PRINTED: 02/12/2021 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 151605		(X2) MULTIPLE CONSTRUCTION       (X3) DATE SURVEY         A. BUILDING       00       COMPLETED         B. WING       01/29/2021				ETED	
NAME OF PROVIDER OR SUPPLIER  AMEDISYS HOSPICE				305 QU	ADDRESS, CITY, STATE, ZIP COD ARTERMASTER CT RSONVILLE, IN 47130		
	<u> </u>			1	COUNTELL, IN 47 150		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROP	E	(X5) COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
L 0000							
Bldg. 00	investigation of a de	CMS, a federal complaint eemed hospice agency was	L 0	000			
	conducted by the In	diana Department of Health.					
	Survey Dates: Janua of 2021	ary 26th, 27th, 28th, and 29th					
	Complaint IN00345 sufficient evidence.	5548 Unsubstantiated: Lack of					
	Complaint IN00340 findings cited.	977 Substantiated: No federal					
S 0000							
Bldg. 00							
	1	a state relicensure survey and aint investigation of a hospice	S 00	000			
	Survey Dates: Janua of 2021.	ary 26th, 27th, 28th, and 29th					
	Complaint IN00345 sufficient evidence.	5548 Unsubstantiated: Lack of					
		9977 Substantiated: State to the allegation were cited.					
		0635 Substantiated: State to the allegation were cited.					
	Complaint IN00269 sufficient evidence.	0051 Unsubstantiated: Lack of					
	Quality Review con	mpleted on 2/8/2021 A4					

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

(X6) DATE

TITLE

Any defiency statement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclodays 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.

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		COMPLETED		
151605		B. W	B. WING 01/29			2021	
NAME OF PROVIDER OR SUPPLIER  AMEDISYS HOSPICE			STREET ADDRESS, CITY, STATE, ZIP COD  305 QUARTERMASTER CT  JEFFERSONVILLE, IN 47130				
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
S 0512  Bldg. 00	(1) Receive effective symptom control for conditions related  Based on record reversal failed to respond profor 1 of 8 records responding include:  A 10/20/2020 revised Family Rights and It was not limited to, have the right to It symptom management conditions relation to the complete record diagnosis of COPD pulmonary disease). The record evidence A document titled Ventered by Employed limited to: "Patient movements and son date of last BM: 3/3 significantly affect to treatment initiated?  A document titled Ventered by Employed limited to, "Reports supplies or medication Does the nausea significant in the condition of t	right to the following:  Ve pain management and rom the hospice for to the terminal illness;  riew and interview the agency comptly symptom management viewed. (Patient 3)  ed policy titled "Patient and Responsibilities" indicated, but "The patient and the family Receive effective pain and ent from the hospice for to the terminal illness."  d for patient 3, with a terminal (chronic obstructive was reviewed on 1/26/21. The determinal indicated, but was not reports decreased bowel the nausea todayIndicate 0/18Does nausea the patient? YesWas nausea the patient? YesWas nausea	S 0:	512	S512 418.52 (c)(1) Rights of the Patient-The patient has a right the following: (1) Receive effer pain management and symptocontrol from the hospice for conditions related to the terminillness.  Compliance of this standard with the patient interventions to ensure the patient has a right to receive effective symptom control from hospice for conditions related the terminal illness.  2. Effective 2/9/2021 the Administrator, Director of Operations (DOO) with the assistance of the Clinical Maninitiated comprehensive and systematic changes for the cacenter to ensure changes in the patient's condition will be reflein the patients ongoing plan of care by the Clinical Manager of RN overseeing the patient's candition will be reflein the patients ongoing plan of care by the Clinical Manager of RN overseeing the patient's candition all nurses by the Administrator/Director of Operations on appropriate and other patients on appropriate and other patients.	t to ctive ctive com nal rill con rator/ to sure ve n the to ager re ne cted crare. ed for	03/05/2021

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

PRINTED: 02/12/2021 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 151605	(X2) MULTIPLE C A. BUILDING B. WING	onstruction 00	(X3) DATE S COMPLE 01/29/2	TED
NAME OF PROVIDER OR SUPPLIER  AMEDISYS HOSPICE		305 QI	ADDRESS, CITY, STATE, ZIP COI JARTERMASTER CT RSONVILLE, IN 47130	)		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APP DEFICIENCY)	CTION JLD BE ROPRIATE	(X5) COMPLETION DATE
	Report dated 4/9/18 indicated, but was a extreme nausea forHospital 1 to get mediation".  A document titled 1 4/10/18 entered by not limited to, an or hours as needed for On 1/29/21 at 1:00 interviewed. When 3/3/0/18 and 4/9/18 being initiated ever significantly affecti stated they would be Employee B return not answer for Emp	Client Coordination Note Bentered by Employee L not limited to, "Been having the past week. Will contact an order for an anti-nausea  Hospice Physician Order dated Employee L indicated, but was rder for Zofran 8 MG every 8 r nausea.  p.m. Employee B was a sked about the entries on and nausea treatment not a though the nausea was ng the patient, Employee B ave to look into it. When ed, they stated that they could ployee L, but Employee B L should have addressed it.		policies related to deficie Review of Agency and Procedures: to be co by administrative staff or and 2/11/21 o AA-005 Hospice Plan o o AA-006 Interdisciplinar o RI-001 Patient Right at Responsibility o MM-004 Comfort Medic o MM-003 Pain and sym management o MM-001A Medication Management o AA-003 Assessment  4. 4. To ensure the completion of: developm adherence, and ongoing with appropriate revision patient-specific plan of ca accordance with the patic current condition/needs a agency's policies and pro a comprehensive auditin will be started beginning 2/15/2021. The audit will weekly review of clinical documentation (nursing coordination notes) of 10 patient census to ensure follow up was completed pain and symptom mana This will be reviewed unt compliance is achieved, 10% or 10 charts, whiche larger, will be reviewed of until 100% compliance in sustained for 3 quarters. 5. 5. All findin	Policies ompleted in 2/10/21 of Care y Team and cation ptom onent, evaluation to the are in ent's and ocedures, g process consist of proper timely for gement. ii 100% and then ever is quarterly as been	

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

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 151605		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 01/29/2021	
	PROVIDER OR SUPPLIER		305 QL	ADDRESS, CITY, STATE, ZIP COD JARTERMASTER CT RSONVILLE, IN 47130	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BATE
S 0650 Bldg. 00		OSPICE PATIENT AND		be reported at the quarterly Committee meeting and Gove Body as appropriate, but at leannually. 6. 6. Completion date of 3/5/2021	erning east
Bldg. 00	SERVING THE HOSPICE PATIENT AND FAMILY The hospice must provide hospice care that- (1) Optimizes comfort and dignity; and (2) Is consistent with patient and family needs and goals, with patient needs and goals as priority.  Based on record review and interview, the agency failed to provide care that optimized end of life comfort in 1 of 8 records reviewed. (Patient 3).  Findings include:  A 10/20/2020 revised policy titled "Patient and Family Rights and Responsibilities" indicated, but was not limited to, "The patient and the family have the right to Receive effective pain and symptom management from the hospice for conditions relation to the terminal illness."  The complete record for patient 3, with a terminal diagnosis of COPD (chronic obstructive pulmonary disease), was reviewed on 1/26/21. The record evidenced the following:  A document titled Visit Note Report dated 3/30/18 entered by Employee L indicated, but was not limited to: "Patient reports decreased bowel movements and some nausea todayIndicate		S 0650	S650 418.100(a) Serving the Hospice patient and Family: hospice must provide hospic that-(1) Optimizes comfort ar dignity and 2. Is consistent vipatient and family needs and goals, with patient needs and goals as priority.  Compliance of this standard be met:  1. Effective 2/9/2021 base on survey findings, The Administrator/Director of Operation(DOO) to implement interventions to ensure the period has a right to receive effective symptom control from the hofor conditions related to the terminal illness.  2. Effective 2/9/2021 the Administrator, Director of Operations(DOO) with the assistance of the Clinical Market in the service of the Clinical Market in the service patients.	The e care nd vith l d will sed nt atient e spice

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		COMPLETED		
151605		B. WING 01/29/2021			/2021		
				STREET /	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF PROVIDER OR SUPPLIER					JARTERMASTER CT		
VMEDIC	YS HOSPICE				RSONVILLE, IN 47130		
AMEDIS	TOTIOSFICE			JEFFER	ASONVILLE, IN 47 130		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	treatment initiated?	No".			initiated comprehensive and		
					systematic changes for the ca	re	
		Visit Note Report dated 4/9/18			center to ensure changes in the	ne	
		ee L indicated, but was not			patient's condition will be refle	cted	
	_	s lots of nausea this weekNo			in the patient's ongoing plan o	f	
		tions needed at this time			care by the Clinical Manager		
		significantly affect the patient?			RN overseeing the patient's ca	are.	
	YesWas nausea	treatment initiated? No".			<ol><li>Education/Training-</li></ol>		
					Initiated 2/9/2021, Compreher	ısive	
		Client Coordination Note			re-education and remediation	for	
	_	8 entered by Employee L			all nurses by the		
		not limited to, "Been having			Administrator/Director of		
		the past week. Will contact		Operations on appropriate agency			
	Hospital 1 to get an order for an anti-nausea			policies related to deficient areas:			
	mediation".				. Review of		
					Agency Policies and Procedu	res:	
	A document titled Hospice Physician Order dated				to be completed by administra	ıtive	
	4/10/18 entered by Employee L indicated, but was				staff on 2/10/21 and 2/11/21		
	not limited to, an order for Zofran 8 MG every 8				O AA-005		
	hours as needed for	r nausea.			Hospice Plan of Care		
					O-AA-006		
		p.m. Employee B was			Interdisciplinary Team		
	interviewed. When asked about the entries on				O-RI-001		
		3 and nausea treatment not			Patient Right and Responsibil	ity	
	being initiated even though the nausea was				O-MM-004		
	significantly affecting the patient, Employee B				Comfort Medication		
	stated they would have to look into it. When				O-MM-003 P	ain	
	Employee B returned, they stated that they could				and Symptom management		
	_	oloyee L, but Employee B			O-MM-001A		
	thought Employee	L should have addressed it.			Medication Management		
					O-AA-003		
					Assessment		
					4. To ensure the complet		
			of: development, adherence, and				
					ongoing evaluation with		
					appropriate revision to the pat		
					specific plan of care in accord	ance	
					with the patient's current		
					condition/needs and agency's		
		1		policies and procedures, a			

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

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NAME OF PROVIDER OR SUPPLIER  AMEDISYS HOSPICE  (X4) ID PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG  REGULATORY OR LSC IDENTIFYING INFORMATION  TAG  Comprehensive auditing process will be started beginning 2/15/21. The audit will consist of weekly review of clinical documentation/(nursing coordination notes) of 100% patient census to ensure proper follow up was completed timely for pain and symptom management. This will be reviewed until 100% compliance is achieved, and then 10% or 10 charts, whichever is larger, will be reviewed quarterly until 100% compliance has been sustained for 3 quarters.  5. All findings will be reported at the quarterly committee meeting and Governing Body as appropriate, but at least	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 151605	(X2) MULTIPLE CONSTRUCTION A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 01/29/2021	
PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION  Comprehensive auditing process will be started beginning 2/15/21. The audit will consist of weekly review of clinical documentation(nursing coordination notes) of 100% patient census to ensure proper follow up was completed timely for pain and symptom management. This will be reviewed until 100% compliance is achieved, and then 10% or 10 charts, whichever is larger, will be reviewed quarterly until 100% compliance has been sustained for 3 quarters.  5. All findings will be reported at the quarterly QAPI committee meeting and Governing Body as appropriate, but at least				305 (	QUARTERMASTER CT		
annually. 6. Completion date of 3/5/2021	(X4) ID PREFIX	SUMMARY (EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)  comprehensive auditing proc will be started beginning 2/15. The audit will consist of weel review of clinical documentation(nursing coordination notes) of 100% patient census to ensure profollow up was completed time pain and symptom managem. This will be reviewed until 100 compliance is achieved, and 10% or 10 charts, whichever larger, will be reviewed quart until 100% compliance has be sustained for 3 quarters.  5. All findings will be reported at the quarterly QAR committee meeting and Gove Body as appropriate, but at leannually.  6. Completion date of	cess 5/21. kly  per ely for nent. 0% then is erly eeen	

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