contained, dosage tons for use, possible side interactions with other and patient #8 was reviewed and indicated a hospice and the plan of		530		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			· ,	(X3) DATE SURVEY COMPLETED	
		151577	B. WING _			C 95/11/2021	
	ROVIDER OR SUPPLIER N ANGEL HOSPICE INC			STREET ADDRESS, CITY, STATE, ZIP CO 513 W LINCOLN RD KOKOMO, IN 46902		1 00/1/1/2021	
(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 ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
L 530	benefit period of 3/6/2 indicated an order for medication list failed ComfortPak is, what information, instruction effects, and possible medications. The plan order for "oxygen 2-6 cannula; as needed; dyspnea [labored bredoes not specify titrat saturation percentage physician. 9. The clinical record on 5/4/21 at 10:30 AM election date of 7/1/2 of Alzheimer's Diseas causes problems with behavior). The record with a benefit period of indicated an order for medication list failed ComfortPak was, who information, instruction effect, and possible in medications. 10. The clinical record reviewed on 5/5/2021 hospice election date diagnosis of cauda ed are compressed and function to the lower of The record contained benefit period of 12/9 an order for "Comfort".	a plan of care, with a 2021 to 6/3/2021, which "ComfortPak." The to specify what the it contained, dosage ons for use, possible side interactions with other in of care also indicated an liters per minute via nasal may titrate for increased athing]." The plan of care cion orders, a goal oxygen e, or when to notify the of patient #11 was reviewed of and indicated a hospice of patient #11 was reviewed of and indicated a hospice of patient #11 was reviewed of and indicated a hospice of patient #11 was reviewed of and indicated a hospice of 12/28/2020 to 2/25/2021, or "ComfortPak." The to specify what the pat it contained, dosage ons for use, possible side interactions with other	L 5	30			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		151577	B. WING			1	C 11/2021
	ROVIDER OR SUPPLIER N ANGEL HOSPICE INC		<u> </u>	5	STREET ADDRESS, CITY, STATE, ZIP CODE 513 W LINCOLN RD KOKOMO, IN 46902	1 03/	11/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
L 530	use, possible side effiniteractions with othe 11. The clinical record reviewed on 5/5/2021 hospice election date diagnosis of Alzheime that causes problems behavior). The record with a benefit period of indicating an order formedication list failed to ComfortPak was, who information, instruction effect, and possible in medications. 12. The clinical record reviewed on 5/5/21 at hospice election date diagnosis of atheroso (progressive buildup of blood flow to the hear contained a plan of cat 4/8/3021 to 6/6/2021, "Morphine 20 mg/ml [mg/0.5 ml by mouth Flours for pain or shor 20 mg/ml 5 mg/0.25 meded] every 2 hour breath Morphine Stake 7.5 - 15 milligram needed for pain; Take daily] for pain Oxynasal cannula; prn as increased dyspnea evidence when to use	formation, instructions for ect, and possible r medications. If of patient #16 was at 4:40 PM and indicated a of 4/23/2021 with a primary er's Disease (brain disorder with memory, thinking and I contained a plan of care, of 4/23/2021 to 7/21/2021, r "ComfortPak". The to specify what the at it contained, dosage ens for use, possible side interactions with other If of patient #21 was at 3:35 PM and indicated a of 8/11/2020 with a primary elerotic heart disease of plaque that causes less at muscle). The record eare, with a benefit period of which indicated orders for similigrams/milliliters] 10 PRN [as needed] every 4 thess of breath Morphine	L	530			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		151577	B. WING		C 05/11/2021
	ROVIDER OR SUPPLIER N ANGEL HOSPICE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 513 W LINCOLN RD KOKOMO, IN 46902	1 00/11/2021
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	D BE COMPLETION
L 530	the physician. 13. The clinical recorreviewed on 5/6/202 hospice election date diagnosis of atherose extremities (narrowin arteries that supply the contained a plan of call 4/2/2021 to 6/30/202 "ComfortPak." The magnetic specify what the Comparison of the contained a plan of call 2/2021 to 6/30/202 "ComfortPak." The magnetic specify what the Comparison of the contained a plan of call 2/2021 to 6/30/202 "ComfortPak." The magnetic specify what the Comparison of the contained a plan of call 2/2021 to 6/30/202 "ComfortPak." The magnetic specific spe	d of patient #24 was 1 at 1:50 PM and indicated a 2 of 1/2/2021 with a primary clerosis native arteries of g and hardening of the ne legs and feet). The record are, with a benefit period of 1, indicated an order for nedication list failed to nfortPak was, what it formation, instructions for fect, and possible	L 53		
L 533	when asked how the how to take pain med one dose, the Family indicated that it would Additionally, when as should be detailed ar medication list, she suppart of CFR(s): 418.54(d) The update of the comust be accomplished interdisciplinary groundividual's attending consider changes the initial assessment. It the patient's progress as well as a reassess response to care. The	mprehensive assessment of by the hospice p (in collaboration with the physician, if any) and must at have taken place since the must include information on so toward desired outcomes,	L 53	33	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		l ` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		151577	B. WING	B. WING		C 05/11/2021	
	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE 613 W LINCOLN RD COKOMO, IN 46902	1 03/	11/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
L 533	Continued From page the patient requires, be every 15 days.	e 12 out no less frequently than	L	533			
	Based on record revi hospice's comprehen include information or toward desired outcon policy to direct the sta	not met as evidenced by: ew and interview, the sive assessment failed to n the patient's progress mes and failed to have a aff to do this for 13 of 25 ved (2, 3, 5, 6, 7, 11, 13, 14,					
	Findings include:						
	on 4/29/2021 at 9:00 election date of 4/1/20 of congestive heart fa	of patient #2 was reviewed AM and indicated a hospice 021 and a primary diagnosis illure (chronic condition in n't pump blood as well as it					
	Practical Nurse (LPN Visit Note," stated " Visit Care Plan Do Patient/caregiver can effective use of home storage, compliance a Progress: 10% Go demonstrate knowled including prognosis, scomplications Progretient/caregiver demadministration of oxyg Goal: Patient/careg	I by Employee G Licensed) G, titled "Skilled Nursing .Description LPN Routine commentation Goal: demonstrate safe and oxygen including: safe and precautions al: Patient/caregiver ge of disease process symptoms, and gress: 10% Goal: nonstrate proper gen Progress: 10%					

PRINTED: 06/28/2021 FORM APPROVED OMB NO. 0938-0391

OLIVILIY	OT OIL MEDIO/IILE A	WEDIO/ ND CEITTIGE				CIVID ITC	7. 0000 0001
_ ` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
							С
		151577	B. WING			1	11/2021
NAME OF PR	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		-
OUADDIA	NAMOEL HOODIGE ING			5′	13 W LINCOLN RD		
GUARDIA	N ANGEL HOSPICE INC			K	OKOMO, IN 46902		
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL	ID PREF	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B	E	(X5) COMPLETION
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	DATE
1 500	0 " 15	40					
L 533	Continued From page		L	533			
		0% Patient/caregiver will					
		t and understanding of plan					
	•	Patient/caregiver able to					
		nptoms] to report to MD					
	=	ons to take Progress: nptoms will be consistent					
		and problems managed as					
		ess will allow Progress:					
	10% Patient/careg	· ·					
	verbalize/demonstrate						
		g when the patient is using					
		rogress: 10% Goal:					
	Family will have need	ded support at time of death Goal: Survivor will be					
		reavement services and,					
	_	e available support to					
	achieve a more positi	• •					
		pal: Patient/caregiver will					
		ing of pain management					
	regimen Progress						
	Patient/caregiver will						
	understanding/demor	nstrate compliance and					
	independence of med	dication regimen and s/s					
	[signs/symptoms] adv	verse reactions to report					
	•	oal: Healing of scabbed area					
	on left medial inner le						
	_	ne record failed to evidence					
	objective measureme	ent of patient-specific goals.					
	2. The clinical record	of patient #3 was reviewed					
		AM and indicated a hospice					
	election date of 12/17						
		nyelia (a fluid-filled cyst					
	within the spinal cord						
	The record contained						
		d by LPN H titled "Skilled stated "Description LPN					

Routine Visit ... Care Plan Documentation ...

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
				-		С	
		151577	B. WING			05/	11/2021
NAME OF P	ROVIDER OR SUPPLIER	•	•	5	STREET ADDRESS, CITY, STATE, ZIP CODE		
				5	513 W LINCOLN RD		
GUARDIA	N ANGEL HOSPICE INC			ŀ	KOKOMO, IN 46902		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE
L 533	Continued From page	e 14		533			
		er will be independent with		000			
		zation Progress: 70%					
	Goal: Knowledge of u	•					
		ress: 70% Goal: Patient					
		ome Goal: 70% Goal:					
		cations 60% Goal:					
		ducation related to her rare					
		: 60% Goal: Anxiety level					
		chievement of health and					
	functioning Progre						
		ntrol of anxiety level					
		Goal: Patient/caregiver can					
	_	ss reduction strategies					
	,	er verbalize understanding					
		ritating foods/fluids that can					
	affect condition Pr	rogress: 60% Goal:					
	Patient/caregiver verl	balizes understanding					
	regarding signs/symp	otoms of urinary tract					
	infections and what to	o report Progress: 60%					
	Goal: Patient/care	giver will acknowledge					
	support and understa	anding of communication					
	needs Progress: 9	90% Goal: Continuity of					
	care will be maintaine	ed as appropriate to					
	patient/primary careg	jiver needs Progress:					
	60% Goal: Patient	t will verbalize decreased					
		ression/hopelessness					
		oal: Patient will discuss her					
		in Angel Hospice Staff					
		oal: Caregiver will identify					
		resources for support					
		oal: Patient will identify					
		resources for support					
		oal: Patient/caregiver can					
		ll with grief Progress: 70%					
		dentify achievable goals,					
		f action Progress: 70%					
	Goal: Patient to allow	•					
	unaffected arm only o						
	lymphoma Progre	ss: 60%" The record					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE S COMPL							
			A. BOILD	_		، ا	C
		151577	B. WING				11/2021
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		-
GHABDIA	N ANGEL HOSPICE INC			5	13 W LINCOLN RD		
GUANDIA	N ANGLE HOSFICE INC			K	OKOMO, IN 46902		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
L 533	3. The clinical record on 5/3/2021 at 1:25 Felection date of 7/6/2 of ischemic cardiomy coronary arteries). The document dated 4/22 Registered Nurse (RI Visit Note," stated " Supervision with RN Documentation Gracknowledge support communication need Goal: Patient/caregivand understanding of Goal: Patient/caregivand understanding of Goal: Patient/caregiver will treatment/prevention 100% Goal: Caregiver by Caregiver device Pwill be able to demonstrate assistance and cuein assistive device Pwill be able to demonstrate the component of the compon	of patient #5 was reviewed PM and indicated a hospice 019 with a primary diagnosis ropathy (narrowing of the ne record contained a 2/2021, completed by N) I, titled "Skilled Nursing "Description RN Aide Visit Care Plan oal: Patient/caregiver will thank and understanding of some support of plan Progress: 100% rer will acknowledge support of plan Progress: 100% goal: verbalize understanding of of diarrhea Progress: giver will be able to the appropriate level of the gwhen the patient is using progress: 100% Patient the strate safely sitting in swivel 100% Goal: Family will that time of death goal: Survivor will be the greavement services and, the available support to	L	533	DEFICIENCY)		
	of disease process a well as disease proce	vill be consistent with stage nd problems managed as ess will allow Progress: ly/caregiver will demonstrate					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
						С	
		151577	B. WING	B. WING		05/	11/2021
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE		
OUADDIA	N 4NOEL HOODIGE ING				513 W LINCOLN RD		
GUARDIA	N ANGEL HOSPICE INC				KOKOMO, IN 46902		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
L 533	Continued From page	<u> 16</u>		533	3		
2 000	, •			00.	3		
		endent patient Progress: alled to evidence objective					
	measurement of patie	<u> </u>					
	measurement or patie	ent-specific goals.					
	4 The clinical record	of patient #6 was reviewed					
		PM and indicated a hospice					
	election date of 3/10/2	•					
		ve heart failure (chronic					
		heart doesn't pump blood					
		The record contained a					
	document dated 4/25	/2021, completed by RN I,					
	titled "Skilled Nursing	Visit Note," stated "					
	Description RN	Aide Supervision with RN					
	Visit Care Plan Do	cumentation Goal:					
	-	ormed stool at frequency					
		patient Progress: 10%					
	Goal: Patient/caregive						
		asures to manage episodes					
	of constipation Pro						
		to verbalize/demonstrate					
		ssistance and cueing when					
		ssistive device Progress:					
		/caregiver will verbalize					
		/injury prevention and home Progress: 10% Goal:					
	l _	. · ·					
		demonstrate necessary good safety awareness and					
	minimize the risk of fa						
		pal: Family will have needed					
		ath Progress: 20%					
	Goal: Survivor will be						
		s and, when needed, will					
		to achieve a more positive					
	grief outcome Prog						
		rill be consistent with stage					
	, ,	nd problems managed as					
		ess will allow Progress:					
	10% Goal: Patient						
		ease process including					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		151577	B. WING	B. WING		C 05/11/2021	
NAME OF P	ROVIDER OR SUPPLIER	10.0			TREET ADDRESS, CITY, STATE, ZIP CODE	1 05/	11/2021
	N ANGEL HOSPICE INC			5	13 W LINCOLN RD COKOMO, IN 46902		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
L 533	of disease on body sy Progress: 10% Go demonstrate complian" The record failed measurement of patie 5. The clinical record on 5/3/2021 at 2:45 Felection date of 7/2/20 of malignant neoplasi (abnormal cells divide body tissue). The record dated 7/18/2018, com "Skilled Nursing Visit RN Routine Visit Goal: Patient/caregiver will of appropriate use of symptom manageme Goal: Patient will be pacceptable pain level management regimer Patient/caregiver will pain management regimer Patient/caregiver will pain management regions Patient/caregiver will pain management regions Patient/caregiver will pain management of patient on 5/4/21 at 10:30 AM election date of 7/1/20 of Alzheimer's Diseas causes problems with behavior). The record	ptoms, complications, effect ystems and what to report oal: Patient/caregiver will nee with treatment regimen to evidence objective ent-specific goals. of patient #7 was reviewed the and indicated a hospice on the with a primary diagnosis of right female breast e uncontrollably and destroy ord contained a document opleted by RN J, titled Note, "stated "Description Care Plan Documentation giver can describe sic] adequate Progress: 80% Goal: demonstrate understanding medications for pain and ont Progress: 10% oain free or verbalize with current pain on Progress: 0% verbalize understanding of gimen Progress: 20% er will demonstrate correct g changes Progress: failed to evidence objective	L	533			

11/2021
(X5) COMPLETION DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPI A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		151577	B. WING			C 5/11/2021	
	ROVIDER OR SUPPLIER N ANGEL HOSPICE INC		STREET ADDRESS, CITY, STATE, ZIP CODE 513 W LINCOLN RD KOKOMO, IN 46902		•		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC 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 533	risks of altered mobil Goal: Family/caregiv measure to achieve or Progress: 10% Goverbalize understand including prognosis, complications Profailed to evidence ob patient-specific goals 8. The clinical record on 5/5/2021 at 9:48 delection date of 12/9 diagnosis of cauda e are compressed and function to the lower The record contained 4/27/2021, complete Nursing Visit Note, saide Supervision with Documentation Gomaintained in safe erappropriate for stage Progress: 90% Go of preventable compl Goal: Patient's syr with stage of disease managed as well as Progress: 90% Paacknowledge suppor Progress: 100% identify ways to deal 90%" The record for measurement of patients.	ess: 10% Goal: verbalize how to minimize ity Progress: 10% er verbalize/demonstrate optimum comfort level oal: Family/caregiver will ing of disease process, symptoms, treatment, and gress: 10%" The record jective measurement of i of patient #14 was reviewed AM and indicated a hospice 2020 with a primary quina syndrome (nerve roots disrupt motor and sensory extremities and bladder). If a document dated did by RN L, titled "Skilled stated"Description RN in RN Visit Care Plan oal: Patient will be invironment and oriented as of disease process oal: Patient will remain free ications Progress: 90% inptoms will be consistent is process and problems disease process will allow atient/caregiver will it and understanding of plan Patient/caregiver can with feelings Progress: ailed to evidence objective	L 53:	3			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '		NSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		151577	B. WING			1	C / 11/2021
	ROVIDER OR SUPPLIER N ANGEL HOSPICE INC	10.007		513 W	ET ADDRESS, CITY, STATE, ZIP CODE / LINCOLN RD OMO, IN 46902	1 03/	11/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
L 533	election date of 9/25// diagnosis of chronic is (narrowed heart arter and oxygen to reach a record contained a do completed by RN E, to Note, "stated "Deso Supervision with RN or Documentation Go signs/symptoms to re nurse/medical doctor Knowledgeable of use medications Progr Patient/caregiver den administration of oxyg Goal: Patient/caregiver and understanding of Goal: Establish/maint Progress: 70% Go verbalize decreased s constipation Goal: verbalizes/demonstra assistance and cuein device: Electric hospi with pump, rollator, w oxygen concentrator Progress: 80%" Th objective measureme 10. The clinical record reviewed on 5/5/2021 a hospice election da primary diagnosis of I (heart conditions that structural problems, a contained a document	2020 with a primary schemic heart disease ies that cause less blood the heart muscle). The ocument dated 1/15/2021, itled "Skilled Nursing Visit cription RN Aide Visit Care Plan oal: Knowledgeable of port to registered Progress: 70% Goal: e, side effects of ess: 70% Goal: nonstrate proper gen Progress: 70% er understand all aspects of its Progress: 70% er will acknowledge support plan Progress: 80% ain normal bowel habits er will acknowledge support signs/symptoms of Patient will be able to the appropriate level of g when using assistive tal bed, reactive air mattress heelchair, gel cushion, with nasal cannula er record failed to evidence ent of patient #17 was at 12:07 PM and indicated the of 4/23/2021 with a neart disease unspecified include diseased vessels, and blood clots). The record		533			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
						С	
		151577	B. WING	B. WING		05/11/2021	
NAME OF P	ROVIDER OR SUPPLIER			;	STREET ADDRESS, CITY, STATE, ZIP CODE		
CHARDIA	N ANCEL HOSPICE INC			,	513 W LINCOLN RD		
GUARDIA	N ANGEL HOSPICE INC			ı	KOKOMO, IN 46902		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC 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 533	Note," stated "Desc Care Plan Docume Patient/caregiver verbunderstanding/demor Progress: 10% will be maintained wit of adult incontinence Goal: Patient's skir Progress: 10% describe measures-mutrition/hydration Patient's nutritional necondition/comfort allo The record failed to e measurement of patient 11. The clinical record reviewed on 5/7/2021 hospice election date diagnosis of malignar (abnormal cells divide body tissue in the maseminal fluid that nou sperm). The record condition/completed Nursing Visit Note," so Aide Supervision with Documentation Goverbalize feelings, em Progress: 80% Goverbalize appropriate stress/anxiety manag Goal: Patient/caregive and understanding of Progress: 80% Goable to verbalize/demassistance and cueing assistive device Progress: Progress: Row Goable to verbalize/demassistive device Progress: Row Goable to verbalize/demassis	cription LPN Routine Visit Intation Goal: palize Instrate adequate fluid intake Goal: Patient's skin integrity In proper skin care and use Insupplies Progress: 10% In remains free of breakdown Goal: Patient/caregiver can Inaintain [sic] adequate Insupplies Goal: Progress: 10% Goal: Progress: 10% Goal: Progress: 10% Goal: Progress: 10% Which is the met as patient's Insupplies with a primary of the prostate of 3/15/2021 with a primary of the prostate of and that produces the prishes and transports ontained a document dated of by RN E, titled "Skilled Itated "Description RN RN Visit Care Plan Insul: Patient/caregiver will Insulications and stressor [sic] al: Patient/caregiver will	L	533			

1, ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATE SURVEY COMPLETED	
		151577	B. WING			C 05/11/2021	
	ROVIDER OR SUPPLIER	NC		STREET ADDRESS, CITY, STATE, 513 W LINCOLN RD KOKOMO, IN 46902		0/11/2021	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIV CROSS-REFERENCEI	AN OF CORRECTION E ACTION SHOULD BE D TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE	
L 533	Progress: 80%" objective measure 12. The clinical recreviewed on 5/7/20 hospice election dadiagnosis of senile (changes in mental judgment or memoral adocument dated M, titled "Skilled NiDescription Record Note: The progress: will demonstrate or agitation/anxiety. Family/caregiver or environment accord comfort status Family/caregiver or decrease patient's 50% Goal: Family be knowledged and, when needed achieve a more porecord failed to evit of patient-specific of the progress of atherograms of the progress of a therograms of the progress of the pro	avoid wound infection The record failed to evidence ment of patient-specific goals. Ford of patient #23 was 221 at 2:00 PM and indicated a ate of 2/9/2021 with a primary degeneration of brain I health, such as a decline in ory loss). The record contained 4/29/2021, completed by RN ursing Visit Note," stated "N Aide Supervision with RN Documentation Goal: ontrolled through course of 50% Goal: Family/caregiver leasures to decrease patient's Progress: 50% Goal: naintain and modify ding to patient's cognitive and Progress: 50% Goal: will demonstrate measures to agitation/anxiety Progress: illy will have needed support at rogress: 30% Goal: Survivor able of bereavement services , will use available support to sitive grief outcome" The dence objective measurement	L	533			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION IG	' '	OATE SURVEY OMPLETED	
		151577	B. WING _			C 05/11/2021	
	ROVIDER OR SUPPLIER N ANGEL HOSPICE INC		STREET ADDRESS, CITY, STATE, ZIP CODE 513 W LINCOLN RD KOKOMO, IN 46902		05/11/2021		
(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 CORR (EACH CORRECTIVE ACTION SHORT CROSS-REFERENCED TO THE AP	HOULD BE	(X5) COMPLETION DATE	
L 533	Note," stated "Des Supervision with RN Documentation Goverbalize understand treatments, s/s [signs to report Progress Patient/caregiver can measures to improve Progress: 30% Go describe intervention Progress: 30% avoid personal conta Goal: Patient/caregiv understanding/demon to reduce risk and av 100% Goal: Patie understanding/demon handwashing Progression	cription RN Aide Visit Care Plan val: Patient/caregiver will ing of disease process, /symptoms] exacerbations : 30% Goal: describe/demonstrate /maintain skin integrity val: Patient/caregiver can is to prevent skin breakdown Goal: Patient/caregiver to ct Progress: 100% er verbalize instrate necessary measures oid infection Progress: int/caregiver verbalize instration proper gress: 100%" The record ective measurement of	L 5	33			
L 545	when asked if all goal and measurable, the Coordinator, indicate the agency evaluated towards goals, she in percentage they have outline of the percent CONTENT OF PLAN CFR(s): 418.56(c) The hospice must de written plan of care for care must reflect patienterventions based of the initial, compreher	d "yes." When asked how I the patient's progress dicated, "There's a e to meet, but there's no age requirements." OF CARE velop an individualized or each patient. The plan of ent and family goals and on the problems identified in	L 5	45			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:	1 ` '	PLE CONSTRUCTION	' '	(X3) DATE SURVEY COMPLETED		
		151577	B. WING			C 05/11/2021
	ROVIDER OR SUPPLIER	C		STREET ADDRESS, CITY, STATE, ZIP COD 513 W LINCOLN RD KOKOMO, IN 46902	E	03/11/2021
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
L 545	palliation and managand related condition	ge 24 vices necessary for the gement of the terminal illness ns, including the following:	L 54	15		
	Based on record re hospice failed to dev care for all needs id	view and interview, the velop an individualized plan of entified in the comprehensive 25 clinical records reviewed				
	Content," stated, "	y titled, "Plan of Care - The plan of care includes, treatments necessary to ne patient"				
	on 4/27/21 at 5:30 F election date of 3/11 diagnosis of cerebro (group of conditions affect the blood vest brain). The record c the benefit period da which stated "Oth Other seizures" T	d of patient #1 was reviewed PM and indicated a hospice 1/2021 with a primary ovascular disease unspecified , diseases, and disorders that sels and blood supply to the ontained a plan of care with lates 3/11/2021 to 5/9/2021, her Pertinent Diagnosis The plan of care failed to ecautions being listed.				
	on 4/28/2021 at 3:4 election date of 10/1 diagnosis of conges condition in which the as well as it should)	d of patient #4 was reviewed 1 PM and indicated a hospice 13/2017 with a primary tive heart failure (chronic ne heart doesn't pump blood . The record contained a plan efit period dates 3/26/2021 to				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		151577	B. WING			l	244/2024
	ROVIDER OR SUPPLIER N ANGEL HOSPICE INC	101077		STREET ADDRESS, CITY, STATE, ZIP COD 513 W LINCOLN RD KOKOMO, IN 46902	E	<u> U5/</u>	11/2021
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	X (EACH CORRECTIVE ACTION	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
L 545	5/24/2021, which stated "Medication Xarelto [treats and prevents blood clots] oxygen [supplement]" The plan of care failed to evidence bleeding and oxygen precautions being listed. 4. The clinical record of patient #6 was reviewed on 5/3/2021 at 2:30 PM and indicated a hospice election date of 3/10/2021 with a primary diagnosis of congestive heart failure (chronic condition in which the heart doesn't pump blood as well as it should). The record contained a plan of care with the benefit period dates 3/10/2021 to 6/7/2021 which failed to evidence any skilled nursing interventions. 5. During an interview on 5/10/2021 at 2:25 PM, when asked if a patient with a history of seizures should have seizure precautions listed on their plan of care, the Family Patient Care Coordinator stated, "yes." REVIEW OF THE PLAN OF CARE CFR(s): 418.56(d) A revised plan of care must include information from the patient's updated comprehensive assessment and must note the patient's progress		TAG CROSS-REFERENCED TO THE APPRO				
	This STANDARD is r Based on observatio interview, the hospice IDG (Interdisciplinary problems identified or	n the problem list and its of 2 observations of a					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		151577	B. WING			·	11/2021
	ROVIDER OR SUPPLIER N ANGEL HOSPICE INC			5	TREET ADDRESS, CITY, STATE, ZIP CODE 13 W LINCOLN RD COKOMO, IN 46902	1 03/	11/2021
(X4) ID PREFIX TAG			(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE	
L 553	Services," stated "T team] meets every two planning for the hospicach patient/caregive minimum, every 15 da 2. The clinical record on 4/28/2021 at 3:41 election date of 10/13 diagnosis of congestic condition in which the as well as it should). of care, with a benefit 3/25/21, that indicated limited to, "Albuterol. Lantus Lasix Mir per minute via nasal on needed; For SOB ma Potassium chloride" On 4/29/2021, during the medications that we the patient were obseincluded Aldactone, Fixarelto, Aspirin, and I Loratadine were not in medications on the pluring observation of Group's meeting on 5 patient's recertifications.	titled "Coordination of The IDT [interdisciplinary to weeks to provide care ice's patients/caregivers er is discussed, at a lays" of patient #4 was reviewed PM and indicated a hospice of 1/2017 with a primary we heart failure (chronic en heart doesn't pump blood. The record contained a plan aperiod of 1/25/21 to dorders for, but are not Aldactone Carvedilol aLAX Oxygen 2-6 liters cannula; continuous as y titration [sic] Pepcid a Reglan Spiriva psin Trazodone Xarelto a home visit with patient #4, were reported to be taken by served. The medications Reglan, Spiriva, Symbicort, Loratadine. Aspirin and included on the list of an of care.		553			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			7 56.25			С
		151577	B. WING _		0	5/11/2021
	ROVIDER OR SUPPLIER N ANGEL HOSPICE INC			STREET ADDRESS, CITY, STATE, ZIP CC 513 W LINCOLN RD KOKOMO, IN 46902	DDE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETION DATE
L 553	3. The clinical record on 5/4/2021 at 1:15 P election date of 10/30 diagnosis of dementia social symptoms that functioning). During observation of Group's meeting on 5 patient's recertificatio to evidence a discuss of care and review of 4. During an interview when asked if the Interview when asked if the Interview of each patient changes, the adminisit says we are going the COORDINATION OF CFR(s): 418.56(e)(2) [The hospice must desystem of communication accordance with the reprocedures, to-] (2) Ensure that the caprovided in accordance with the response of the provided in accordance of the provid	of patient #12 was reviewed M and indicated a hospice 1/2020 with a primary a (group of thinking and interferes with daily If the Interdisciplinary 1/6/2021 at 9:00 AM, the n was discussed, but failed sion of the patient's total plan all active problems. If on 5/11/2021 at 4:45 PM, erdisciplinary Group over the comprehensive at, even if there are no trator stated, "Per our policy, o update as needed." SERVICES Evelop and maintain a ation and integration, in nospice's own policies and are and services are ce with the plan of care. Into met as evidenced by: iew and interview, the ence that all services were ce with the plan of care for 1		553		
	of 17 active records re					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		151577	B. WING _				C 11/2021
	ROVIDER OR SUPPLIER N ANGEL HOSPICE INC			513 V	ET ADDRESS, CITY, STATE, ZIP CODE V LINCOLN RD OMO, IN 46902	1 03/	11/2021
(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)		(X5) COMPLETION DATE
L 555	Case Manager," datesubmits accurate de hours of visit responsition responsition and procedure service delivery, docto coordination" An undated policy title stated, " Verbal order physician in order to services to meet the Documentation of the and of the written order maintained in the pattern of the stated, " The plan of limited to treatmen needs of the patient The clinical record of on 5/5/2021 at 9:48 Arelection date of 12/9/diagnosis of cauda erare compressed and function to the lower of the record contained 1/14/2021, completed O, titled "Skilled Nurs Description RN F. Narrative Notes W 10 cc [cubic centimet using sterile technique evidence an order was serviced and order wa	at titled "Registered Nurse - d 6/6/2017, stated, " coumentation within 24 consible for following all res of the agency regarding umentation, and care ed, "Physician Orders," ers are obtained from the provide the following the needs of the patient the receipt of the verbal order er sent to the physician are itent's clinical record" ed, "Plan of Care - Content," of care includes, but is not tts necessary to meet the" patient #14 was reviewed with and indicated a hospice 2020 with a primary quina syndrome (nerve roots disrupt motor and sensory extremities and bladder).		555			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
						(
		151577	B. WING			05/	11/2021
	ROVIDER OR SUPPLIER N ANGEL HOSPICE INC			51	TREET ADDRESS, CITY, STATE, ZIP CODE I3 W LINCOLN RD OKOMO, IN 46902		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
L 555	patient, should there I their chart, the Family stated, "yes."	e 29 e anchored a catheter on a be an order for a catheter in Patient Care Coordinator GNMENTS AND DUTIES		555 625			
	patient by a registered the interdisciplinary grant instructions for a hosp by a registered nurse supervision of a hosp paragraph (h) of this s						
	Based on record revihospice failed to provinstructions for the aid 25 records reviewed t services (#1, 2, 3, 4, 6, 16, 17, 20, 21, 22, 23)	not met as evidenced by: ew and interview, the ide patient-specific written de for patient care in 21 of that have home health aide 6, 8, 9, 10, 12, 13, 14, 15, , 24).					
	Aide," stated "Job I	scription titled "Hospice Duties Renders services vith the written plan of care					
	RN [Registered Nurse supervising the hospi patient care instructio and not generic"	ies," stated "The hospice e] responsible for ce aide prepares written ns that are patient-specific					
	3. The clinical record	of patient #1 was reviewed					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION 3	(X3) DATE SURVEY COMPLETED
		151577	B. WING		C 05/11/2021
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 513 W LINCOLN RD KOKOMO, IN 46902	1 03/11/2021
(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 CORREC' (EACH CORRECTIVE ACTION SHOUNDER OF THE APPRENCED TO THE APPRENC	JLD BE COMPLETION
L 625	on 4/27/21 at 5:30 PI election date of 3/11/a document titled "AiInterventions ox standard precautions bath straighten ro document skills, equi often to complete intervention of 4/29/2021 at 9:00 election date of 4/1/2 document titled "AideInterventions as repositioning, alignm ambulation, exercise bed/chair with assists shower", but failed equipment needed, v complete intervention 5. The clinical record on 5/3/2021 at 11:47 election date of 12/13 a document titled "AiInterventions co support recognize the patient's skin con [Registered Nurse] if change patient linen standard precautions", but failed to documeded, when or how interventions.	M and indicated a hospice 2021. The record contained de Care Plan," and stated, " ygen precautions bath bed Sponge om", but failed to pment needed, when or how erventions. of patient #2 was reviewed AM and indicated a hospice 021. The record contained a c Care Plan," and stated, " sist with positioning, ent assist with transfers, program transfer to ance bath partial bath d to document skills, when or how often to as. of patient #3 was reviewed AM and indicated a hospice 7/2018. The record contained de Care Plan," and stated, " mpanionship/emotional and report any changes in dition report to RN no BM [bowel movement] light housekeeping light housekeeping universal precautions ument skills, equipment	L 62	25	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		151577	B. WING		C 05/11/2021
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 513 W LINCOLN RD COKOMO, IN 46902	03/11/2021
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
L 625	fall precautions standard precaution skills, equipment ne complete intervention 7. The clinical record on 5/3/2021 at 2:30 election date of 3/10 a document titled "AInterventions a repositioning, alignm incontinent [sic] c light housekeepin companionship and precautions oxyg	ssist with transfers, e program companionship oxygen precautions s", but failed to document eded, when or how often to ons. d of patient #6 was reviewed PM and indicated a hospice 1/2021. The record contained ide Care Plan," and stated, " ssist with positioning, nent assist with transfers are change patient linen g may provide emotional support fall en precautions", but failed equipment needed, when or	L 625		
	on 5/3/2021 at 2:45 election date of 3/6/document titled "AidInterventions a repositioning, alignn Total hip precauti report to RN [Reg [bowel movement] companionship and failed to document swhen or how often to 9. The clinical record on 5/4/2021 at 9:30 election date of 5/9/document titled "AidInterventions a	d of patient #8 was reviewed PM and indicated a hospice 2021. The record contained a e Care Plan," and stated, " ssist with positioning, nent assist with transfers ons incontinent [sic] care istered Nurse] if no BM shampoo emotional support", but kills, equipment needed, o complete interventions. d of patient #9 was reviewed AM and indicated a hospice 2019. The record contained a e Care Plan," and stated, " ssist with transfers e fall precautions safety			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		151577	B. WING		05/11/2	021
	ROVIDER OR SUPPLIER	3		STREET ADDRESS, CITY, STATE, ZIP CODE 513 W LINCOLN RD KOKOMO, IN 46902	03/11/2	<u>021</u>
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE CO	(X5) MPLETION DATE
L 625	equipment needed, complete intervention 10. The clinical recording reviewed on 5/4/202 a hospice election do contained a docume and stated, "Interreport any changes ROM [range of moti transfers report the BM [bowel moveme companionship recomplete intervention of the companionship recomplete intervention of the companionship recomplete intervention.	rfailed to document skills, when or how often to ons. and of patient #10 was 21 at 10:00 AM and indicated ate of 11/23/2019. The record ent titled "Aide Care Plan," eventions recognize and in patient's skin condition on] exercises assist with o RN [Registered Nurse] if no ent] may provide may provide emotional support cument skills, equipment	L 62	5		
	11. The clinical recoreviewed on 5/4/202 hospice election dat contained a docume and stated, "Interbed/chair with assis chair/wheelchair Nurse] if no BM [box [sic] care cathete aromatherapy Ar laundry", but faile equipment needed, complete intervention 12. The clinical recoreviewed on 5/4/202 hospice election dat contained a docume and stated, "Intercare universal pr	report to RN [Registered wel movement] incontinent er care companionship ngel Touch do patient ed to document skills, when or how often to				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	COMPLETED			
		151577	B. WING			C 05/11/2021
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 513 W LINCOLN RD KOKOMO, IN 46902	.	03/11/2021
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
L 625	shampoo", but equipment needed, complete intervention 13. The clinical reconstruction reviewed on 5/5/202 hospice election data contained a docume and stated, "Intervention positioning, reposition with transfers incomposition to RN [Registered Not movement] change companionship and precautions standard precautions", but	remotional support shave failed to document skills, when or how often to ns. In at 9:48 AM and indicated a se of 12/9/2020. The record int titled "Aide Care Plan," wentions assist with oning, alignment assist ontinent [sic] care report urse] if no BM [bowel ge patient linen emotional support fall dard precautions universal failed to document skills, when or how often to	L 62	5		
	reviewed on 5/5/202 a hospice election decontained a docume and stated, "Intervention of the chair/wheelchair report to RN [Reg [bowel movement] change patient linent emotional support standard precautions shave", but failed equipment needed, complete intervention of the content of the content of the change patient linent emotional support standard precautions shave", but failed equipment needed, complete intervention of the change of the content of the change of the content of the change of the content o	fluid intake - encourage fluids istered Nurse] if no BM incontinent [sic] care s companionship and universal precautions s oxygen precautions to document skills, when or how often to				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		151577	B. WING _				C 11/2021
	ROVIDER OR SUPPLIER N ANGEL HOSPICE INC		•	STREET ADDRESS, CITY, STATE, 513 W LINCOLN RD KOKOMO, IN 46902	ZIP CODE		-
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION E ACTION SHOULD B D TO THE APPROPRIA CIENCY)		(X5) COMPLETION DATE
L 625	directed by RN [Regis [sic] care make parecautions stands failed to document sk when or how often to 16. The clinical record reviewed on 5/5/2021 a hospice election das contained a document and stated, "Intervereport any changes in companionship bath - shower b report to RN [Regis [bowel movement] companionship and exprecautions stands precautions stands precautions shamp care", but failed to needed, when or how interventions. 17. The clinical record reviewed on 5/5/21 at hospice election date contained a document and stated, "Intervereport any changes in give SSE [sic] as d Nurse] incontinent [Registered Nurse] if change patient linen bed bath - shower water temperature charge remotional support	entions give SSE [sic] as stered Nurse] incontinent tient bed shave fall and precautions", but ills, equipment needed, complete interventions. If of patient #17 was at 12:07 PM and indicated the of 4/23/2021. The record at titled "Aide Care Plan," entions recognize and in the patient's skin condition bath - partial bath - bed ath change patient linen stered Nurse] if no BM incontinent [sic] care motional support fall and precautions universal coo shave denture document skills, equipment of often to complete	L	525			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		, , ,	(X3) DATE SURVEY COMPLETED	
		151577	B. WING			C 5/11/2021	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 513 W LINCOLN RD KOKOMO, IN 46902		S/11/2021	
(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 ((EACH CORRECTIVE ACTIVE	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
L 625	equipment needed, we complete intervention 18. The clinical recorreviewed on 5/5/21 a hospice election date contained a documer and stated, "Interventransfers recognize the patient's skin con bath - tub bath bath - bed chare RN [Registered Nursmovement] incont [sic] as directed by R shampoo water the pain report pain to oxygen precautions universal precautions universal precautions skills, equipment needecomplete intervention 19. The clinical recorreviewed on 5/7/2022 hospice election date contained a documer and stated, "Intervention and stated, "Intervention incontinent [sic] care Nurse] if no BM [bow patient linen do pa shave fall precaprecautions universalled to document skilled to document skill	failed to document skills, when or how often to his. d of patient #21 was to 3:35 PM and indicated a for 68/11/2020. The record in titled "Aide Care Plan," entions assist with the eand report any changes in dition bath - shower chair partial bath - complete high patient linen report to help if no BM [bowel inent [sic] care give SSE N [Registered Nurse] mperature check assess on nurse fall precautions should be shown of the to his. d of patient #22 was to at 1:30 PM and indicated a for 63/15/2021. The record hit titled "Aide Care Plan," entions provide emotional support report to RN [Registered helmovement] change attent laundry shampoo autions standard real precautions", but faills, equipment needed, complete interventions.	L 629	5			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		151577	B. WING _			C 05/11/2021	
NAME OF PROVIDER OR SUPPLIER GUARDIAN ANGEL HOSPICE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 513 W LINCOLN RD KOKOMO, IN 46902			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETION DATE		
L 625			L6	25	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		