PRINTED:	09/08/2020
FORM API	PROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED OMB NO. 0938-039

	VT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 151544	A. BUILD B. WING		COI	ATE SURVEY MPLETED 7 29/2020	
NAME OF PROVIDER OR SUPPLIER HARBOR LIGHT HOSPICE			STREET ADDRESS, CITY, STATE, ZIP COD 1229 ARROWHEAD COURT CROWN POINT, IN 46307				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION		FIX (EACH CORRECT)	PLAN OF CORRECTION IVE ACTION SHOULD BE CED TO THE APPROPRIATE FICIENCY)	(X5) COMPLETION DATE	
E 0000							
Bldg. 00		Infection Control and vas conducted from 6/23/20 -	E 0000				
	Facility #: 009088 Active Patients: Cr 14; Mishawaka - 6:	own Point - 60; Indianapolis - 5					
	Preparedness surver implementation of s was found to be in o 418.113 Emergency	ection Control Emergency y, in regards to staffing and staffing, Harbor Light Hospice compliance with 42 CFR 7 Preparedness Requirements ipating Providers and Suppliers es.					
L 0000							
Bldg. 00		Infection Control and was conducted from 6/23/20 -	L 0000				
	Federal and State D related and unrelate	eficiencies were cited with d findings.					
	Facility #: 009088						
	Active Patients: Cr 14; Mishawaka - 6:	own Point - 60; Indianapolis - 5					
	Complaints:						
	IN00322120 - subst	antiated with findings.					
	A DIRECTOR'S OR PRO	VIDER/SUPPLIER REPRESENTATIVE'S S	IGNATURE		I F	(X6) DATE	

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

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

	IT OF DEFICIENCIES OF CORRECTION	x1) provider/supplier/clia identification number 151544	(X2) MULTIPLE C A. BUILDING B. WING	<u>00</u>) DATE SURVEY COMPLETED 06/29/2020
	PROVIDER OR SUPPLIE		1229 A	ADDRESS, CITY, STATE, ZIP COD ARROWHEAD COURT VN POINT, IN 46307	
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	IN00296797 - sub	estantiated with findings.			
L 0512	Quality Review c 418.52(c)(1)	ompleted on 8/17/2020 A4			
Bidg. 00	RIGHTS OF THI The patient has (1) Receive effect symptom contro conditions relate Based on record r agency failed to e evaluated the pati discharged clinica of 10 clinical record The findings inclu The agency policy number 09.09.01, Reassessment" sta Hospice staff will pain. Each patien management and related to the term define processes fi management reassessed on an of criteria, including rating scale). Dur e.g., dull, throbbin pain therapy or tro current therapy or	a right to the following: ctive pain management and l from the hospice for d to the terminal illness; eview and interview, the hospice insure the registered nurse ents pain level in 1 of 6 il records reviewed, out of a total ords reviewed. (#1) de: v dated April 1, 2014, policy titled "Pain Assessment and tted " Policy Appropriate assess and reassess patient's t will receive effective pain symptom control for conditions tinal illness Purpose To for pain assessment and 2. Each patient will have pain ongoing basis using established : Location Intensity (using pain ration. Frequency. Character, ng, aching, sharp, etc. Current eatment. Effectiveness of	L 0512	L512 What is the deficiency? L512 418.52c(1) Rights of the Patient (1) Patient has the right to receive effective pain management and symptom control from the hospice conditions related to terminal illness. 1. How are you going to correct the deficiency? Tag 512 L512 418.52c(1) Rights the Patient- The Clinical Management staff have educated all nursing staff on patient rights and policy 9.09.01 Pain assessment and reassessment. 2. How are you going to prevent the deficiency from recurring in th future, even if already corrected? Monitoring and management for pain assessment will occur on 100% of admissions, recerts and during IDG meetings. This monitoring tool for tracking will be completed until the QAPI	of I

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 151544	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/29/2020		
NAME OF	PROVIDER OR SUPPLIE	R		1229 A	ADDRESS, CITY, STATE, ZIP COD RROWHEAD COURT		
HARBO	R LIGHT HOSPICE			CROW	N POINT, IN 46307		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)	ATE	(X5) COMPLETION DATE
	electronically sign document had an a Evaluation \ Pain A Pain Assessment A needs ongoing edu pain regimen, Fan ongoing education regimen, Pain repo provide details pain is also in Clin location: 6. No st was no evidence o evaluation, either of through patient ver During an intervie employee A indica not report a numer indicated that a FL assess pain for nor	w on 6/29/20 at 10:41 a.m., ted the patient caregiver could ic pain for the patient and ACC scale [a tool used to werbal patients] should have			Committee determines deficie is fully corrected. 3. Who is going to be respons for numbers 1 and 2- The Executive Director, Patient ca manager or designee is responsible for correcting the deficiency. 4. By what date are you going have the deficiency corrected September 18, 2020	sible ire g to	
_ 0513 Bldg. 00	[The patient has (2) Be involved in hospice plan of c Based on record re failed to ensure the be involved in dev care in 1 of 10 clin The findings inclu Review of an agen "Notice of Patient stated, " Hospice	s pain for nonverbal patients] should have used by the skilled nurse. 52(c)(2) HTS OF THE PATIENT patient has a right to the following:] e involved in developing his or her ice plan of care; d on record review and interview, the agency t to ensure the patient/family had the right to volved in developing the hospice plan of n 1 of 10 clinical records reviewed. (#5)		513	L513 What is the deficiency? L51 418.52c(2) Rights of the Pati 1. How are you going to correct the deficiency ? Tag L513 418.52c(2) Rights of Patient- The Clinical Manage staff have educated all staff of patient rights. This includes the right to be involved in develop his or her hospice plan of carr 2. How are you going to prevent	ent ect of the ment n bing e.	09/18/2020

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 151544	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		СОМ	e survey pleted 9/2020
	PROVIDER OR SUPPLIE R LIGHT HOSPICE		1229 A	ADDRESS, CITY, STATE, ZIP (RROWHEAD COURT 'N POINT, IN 46307	COD	
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	RRECTION SHOULD BE APPROPRIATE	(X5) COMPLETIC DATE
	initial assessment promotes the right Review of an ager "Patient/Family O stated, " You hay developing your h participate in chan possible and to the to do so; and to be plan of care before Clinical record rev evidenced an agen Statement" dated a Power of Attorney stated, " Harbor patients and their f These rights includ decisions" Record review evi titled "Team Care indicated intervent provide to the pati transfers, assist wi (cleaning of the pati surrounding area), care, shower, hair Record review of a "Charts/Clinical N completed by the s was called and ver shower from facili nail and hair care f Hospice] and com collaborated with	visit Hospice protects and s of each patient" cy document on 6/23/2020 titled rientation for Hospice Care" ve the right to: Be involved in ospice plan of care; and to ging the plan whenever extent that you are competent advised of any change in your e the change is made" riew on 6/25/2020 for patient #5 cy document titled "Disclosure and signed by the patient's of (POA) on 1/30/2020 which Light Hospice recognizes that families have several rights. de: participation in health care denced an agency document Plan" dated 6/24/2020 which ions the hospice aide was to ent including assist with th feeding, perineal care tient's genitals, buttocks and assist with dressing, mouth		the deficiency from rea future, even if already 100% of admissions of be called within the first Monitoring tools will be ensure that the patient been educated on the develop the hospice p This monitoring tool w completed until the QA Committee determines is fully corrected. 3. Who is going to be for numbers 1 and 2- Executive Director , Pa manager or designee responsible for correct deficiency. 4. By what date are you have the deficiency co September 18, 2020	corrected? contacts will st 15 days. e reviewed to t/POA have right to help lan of care. ill be API s deficiency responsible The atient care is ting the bu going to	

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 151544	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING			(X3) DATE COMPI 06/29	LETED
	PROVIDER OR SUPPLIE			1229 A	ADDRESS, CITY, STATE, ZIP COD RROWHEAD COURT /N POINT, IN 46307		
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL PR LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
L 0516 Bldg. 00	services were prov During an intervie person I, patient's unaware that hosp discontinued. During an intervie employee A indica was on 2/6/2020 a documenting comm family in regards t aide services. 418.52(c)(5) RIGHTS OF THE [The patient has (5) Have a confic Access to or rele and clinical record accordance with Based on record re failed to ensure pa clinical records rev The findings inclu 1. An agency polic 12/1/2015, titled " "Policy All info Hospice for specifi including patient r records will not be office "	w on 6/29/2020 at 11:28 a.m., ted the last hospice aide visit nd there was no clinical note munication with the patient and o the discontinuation of hospice E PATIENT a right to the following:] lential clinical record. ase of patient information ds is permitted in 45 CFR parts 160 and 164. eview and interview, the hospice tient confidentiality in 1 of 10 viewed. (Patient #7)	L 05	516	L516 What is the deficiency? L516 418.52c(5) Rights of the Patie The patient has a right to har a confidential clinical record Access to or release of patie information and clinical records is permitted in accordance with 45 CFR par 160 and 164. 1. How are you going to corre the deficiency? Tag 516 418.52c (5) Rights of Patient- The Clinical Manager staff have educated all staff of patient rights. This includes th	ent ve nt ts ct f the ment n	09/18/2024

	R MEDICARE & MEDI				NOTRICTION		MB NO. 0938-039
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 151544	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING			COMI	e survey pleted 9/2020
	PROVIDER OR SUPPLIE			1229 AF	DDRESS, CITY, STATE, ZIP COD RROWHEAD COURT N POINT, IN 46307		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPRO DEFICIENCY)) BE	(X5) COMPLETION DATE
	pages of medical r family Family r [received] reco [re reco for another pa During an intervie Person E indicated person G's clinical During an intervie Employee A, path record of Person G patient #7's record	e 2 of this document stated " 27 ecords given to wrong patients equested medical records. Rcvd cord] and found 27 pages of tient " reported on 3/6/2020. w on 6/29/2020, at 12:10 PM, they received 27 pages of record. w on 6/29/2020, at 3:44 PM, ent care manager, indicated the became incorporated with and sent to patient #7's family a possible mix up in the copy			right to have a confidential record. 2. How are you going to put the deficiency from recurri future, even if already corr 100% of all records being outside Harbor Light Hosp be monitored to ensure confidentiality. This monit will be completed until the Committee determines der is fully corrected. 3. Who is going to be resp for numbers 1 and 2- The Executive Director, Patien manager or designee is responsible for correcting deficiency. 4. By what date are you go have the deficiency correct	revent ng in the ected? sent ice will oring QAPI ficiency onsible t care the bing to	
_ 0524 Bldg. 00	ASSESSMENT The comprehens identify the physi emotional, and sy terminal illness the order to promote well-being, comfor the dying process Based on record re agency failed to er completed a comp in 1 of 6 discharge	view and interview, the hospice sure the skilled nurse ete comprehensive assessment d clinical records reviewed, out iical records reviewed. (#3)	L 05	524	L524 What is the deficiency? L content of Comprehensiv Assessment CFR(s):418. The comprehensive assessment must identify physical, psychosocial, emotional and spiritual n	ve 54(c) V	09/18/2020

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	ì í	ULTIPLE CO JILDING	ONSTRUCTION	î î	E SURVEY PLETED
151544		B. WI		<u></u>	06/29/2020		
JAME OF	PROVIDER OR SUPPLIE	R	•		ADDRESS, CITY, STATE, ZIP COD RROWHEAD COURT	•	
HARBO	R LIGHT HOSPICE				N POINT, IN 46307		
X4) ID PREFIX		' STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ON D BE DPRIATE	(X5) COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG			DATE
		with a revised date of 5, policy number 09.06.01, titled			related to the terminal illr that must be addressed i		
		t/Comprehensive Assessment"			order to promote the hos		
		Each patient admitted by			patients well-being, com	-	
		an appropriate initial			and dignity.	on	
	-	mprehensive assessment			1. How are you going to co	orrect	
		cumented Procedure 2.			the deficiency?		
	Each patient admit				Tag L524 content of		
	-	sessment. The comprehensive			Comprehensive Assessme	ent	
	~	entify the patient's need for			CFR(s):418.54(c)- The Cli		
Hospice	Hospice care and i	dentify the patient's need for:			Management staff will edu		
	Physical care A	All areas of Hospice care related			Registered Nursing staff o		
	to the palliation an	d management of the terminal			and 418.54(c). This will inc	clude	
	illness and related	conditions. 3. The			education on policy 09.09.	01 Initial	
	comprehensive ass	sessment will take into			Assessment/Comprehensi	ve	
		following factors:			assessment.		
	-	risk factors that affect care			2. How are you going to pr		
		ach patient's comprehensive			the deficiency from recurri	-	
		es a review of all medications			future, even if already corr		
	-	ntly taking (prescription,			100% of all admission reco		
		herbs, home remedies, other			be monitored to ensure that	at the	
		ents, etc.) to identify: Side			physical comprehensive		
	effects Potentia	al adverse effects"			requirements are being me		
					percent of monthly averag	e daily	
		view on $6/26/20$ for patient #3,			census will be monitored	:0	
		18, evidenced an agency Initial Visit on 12, 18, 18"			monthly. This monitoring		
		. Initial Visit - on 12-18-18" ed and dated by employee R.			continue until the QAPI co	mmutee	
		nent had an area subtitled			determines deficiency is corrected.		
		itestinal" which stated " Last			3. Who is going to be resp	onsihle	
	-	Unknown" Skilled nurse			for numbers 1 and 2- The		
		ents dated 12/27/18, 12/31/18,			Executive Director, Patien	t care	
		to have the patient's last bowel			manager or designee is		
		a gastrointestinal assessment.			responsible for correcting	the	
		eported as incontinent of bowel			deficiency.	-	
		ed in a skilled nursing facility,			4. By what date are you go	ping to	
		d nurse was unable to assess			have the deficiency correct	•	
	the patient's last be initial/comprehens	owel movement during the ive assessment.			September 18, 2020		

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	X3) DATE SURVEY
AND PLAN OF CORRECTION IDENTIFICATION NUMBER 151544		A. BUILDING B. WING	<u>00</u>	COMPLETED 06/29/2020	
NAME OF I	PROVIDER OR SUPPLIE	R	1229 A	ADDRESS, CITY, STATE, ZIP COD RROWHEAD COURT	
HARBOF	R LIGHT HOSPICE		CROW	N POINT, IN 46307	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCE	DATE
	-	w on 6/26/20 at 3:12 p.m., nt care manager, indicated this			
		ne skilled nurse should have			
	"got".	io skilled hulse should huve			
0530	418.54(c)(6)				
0000		OMPREHENSIVE			
Bldg. 00	ASSESSMENT				
-		sive assessment must take			
	into consideratio	n the following factors:]			
	(6) Drug profile.	A review of all of the patient's			
		over-the-counter drugs,			
		and other alternative			
		ould affect drug therapy.			
	identification of t	t is not limited to,			
		le following.			
	(i) Effectiveness	of drug therapy			
	(ii) Drug side effe				
		ential drug interactions			
	(iv) Duplicate dru				
	(v) Drug therapy laboratory monito	currently associated with			
		ion, record review, and	L 0530	L530	09/18/202
		bice agency failed to ensure that	L 0550	What is the deficiency? L530	09/18/202
		nsured prn [as needed]		content of Comprehensive	
		idications on use and		Assessment CFR(s):418.54(c)	6
		es were properly calculated in 4		The comprehensive	
		ords, in a total sample of 10		assessment take into	
	patient records rev	riewed. (#2, #5, #8, #10)		consideration the following	
	The findings inclu	de:		factors (6) Drug profile. A review of all the patients prescription and over the	
	1. The agency pol	icy with a revised date of		counter drugs, herbal remedi	es
		'Medication Orders" stated "		and other alternative	
		vill minimize errors and		treatments could affect drug	
	misinterpretation of	of written or verbal medication		therapy. This includes but is	
	· · ·	ent's record will reflect a		not limited to identification of	-
	-	on, or indication for use for each		the following, -Effectiveness	of
	I medication Proc	edure:8. Staff will verify with		drug therapy, ii-Drug side	

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NAME OF PROVIDER OR SUPPLIER HARBOR LIGHT HOSPICE				TADDRESS, CITY, STATE, ZIP COD		
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(X4) ID PREFIX		Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	(X5) E COMPLETIO	
TAG		OR LSC IDENTIFYING INFORMATION	TAG		DATE	
		incomplete, illegible or unclear		effects, iii-Actual or potent		
		prior to administering the		drug interactions, iv duplic		
	about the medicati	providing patient education		drug therapy, v-Drug thera	ру	
	about the medicati	ion.		currently associated with		
	2 Clinical record	raview on 6/25/2020 for nationt		laboratory monitoring.	reat	
		review on 6/25/2020 for patient 8/7/2019, evidenced an agency		1. How are you going to corr	eci	
		Medication Status" dated		the deficiency? Tag L530 content of		
		cument evidenced the order,		Comprehensive Assessmen	+	
		outh Suspension 100MG/5ML,		CFR(s):418.54(c)6 The Clini		
	· ·	6 hours as needed PO [by		Management staff have edu		
		structions: Take 10ml to $= 400$		all Nursing staff on L530 an		
	3. 4	date 12-23-19, End date		418.54(c)6. All nursing staff		
		s document also evidenced order		also been educated on 08.0		
	which stated, "Ens	sure By Mouth Liquid 8 Ounce		Medication orders, 08.14.01		
		O. Special Instructions: 1 bottle		Medication Monitoring, 08.19	9.01	
	as tolerated daily	orn [as needed], Start date		Medication reconciliation, an		
	08-07-2019". The	order failed to list the prn		policy 09.09.01 Initial		
	indications.			Assessment/Comprehensive	e	
				assessment.		
	-	w on 6/29/2020 at 2:05 p.m.,		2. How are you going to prev		
		l regarding Ibuprofen dosage,		the deficiency from recurring		
		Employees A and B indicated		future, even if already correc		
		use of Ensure PRN was not		100% of all active charts will		
		record review on $6/26/20$ for		audited to ensure compliance		
	-	care 7/25/18, evidenced an		then 100% of all patients wil		
		titled "Medication Status"		reviewed in IDG to ensure th		
		2020. This medication document		of the patients prn medication		
		Tears Ophthalmic Solution ou [both eyes] drop twice a day		have an indication listed. The		
		ecial Instructions: 1 drop to		monitoring will continue until		
	_	ly as needed" There failed to		QAPI committee determines deficiency is corrected.		
		when to give the eye drops as		3. Who is going to be respor	sible	
	needed.			for numbers 1 and 2- The		
				Executive Director, Patient of	are	
	This concern was	reviewed with employee A and		manager or designee is		
		oyee A and B remained silent.4.		responsible for correcting the	e l	
		view on $6/26/2020$ for patient #5		deficiency.	-	
		nent titled "Clinical Physician		4. By what date are you goir	na to	
		by B with a last reviewed date of		have the deficiency correcte	-	

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TAG	 6/10/2020 which i medications include medication) liquid (medication for sk supplement). Review of an ager Status" dated 6/26 patient's current m Sulfate liquid solu Ensure. The clinic the patient's medic During an intervie employee A indica match between the and the skilled nun omission of the lic indicated the was medications were on the agency's medications were sharrier cream) to p prevent skin break failed to evidence 	rvation on 6/25/2020, at 10:34 applied Calmoseptine (moisture batient #8's perineal area to down. The medication profile the Calmoseptine ointment iption, dose, frequency, and	TAG	September 18, 2020	DATE
	Employee A, patie	w on 6/29/2020, at 2:37 PM, ent care manager, indicated OTC d be included on the patient's			
	start of care 12/16 document titled "T This document ha "Medications" wh				

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	PROVIDER OR SUPPLIE		1229	T ADDRESS, CITY, STATE, ZIP COD ARROWHEAD COURT NN POINT, IN 46307		
(X4) ID PREFIX TAG	(EACH DEFICIE REGULATORY C [anti-nausea medic Tablet Three times document failed to	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION eation] By Mouth Tablet 4 MG 1 a day as needed PO " This e evidence indications in which	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROP DEFICIENCY)	E COMP	X5) LETION ATE
L 0543 Bidg. 00	Employee A, patie care plan did not e medication Zofran 418.56(b) PLAN OF CARE All hospice care a patients and their individualized wri by the hospice in collaboration with any), the patient primary caregive patient's needs if Based on record re failed to ensure the patients followed a clinical records rew The findings inclu 1. Review of an ag "IDG [interdiscip] stated, " All care patients and their f individualized wri the IDG in collabor physician (if any), and the primary car 2. Clinical record for #4 evidenced an ag	w on 6/29/2020, at 2:35 PM, nt care manager, indicated the vidence PRN indications for the and services furnished to r families must follow an tten plan of care established terdisciplinary group in the attending physician (if or representative, and the r in accordance with the any of them so desire. wiew and interview, the agency e care and services furnished to a written plan of care in 4 of 10 viewed. (#3, #4, #5, #6) de: gency policy dated 4/1/14 titled inary group] Care Plan Process" and services furnished to a milies follows an tten plan of care established by ration with the attending the patient or representative regiver in accordance with the	L 0543	L543 What is the deficiency? L5 content of Plan of Care CFR(s):418.56(b) All hospic care and services furnishe patients and their families follow an individualized written plan of care establi by the hospice interdiscipl group in collaboration with attending physician (if any patient or representative a the primary caregiver in accordance with the patier needs if any them so desir 1. How are you going to cor the deficiency? Tag L543 content of Plan of CFR(s):418.56(b)-The Clinic Management staff will educa	43 ce d to must shed inary o the), the nd ts e. rect Care cal	8/2020

	IT OF DEFICIENCIES OF CORRECTION	x1) provider/supplier/clia identification number 151544	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/29/2020		
	ROVIDER OR SUPPLI			1229 Al	ADDRESS, CITY, STATE, ZIP COI RROWHEAD COURT N POINT. IN 46307	D	
HARBO (X4) ID PREFIX TAG	(EACH DEFICIE REGULATORY O 11/13/18 - 2/10/19 aide was to provid for personal care a (activities of daily the patient was a f review failed to ev provided 2 times of failed to evidence D. Record review of "Supplemental Or and signed by the the hospice aide v per week effective to evidence aide s during the week o coordination of car During an intervie employee A indic on 11/28/18 and th provided since can Employee A indic documentation of physician and IDO were not complete 3. Clinical record #5 evidenced an a Care Plan" dated o interventions the I the patient includi with feeding, peri- patient's genitals, assist with dressin and nail care.	Y STATEMENT OF DEFICIENCIE ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION Of which indicated the hospice de 2 visits per week for 13 weeks and assistance with ADLs v living). The document indicated resident at entity D. Record vidence aide services were during the week of 11/25/18 and coordination of care with entity an agency document titled refers from 12-29-18 to 2-9-19" physician on 3/4/19 indicated isits were increased to 3 visits e 12/30/18. Record review failed ervices were provided 3 times f 12/30/18 and failed to evidence	P	CROWI ID REFIX TAG	N POINT, IN 46307 PROVIDER'S PLAN OF CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY) staff on L543 & 418.56(b) care, 09.12.01 IDG Care Process. 2. How are you going to the deficiency from recur future, even if already co 100% of all active charts audited to ensure compli aide frequency is being r of all patients that experi frequency changes will b monitored to ensure communication and care updates to family/patient happening. This monitor continue until the QAP1 of determines deficiency is corrected. 3. Who is going to be rest for numbers 1 and 2- The Executive Director, Patient manager or designee is responsible for correcting deficiency. 4. By what date are you have the deficiency corred September 18, 2020	DUDDBE PROPRIATE PROP	(X5) COMPLETIO DATE
	with feeding, perin patient's genitals, assist with dressin and nail care. Record review of	neal care (cleaning of the buttocks and surrounding area), ng, mouth care, shower, hair care					

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 151544	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		COMPL	(X3) DATE SURVEY COMPLETED 06/29/2020	
NAME OF	PROVIDER OR SUPPLIE	ËR	1229 A	ADDRESS, CITY, STATE, ZIP C RROWHEAD COURT	COD		
HARBOI	R LIGHT HOSPICE		CROW				
(X4) ID PREFIX	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A	HOULD BE	(X5) COMPLETIO	
TAG		DR LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE	
	[power of attorney [patient] is to get a Requested that pt HLH [Harbor Lig] if possible. Writer care manager] [em	skilled nurse stated, " POA /] was called and verified that pt a shower from facility. receives nail and hair care from ht Hospice] and companionship collaborated with PCM [patient nployee A] regarding aide care					
		" I failed to evidence hospice aide /ided after 2/6/2020.					
	-	w on 6/29/2020 at 11:28 a.m., ated there were no hospice aide 2020.					
	#6 evidenced an a "Physician Orders 3-26-20" which in provide visits 3 tir beginning 1/2/20. hospice aide servio	review on 6/25/2020 for patient gency document titled /Plan of Care from 1-27-20 to dicated the hospice aide was to mes a week for 8 weeks Record review failed to evidence ces were provided 3 times a reek of 2/2/2020 and 2/16/2020.					
	employee B indica refused on 2/7/202 indicated there wa coordination of ca regarding hospice per plan of care.5. 6/26/20, for patier evidenced an agen Orders/Plan of Ca dated and signed b This plan of care H "Treatments" which 1 x week x 1 week	w on 6/26/2020 at 11:35 a.m., ated the hospice aide visits were 20 and 2/20/2020. Employee B is no clinical documentation of re with the physician and IDG aide visits were not completed Clinical record review on at #3, start of care 12/18/18, acy document titled "Physician's re from 12-18-18 to 03-17-19" by the physician on 1/9/19. and an area subtitled ch stated " AID [sic] 12-18-18 is 12-23-18 2 x week x 12 weeks care and assistance with ADLs					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 151544		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/29/2020	
	PROVIDER OR SUPPLIE		1229	T ADDRESS, CITY, STATE, ZIP COD ARROWHEAD COURT	
HARBUI	R LIGHT HOSPICE		CRU	WN POINT, IN 46307	
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY	DATE
	[activities of daily	living]"			
	health aide visit the The agency failed	view evidenced only 1 home e week of 12/23/18 - 12/29/18. to ensure the hospice aide d on the plan of care 2 times			
	-	w on $6/26/20$ at 3:38 p.m., ted the patient hospice aide harged on $1/2/19$.			
0545	418.56(c)				
	CONTENT OF P	LAN OF CARE			
Bldg. 00		t develop an individualized			
	written plan of ca	re for each patient. The plan			
	of care must refle	ect patient and family goals			
	and interventions	based on the problems			
	identified in the ir	nitial, comprehensive, and			
		nensive assessments. The			
		t include all services			
	-	e palliation and management			
		ness and related conditions,			
	including the follo		L 0545		00/10/2020
		eview and interview, the hospice soure the content on the plan of	L 0545	L545 What is the definione 2 LEAE	09/18/2020
		in 4 of 10 clinical records		What is the deficiency? L545 content of Plan of Care	
	reviewed. (#1, #4,			CFR(s):418.56(c) The hospice	
		, "5, "6)		must develop an individualiz	
	The findings inclu-	de:		written plan of care for each patient. The plan of care mus	
	1. The agency pol	icy dated April 1, 2014, policy		reflect patient and family goa	
		titled "IDG [interdisciplinary		interventions based on the	
		Process" stated " 8. An		problems identified in the	
		tten plan of care is developed for		initial, comprehensive, and	
		plan of care reflects patient and		updated comprehensive	
		nterventions based on the		assessments. The plan of ca	are
	~	d in the initial, comprehensive		must include all services	.
		rehensive assessments. The les all services necessary for the		necessary for the palliation a management of the terminal	Ind

	NT OF DEFICIENCIES OF CORRECTION	x1) provider/supplier/clia identification number 151544	(X2) MULTIPLE CONSTRUCTION A. BUILDING D. WING		(X3) DATE SURVEY COMPLETED 06/29/2020		
	NAME OF PROVIDER OR SUPPLIER			1229 AI	ADDRESS, CITY, STATE, ZIP (RROWHEAD COURT N POINT, IN 46307	COD	
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	Р	ID REFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	RRECTION HOULD BE APPROPRIATE	(X5) COMPLETIC DATE
	 palliation and man and related conditi to manage pain and pain and symptom ongoing assessmen psychosocial, emo reassessing the effi- of care in order to and treatments nece patient" 2. Clinical record start of care 5/9/19 document titled "P from 05-09-19 to (area subtitled "Tre Pulse Oximetry PF to be any indication when the patient w assessed. During an intervier employee G indica indications for prn record review on 6 evidenced an agen Orders/Plan of Car 11/13/2018 - 2/10/ Acetaminophen [p Mouth Tablet 325 as needed PO [by n evidence the indicat was to be administ During an intervier employee A indicat include the indicat 	agement of the terminal illness ons, including: Interventions d other symptoms. Effective management includes the at of the patient's physical, tional and spiritual needs and ectiveness of the current plan address those needs Drugs essary to meet the needs of the review on 6/26/20, for patient #1, c, evidenced an agency hysician's Orders/Plan of Care 98-05-19" This document had an atments" which stated " RN [as needed]" There failed ns on this document as to rould need their pulse oximetry w on 6/26/20 at 10:22 a.m., ted she had seen that too. [no usage of oximeter]3. Clinical /25/2020 for patient #4 cy document titled "Physician's e" for certification period 2019. This document stated, " ain reliever medication] By MG [milligrams] 325 Milligram nouth]" but failed to ations for when the medication ered. w on 6/29/2020 at 10:55 a.m., ted the plan of care should ions for when the medication			illness and related co 1. How are you going the deficiency? Tag L545 content of H Care CFR(s):418.56(c) Clinical Management se educated all Nursing se and 418.56(c). All nur have also been educa 09.12.01 IDG Care pla NOTE- L530 was add prior in POC for prn r indication 2. How are you going the deficiency from read future, even if already 100% of all active cha audited to ensure com indications being listed treatments and then 1 patients will be review ensure that all of the p prn treatments have a listed. This monitoring continue until the QAF determines deficiency corrected. 3. Who is going to be for numbers 1 and 2- Executive Director, Pa manager or designee responsible for correct deficiency. 4. By what date are you have the deficiency co September 18, 2020	pnditions. to correct Plan of b) The staff have staff on L545 rsing staff ted on an process. ressed medication to prevent curring in the corrected? rts will be opliance with d for prn 00% of all ed in IDG to batient with n indication g will Pl committee is responsible The atient care is ting the bu going to	
	4. Clinical record i	review on 6/26/2020 for patient					

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 151544	(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION 00	СОМ	te survey Ipleted 29/2020
NAME OF	PROVIDER OR SUPPLIE	ER		ADDRESS, CITY, STATE, ZIP C ARROWHEAD COURT	COD	
HARBO	R LIGHT HOSPICE	1		/N POINT, IN 46307		
(X4) ID PREFIX		Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A	HOULD BE	(X5) COMPLETION
TAG	REGULATORY C	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE
	Physician Orders" reviewed date of 6 patient's current m Sulfate (pain medi	cument titled "Clinical from entity B with a last //10/2020 which indicated the edications included Morphine cation) liquid solution, nent (medication for skin) and ement).				
	Plan" dated 6/24/2 patient's current m	acy document titled "Team Care 020 failed to indicate the redications included Morphine tion, calmoseptine ointment and				
	employee A indica plan should match and entity B and th	w on 6/29/2020 at 11:40 a.m., ated the medication on the care between the hospice agency he skilled nurse should have on of the liquid morphine.				
	#6 evidenced an a "Physician's Order period 1/27/2020 stated, " Pulse O oxygen saturation " but failed to e	review on 6/25/2020 for patient gency document titled rs/Plan of Care" for certification • 3/26/2020. This document eximetry [a test to determine the in the blood] PRN [as needed] widence the PRN indications for imetry was to be performed.				
	employee B indica	w on 6/26/2020 at 11:30 a.m., ated the plan of care should adications for the pulse				
0554	418.56(e)(1) COORDINATION	N OF SERVICES				
Bldg. 00	The hospice mus system of comm	st develop and maintain a unication and integration, in the hospice's own policies				

	NT OF DEFICIENCIES I OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 151544	(X2) MULTIPL A. BUILDING B. WING	e construction G <u>00</u>	COME	e survey pleted 9/2020
	AME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1229 ARROWHEAD COURT CROWN POINT, IN 46307			
X4) ID PREFIX TAG	(EACH DEFICIE)	' STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFI2 TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APF DEFICIENCY)	CTION JLD BE ROPRIATE	(X5) COMPLETION DATE
	maintains respon coordinating, and services provided Based on record re agency failed to en (IDG) maintained coordination and s services provided f records reviewed, records reviewed, records reviewed. The findings inclue 1. The agency pol number 09.12.01, f stated "Policy In of provided is approp patient's specific n will utilize data/int comprehensive ass comprehensive ass the care planning p consistent with the patient's needs and Procedure The physical, medical, spiritual needs of H facing terminal illf members provide t Hospice. IDG sup Supervision of care accomplished by fa conferences, evalu oversight, as well a registered nurse th designated to prov ensure continuous and family's needs	wiew and interview, the hospice issure the interdisciplinary group responsibility for the upervision of the care and to 2 of 6 discharged clinical out of a total of 10 clinical (#1, #3)	L 0554	L554 What is the deficiency? Coordination of Service 418.56e(1) The hospice develop and maintain a of communication and integration, in accordan the hospices own polic procedures to (1) Ensur the interdisciplinary gro maintains responsibility directing, coordinating supervising the care an services provided. 1. How are you going to the deficiency? What is the deficiency? Coordination of Service 418.56e(1) The Clinical Manageme educate all staff on L554 Coordination of Service 418.56e(1). All staff will educated on 9.12.01 IDC Plan Process, 9.15.01 Pl Patient/Family Education Education will also includ Caregiver/Family membe pharmacological educati safety of medication administration education pharmacy staff. 2. How are you going to the deficiency from recur future, even if already co 100% of all active charts	es must system ace with ies and re that oup y for and d correct L554 es also be also be also be also be also be also be an for and from prevent ring in the urected?	09/18/2020

Event ID: QYKX11 Facility ID: 009088

If continuation sheet Page 17 of 56

	R MEDICARE & MEDI						MB NO. 0938-03
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 151544	A. BUIL	(X2) MULTIPLE CONSTRUCTION A. BUILDING D B. WING		(X3) DATE SURVEY COMPLETED 06/29/2020	
	PROVIDER OR SUPPLIE			1229 A	ADDRESS, CITY, STATE, ZIP COD RROWHEAD COURT	-	
HARBON	R LIGHT HOSPICE			CROW	N POINT, IN 46307		_
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTI	ON	(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL		REFIX	(EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPRC DEFICIENCY)	PRIATE	COMPLETIC
TAG		R LSC IDENTIFYING INFORMATION es education and training		TAG		aco with	DATE
		r responsibilities for the care			audited to ensure complian all care plan changes. 100		
		fied in the plan of care The			current/ active HOME patie		
		es all services necessary for the			be audited to determine		
	•	agement of the terminal illness			competency for administra	tion of	
		ons, including: If the patient			medications. 100% of all n		
	· ·	se of PRN [as needed] visits			admitted HOME patients (OR if	
	-	ll be updated to include the			the person responsible for		
		visits Drugs and			administering medications		
		ry to meet the needs of the			identified through has char	•	
	-	nentation of the patient's or			will be audited to determin		
	-	rel of understanding, greement with the plan of care			competency for administra medications. This monitori		
	in the patient recor				continue until the QAPI co	•	
	in the patient recor	u			determines deficiency is		
	2. The agency pol	icy with a revised date of			corrected.		
		5, policy number 9.15.01, titled			3. Who is going to be resp	onsible	
	"Plan for Patient/F	amily Education" stated "			for numbers 1 and 2- The		
	Policy Hospice with	ill educate and train			Executive Director, Patient	care	
	· ·	ording to the needs assessed by			manager or designee is		
	-	as appropriate to the required			responsible for correcting t	the	
		To assess the patient/family's			deficiency.		
	-	palliative care outcomes and to			4. By what date are you go	•	
		in care provision cational needs related to the			have the deficiency correct	ted?	
		ease process or Hospice			September 18, 2020		
	· ·	sessed as part of the referral					
		prehensive assessment. The					
	patient's record sho	-					
		ed to the education plan for the					
		include, but is not limited to:					
		or motivation to learn.					
		on 2. Hospice staff					
	understands that th						
		ucation needs are ongoing and					
		eassessed as needs change. 3.					
		education, the perceived ility to demonstrate a taught					
		call will be documented in the					
	patient's record"						

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 06/29/2020 151544 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1229 ARROWHEAD COURT HARBOR LIGHT HOSPICE CROWN POINT, IN 46307 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE 3. Clinical record review for patient #1 on 6/26/20, start of care 5/9/19, evidenced an agency document titled "Medication Status" with a range in dates from 4/19/19 - 5/27/19. This medication status document listed the following narcotic/ benzodiazapine medications: Percocet [narcotic pain reliever] By Mouth 10-325 MG [milligram] 1 tablet every 4 hours as needed PO (by mouth), Comfort Kit placed in home in refrigerator. Not to be used until directed by nurse, Morphine Sulfate [narcotic pain medication] (Concentrate) By Mouth Solution 20 MG/ML 5 - 10 Milligram every 2 hours as needed by mouth or sublingual, Ativan [for anxiety, benzodiazipine] Injection solution 2MG/ML 0.5-1 Milligram every 2 hours as needed By mouth or sublingual, Xanax [for anxiety, benzodiazapine] by mouth 0.5 MG 1 tablet three times a day PO, Dilaudid [narcotic pain medication] By Mouth Tablet 2 MG 1-2 Tablet every 4 hours as needed PO. Clinical record review evidenced an agency document titled "... Initial Visit ..." dated 5/9/19 and electronically signed by employee K. This document indicated refills were needed for Xanax and Percocet and the refills were to be delivered. This document indicated there were no dosage errors and the patient caregiver manages the medication appropriately. Clinical record review evidenced an agency document titled "... Routine visit ..." dated 5/10/19 and electronically signed by employee L. This document indicated the patient was out of Dilaudid and Percocet, the refills were to be delivered, indicated no dosage errors and the patient caregiver manages the medications appropriately. Event ID: QYKX11 Facility ID: 009088 Page 19 of 56 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

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09/08/2020

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 151544	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		(X3) DATE SURVEY COMPLETED 06/29/2020	
	PROVIDER OR SUPPLIE		STREET A 1229 A CROW			
(X4) ID PREFIX	SUMMARY	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL	D BE COMPLETIC	
TAG		OR LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPR DEFICIENCY)	DATE	
	document titled "C "Effective Date" of Skilled Nurse. Th signed by employed This document stat said pt [patient] is deluded [sic], call status Percocce pharmacy] along v staff to call in 3 dat	view evidenced an agency Charts / Clinical Notes" with an of 5/10/19, and "Discipline" of e document was electronically ee L and timed 09:54:40 a.m. ted " DIL [daughter in law] out of Percocet but has to admission nurse to check on et was called to [name of with Xanax, asked dr [doctor] ays supply to local [name of p/u [pick up] and take for my				
	document titled "C "Effective Date" of of Skilled Nurse. signed by employer This document sta on getting percoce delivery of a full of Updated meds, cla meds. Person G (C help her sleep self, place, she is a her needs, mild co what day it was). she was receiving dilaudid which wa days ago she ran of giving dilaudid 2n depleating [sic] th percocet, pt was g Clinical record rev document titled "	view evidenced an agency Routine visit" dated				
	This document inc	onically signed by employee L. licated the family/ patient ngoing education and				

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 151544	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		(X3) DATE SURVEY COMPLETED 06/29/2020	
	NAME OF PROVIDER OR SUPPLIER HARBOR LIGHT HOSPICE		STREET A 1229 A CROW)		
(X4) ID PREFIX		Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPI DEFICIENCY)	LD BE CO	(X5) MPLETIO
TAG	reinforcement of p was reported by th patient was unable document also stat manages medication needed, needs rein without any issue. Clinical record reve document titled "C "Effective Date" of of Skilled Nursing electronically sign 10:16:16 p.m. This [social worker] ga Dtr [daughter] in 1 the dosage of pain mattress Perso percocet 2 tablets a 10/325mg q [every the med bottle is 1 down the meds wh medication, and ar she was getting co to give alternating dilaudid 1 2 hrs ur talked about seeing increased confusion Narcotics were con percocet with dilate be increasing quic law, responsible for of doctor] for amb before her hospital While I was in the pain."	A LSC IDENTIFYING INFORMATION an regimen, the patient's pain e patient caregiver, and the e to provide details. This ted that patient caregiver ons appropriately, no refills are forcement, and meds reconciled view evidenced an agency Charts / Clinical Notes" with an f 5/13/19, and the "Discipline" This document was ed by employee L and timed is document stated " Note: SW ve me a message from person G, aw about some confusion on meds, and asked about the on G, DIL had been giving at a time when the order is 1 tab /] 4 hrs [hours], and is written on tab. Noted that in her writing nen she had a 8 hr lapse in pain nother time lapse. She said that nfused. I set up a form for her pain meds of percocet and ttil she is comfortable. We g a increase in sedation, on, and unsteady gain. unted She is alternating udid, DIL says the pain seems to kly. Pt lives with son and dtr in or her care Also asked [name ien 5.0 mg that pt was taking lization and has insomnia. home pt was given dilaudid for	TAG			DATE

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 151544	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		(X3) DATE SURVEY COMPLETED 06/29/2020	
	NAME OF PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD RROWHEAD COURT		
HARBO	R LIGHT HOSPICE		CROW	N POINT, IN 46307		
(X4) ID PREFIX	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPF DEFICIENCY)	LD BE COMPLETI	
TAG	employee L. This law was given adj understand medica caregiver manages were needed, patie verbalized, needs reconciled withou Clinical record rev document titled "C "Effective Date" of of Skilled Nursing electronically sign 08:33:04 p.m. Th Ambien 5 mg q hs taken before she w Xanax 0.5 mg fron times daily], incre pain medication fo pain control , educ on how to give me needed more direct We set up a sched She has the sign o on that sheet to kn when she could gi waking her to give hx [history] or nar different ones, she medication. Pt ha to manage it and I medication" Clinical record rev document titled "C "Effective Date" of of Skilled Nursing electronically sign 08:01:30 a.m. Thi	OR LSC IDENTIFYING INFORMATION document indicated daughter in usted form for ability to ation administration, the patient a meds appropriately, no refills ent caregiver understands / reinforcement, and meds were t issue. view evidenced an agency Charts / Clinical Notes" with an f 5/14/19, and the "Discipline" g. This document was ed by employee L and timed is document stated " Started 6 [bedtime] insomnia, she had vent to the hospital. Changed n BID [twice daily] to TID [three ase in her anxiety, over use of or security Prn visit due to eating main caregiver person G eds for good pain control, tion due to giving wrong doses. ule that she can understand. ut sheets but writes both meds ow what she gave last and ve again, also educated on not e her medication. Pt has a long cotic use for pain with several has become accustomed to the s long hx of anxiety, attempting believe she will use less pain	TAG			

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 151544	(X2) MULTIPLE CONSTRUCTION A. BUILDING D. WING		(X3) DATE SURVEY COMPLETED 06/29/2020		
	PROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZIP COD 1229 ARROWHEAD COURT				
TIANDO	I		CROWN POINT, IN 46307			1	
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPI DEFICIENCY)	LD BE	(X5) COMPLETIO DATE	
	Pt is now unrespon- back, mouth wide Person G states the open, she noted the her PM medicatio Person G states the out, but the pt doe are even and unlate be in any pain or of nursing visit by her contacted on-call fragments assessment." Clinical record rever document titled "C "Effective Date" of of Skilled Nursing IDG summary. The alert and oriented forgetful, mild mater ongoing). Able to able to express som of her time in bed, attempting to adjut continuous teaching caregiver, person the increased Xanax for using pain medicine comfort" During the IDG me indication of the porter reported that more there was no indice patient caregiver (C 2mg of Dilaudid 1 caregiver giving do ordered, and there	has been very lethargic today. nsive with her head hanging open. Pt will not open her eyes. at now that the pt's mouth is at she did not swallow any of ns, as they are still in her mouth. at she did clean the pt's mouth s not look well. Respirations bored and pt does not seem to distress. Family requesting a ospice tonight. Triage nurse, [name], to make visit for view evidenced an agency Charts/ Clinical Notes" with an of 5/15/19, and the "Discipline" g. This note indicated it was an his document stated " Pt is to self/place, mild dementia, naged anxiety (hx anxiety • express simple conversation, me simple needs. Spends most , up to sit in living room, st pain meds for comfort, ng on pain meds with primary G. New medication ambien and from BID to TID. Pt seems to be ne for anxiety periods as meeting on 5/15/19 there was no atient's new condition change sing of difficulty swallowing, ation of discussion of the person G) giving the patient 4 - 16x a day or the patient ouble the dosage of Percocet failed to be mentioned that a n chart was developed for the					

		x1) provider/supplier/clia identification number 151544	FICATION NUMBER A. BUILDING <u>00</u>				
NAME OF PROVIDER OR SUPPLIER HARBOR LIGHT HOSPICE			STREET ADDRESS, CITY, STATE, ZIP COD 1229 ARROWHEAD COURT				
HARBUI	R LIGHT HUSPICE	-	CROW	N POINT, IN 46307			
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE API DEFICIENCY)	ULD BE COMPLETI		
	patient caregiver of managing certain j summary note did be using pain med comfort, however dated 5/9/19, it ind managed the patie During an intervie employee G, patie patient caregiver (incompetent in pro- they would notify worker, and doctor During an intervie employee A indica by the nurse of con- of what he was no 4. Clinical record start of care 12/18, document titled "F from 12-18-18 to 0 the physician on 1 area subtitled "Tree [sic] 12-18-18 1 x x 12 weeks Provid- with ADLs [activi Clinical record rev document titled "C entry dated 1/1/19 the IDG team was of hospice aide vis During an intervie indicated she did r	hue to her having difficulty patient medications. The IDG indicate the patient seemed to icine for anxiety periods as in the "Initial Visit" document dicated the patient caregiver nt's medications. w on 6/26/20 at 3:51 p.m., nt care manager, indicated if the person G) was found to be operly administering medication the whole team, the social r. w on 6/26/20 at 4:06 p.m. ated the physician was notified ncerns, but it was not clarified tified of. review on 6/26/20, for patient #3, /18, evidenced an agency Physician's Orders/Plan of Care 03-17-19" dated and signed by /9/19. This plan of care had an eatments" which stated " AID week x 1 week 12-23-18 2 x week de personal care and assistance ties of daily living]" view evidenced an agency Charts/Clinical Notes" with an . This entry failed to evidence informed of the patient's refusal					

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 06/29/2020 151544 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1229 ARROWHEAD COURT HARBOR LIGHT HOSPICE CROWN POINT, IN 46307 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE L 0556 418.56(e)(3) COORDINATION OF SERVICES Bldg. 00 [The hospice must develop and maintain a system of communication and integration, in accordance with the hospice's own policies and procedures, to-] (3) Ensure that the care and services provided are based on all assessments of the patient and family needs. Based on record review and interview, the agency L 0556 L556 09/18/2020 failed to ensure the care and services were What is the deficiency? L556 provided based on all assessments of the patient **Coordination of Services** and family needs in 1 of 4 active clinical records 418.56e (3) The hospice must reviewed, out of a total of 10 clinical records develop and maintain a system reviewed. (#5) of communication and integration, in accordance with The findings include: the hospices own policies and procedures to (3) Ensure that Review of an agency policy dated 4/1/14 titled the care and services provided "Coordination of Patient Care" stated, "... Hospice are based on all assessments has developed and maintains a system of of the patient and family communication and integration to: ... Ensure that needs. care and services are provided in accordance with 1. How are you going to correct the plan of care and are based on all assessments the deficiency? of the patient and family needs. ..." What is the deficiency? L556 **Coordination of Services** 418.56e (3) Clinical record review on 6/25/2020 for patient #5 evidenced an agency document titled "Initial The Clinical Management staff will Visit" dated 1/31/2020 which indicated the patient educate all staff on L556 needed assistance for grooming, bathing, **Coordination of Services** transferring and feeding. 418.56e (3). All Social Service, Nursing, Aides and Chaplain will Record review evidenced an agency document be educated on policy 09.06.01 titled "Team Care Plan" dated 6/24/2020 which Initial Assessment/Comprehensive indicated interventions the hospice aide was to assessment, 11.03.01 Aide provide to the patient including assist with Documentation, 9.12.01 IDG Care transfers, assist with feeding, perineal care planning process, 9.13.01 (cleaning of the patient's genitals, buttocks and Coordination of patient care, surrounding area), assist with dressing, mouth 7.09.01 Care to residents in a care, shower, hair care and nail care. SNF/NF.

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 151544			A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING			(X3) DATE SURVEY COMPLETED 06/29/2020	
	PROVIDER OR SUPPLIE R LIGHT HOSPICE			1229 A	ADDRESS, CITY, STATE, ZIP C RROWHEAD COURT /N POINT, IN 46307	COD		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	RECTION HOULD BE APPROPRIATE	(X5) COMPLETIC DATE	
	Record review of a "Charts/Clinical N completed by the s [power of attorney [patient] is to get a Requested that pt n HLH [Harbor Ligh if possible. Writer care manager] [em plan clarification. The clinical record services were prov During an intervie person I, patient's unaware the hospic Person I indicated and needs compan to make visits to th resides due to visit During an intervie person A, director patient resides, ind disciplines have no in over a month to restrictions still in the facility believe providing care two hospice aide servio During an intervie employee A indica was on 2/6/2020 a documenting comu facility and physic	an agency document titled otes" dated 2/7/2020 and killed nurse stated, " POA] was called and verified that pt shower from facility. receives nail and hair care from at Hospice] and companionship collaborated with PCM [patient ployee A] regarding aide care " I failed to evidence hospice aide ided after 2/6/2020. w on 6/25/2020 at 5:01 p.m., POA, indicated she was ce aide visits had discontinued. the patient requires total care ionship since family is unable ne facility in which the patient			 How are you going to the deficiency from reactive, even if already 100% of all current/ active receiving hospice aiders visit frequency audits to visits are being met and the tasks being perform the needs of the patien all current/ active patien have changes in the aid frequency will be audite care plan is updated and communication has octomonitoring will continue QAPI committee deterned deficiency is corrected 3. Who is going to be manager or designee i responsible for correct deficiency. By what date are yo have the deficiency constant of the section of the	curring in the corrected? tive patients s will have o ensure all d to ensure med meet nt. 100% of ents that ide visit ed to ensure nd curred. This e until the mines responsible The tient care s ing the u going to		

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 06/29/2020 151544 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1229 ARROWHEAD COURT HARBOR LIGHT HOSPICE CROWN POINT, IN 46307 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE L 0558 418.56(e)(5) COORDINATION OF SERVICES Bldg. 00 [The hospice must develop and maintain a system of communication and integration, in accordance with the hospice's own policies and procedures, to-] (5) Provide for an ongoing sharing of information with other non-hospice healthcare providers furnishing services unrelated to the terminal illness and related conditions. Based on record review and interview, the agency L 0558 1558 09/18/2020 failed to provide for ongoing sharing of What is the deficiency? information with other non-hospice healthcare L558Coordination of Services providers furnishing services in 3 of 10 clinical 418.56e (5) The hospice must records reviewed. (#4, #5, #6) develop and maintain a system of communication and The findings include: integration, in accordance with the hospices own policies and 1. Review of an agency policy dated 4/1/14 titled procedures to (5) Provide for an "Coordination of Patient Care" stated "... Hospice ongoing sharing of information has developed and maintains a system of with other non-hospice communication and integration to: ... Provide for healthcare providers furnishing an ongoing sharing of information with other services unrelated to the non-hospice healthcare providers furnishing terminal illness and related services" conditions. 1. How are you going to correct 2. Review of an agency policy dated 4/1/14 titled the deficiency? "Care to Residents of a SNF/NF [Skilled Nursing What is the deficiency? L558 Facility/Nursing Facility] or ICF/MR [Intermediate **Coordination of Services** Care Facility for Mental Retardation]" stated, " 418.56e (5) Hospice is responsible for providing all Hospice The Clinical Management staff will services including: Provision of Hospice Aide educate all staff on L558 services ..." Coordination of Services 418.56e (5). All Social Service, 3. Clinical record review on 6/25/2020 for patient Nursing, Aides and Chaplain will #4 evidenced an agency document titled be educated on policy 09.06.01 "Physician's Orders/Plan of Care" for period Initial Assessment/Comprehensive 11/13/18 - 2/10/19 which indicated the hospice assessment, 11.03.01 Aide aide was to provide 2 visits per week for 13 weeks Documentation, 9.12.01 IDG Care for personal care and assistance with ADLs planning process, 9.13.01

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	PROVIDER OR SUPPLIE		STREET 1229 A CROW)		
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIE REGULATORY C (activities of daily the patient was a r review failed to ev provided 2 times of failed to evidence D. Record review of f "Supplemental Or and signed by the the hospice aide v per week effective to evidence aide so during the week o coordination of ca During an intervie employee A indica	A STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION living). The document indicated esident at entity D. Record vidence aide services were huring the week of 11/25/18 and coordination of care with entity an agency document titled ders from 12-29-18 to 2-9-19" physician on 3/4/19 indicated isits were increased to 3 visits e 12/30/18. Record review failed ervices were provided 3 times f 12/30/18 and failed to evidence re with entity D. w on 6/29/2020 at 11:11 a.m., ated the aide visit was refused	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPI DEFICIENCY) Coordination of patient ca 7.09.01 Care to residents SNF/NF. 2. How are you going to p the deficiency from recur future, even if already co 100% of all current/ active receiving hospice aides v visit frequency audits to e visits are being met and t the tasks being performe the needs of the patient. all current/ active patients have changes in the aide frequency will be audited care plan is updated and communication has occu facilities where patient re This monitoring will contin	Arch BE ROPRIATE are, s in a prevent ring in the rrected? e patients will have ensure all to ensure d meet 100% of s that e visit to ensure rred with sides.	(X5) COMPLETIO DATE
	 During an interview on 6/29/2020 at 11:11 a.m., employee A indicated the aide visit was refused on 11/28/18 and the aide visit on 1/4/19 was not provided since care was performed by entity D. Employee A indicated there was no clinical documentation of coordination of care with entity D to notify the hospice aide visit was not completed and to confirm patient care was provided. Employee A indicated the agency did not ensure all care on the aide care plan was provided since the agency did not request this information from entity D. 4. Clinical record review on 6/25/2020 for patient #5 evidenced an agency document titled "Team Care Plan" dated 6/24/2020 which indicated the patient was a resident at entity B. This document indicated interventions the hospice aide was to provide to the patient including assist with transfers, assist with feeding, perineal care (cleaning of the patient's genitals, buttocks and surrounding area), assist with dressing, mouth care, shower, hair care and nail care. 		the QAPI committee deterned deficiency is corrected. 3. Who is going to be res for numbers 1 and 2- The Executive Director, Patien manager or designee is responsible for correcting deficiency. 4. By what date are you g have the deficiency correct September 18, 2020	ermines ponsible e nt care g the going to		

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 06/29/2020 151544 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1229 ARROWHEAD COURT HARBOR LIGHT HOSPICE CROWN POINT, IN 46307 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE Record review of an agency document titled "Charts/Clinical Notes" dated 2/7/2020 and completed by the skilled nurse stated, " ... POA [power of attorney] was called and verified that pt [patient] is to get a shower from facility. Requested that pt receives nail and hair care from HLH [Harbor Light Hospice] and companionship if possible. Writer collaborated with PCM [patient care manager] [employee A] regarding aide care plan clarification. ..." The clinical record failed to evidence hospice aide services were provided after 2/6/2020. During an interview on 6/26/2020 at 1:45 p.m., person A, director of nursing at entity B, indicated she believed the hospice aide was providing care two times a week and was unaware hospice aide services were discontinued. During an interview on 6/29/2020 at 11:28 a.m., employee A indicated the last hospice aide visit was on 2/6/2020 and there was no clinical note documenting communication with entity B regarding the discontinuation of hospice aide services. 5. Clinical record review on 6/25/2020 for patient #6 evidenced an agency document titled "Physician Orders/Plan of Care from 1-27-20 to 3-26-20" which indicated the hospice aide was to provide visits 3 times a week for 8 weeks beginning 1/2/20. Record review failed to evidence hospice aide services were provided 3 times a week during the week of 2/2/2020 and 2/16/2020. During an interview on 6/26/2020 at 11:35 a.m., employee B indicated the hospice aide visits were refused on 2/7/2020 and 2/20/2020. Employee B indicated there was no documentation of Event ID: QYKX11 Facility ID: 009088 Page 29 of 56 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

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STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER 151544	A. BUILDING B. WING	00	COMPLETED 06/29/2020	
	PROVIDER OR SUPPLIE		1229 A	ADDRESS, CITY, STATE, ZIP COD RROWHEAD COURT		
HARBOI	R LIGHT HOSPICE		CROW	N POINT, IN 46307		
(X4) ID PREFIX	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT		
0580 Bldg. 00	coordination of car hospice aide visits care. 418.60(b)(1) CONTROL The hospice mus agency-wide prog identification, pre investigation of in diseases that- (1) Is an integral assessment and program; and Based on record re	R LSC IDENTIFYING INFORMATION e with entity J regarding were not completed per plan of t maintain a coordinated gram for the surveillance, vention, control, and fectious and communicable part of the hospice's quality performance improvement view and interview, the home d to maintain a program for	TAG	L580	09/18/202	
	identification, prev investigation of inf diseases to include procedures that are standards for undia COVID-19 includi public health offici respiratory illness identified COVID- the potential to affe The findings includ An agency policy of Control Surveillant Defined" stated, " control surveillant to be reported whil Patient infections t admission: any r disease (as defined Written reporting of	ention, control and ectious and communicable written standards, policies and current and based on national genosed respiratory illness and ng when to notify local and state als if there are clusters of or cases of suspected or 19. This deficient practice had ect all patients.		What is the deficiency? L558 Control CFR(s):418.60(b)(1) T hospice must maintain a coordinated agency-wide program for surveillance, identification, prevention, control and investigation of infectious and communicable diseases that- (1) is an integra part of the hospice's quality assessment and performance improvement. 1. How are you going to correct the deficiency? What is the deficiency? L580 Control CFR(s):418.60(b)(1) A nursing staff including Patient of managers will be educated on L580 and Control CFR(s):418.60(b)(1). Policy 05.11.01 Reporting of Epidemiological illnesses in patients, 5.02.01 Infection cont plan, 10.01.01 Quality Performance and Quality	rhe al al tt ull care	

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STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	LTIPLE CO	ONSTRUCTION	(X3) DAT	E SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUI	ILDING	00	COMPLETED	
		151544	B. WIN	NG		06/2	9/2020
		D	<u> </u>	STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF PROVIDER OR SUPPLIER					RROWHEAD COURT		
HARBOI	R LIGHT HOSPICE			CROW	N POINT, IN 46307		_
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD F	N	(X5)
PREFIX	[×]	NCY MUST BE PRECEDED BY FULL	I	PREFIX	CROSS-REFERENCED TO THE APPROP DEFICIENCY)	RIATE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	Improvement plan.		DATE
	An agency policy of	dated 4/1/14 titled "Reporting			2. How are you going to pre	vent	
		l Illnesses in Patients" stated,			the deficiency from recurring		
		e kept to identify any patterns or			future, even if already corre	-	
		icable diseases. Data regarding			100% of all current/ active p		
	communicable dise			will be audited for any active			
	analyzed on an ongoing basis to identify any				infections and infectious dis		
	trends."			surveillance form completion			
					infection written on the infection	tion	
	Clinical record rev			control log, infection listed c	n care		
		led document dated 4/24/2020			plan, was infection required	to be	
	which indicated the	e patient was tested for			reported / and reported to lo	cal	
	COVID-19 on 4/23/2020 and on 4/24/2020 the lab				and state public officials, an	d were	
	results detected CO			logs turned into QAPI comm			
				100% of all current/ active p			
	Record review of a			with NEWLY diagnosed infe			
		Addication Status" indicated the			- that occurred since last ID	-	
		Vitamin C and Zinc from			be audited for any active inf	ections	
	4/25/2020 to 6/24/2	2020 for COVID.			and infectious diseases,		
	Deview of an unde	tad again as do aumont an			surveillance form completion		
		ted agency document on nfection Control Log Form"			infection written on the infection		
		e of patient #5 with an infection			control log, infection listed c plan, was infection required		
					reported / and reported to lo		
	Ũ	site of the lungs. The document failed to evidence the location of the patient, date of infection,			and state public officials, an		
		tion, infectious organism and			logs turned into QAPI comm		
	treatment of infect	e e			Monitoring will continue unt		
					QAPI committee determines		
	During an intervie	w on 6/29/2020 at 12:23 p.m.,			deficiency is corrected.	-	
	employee A indica				3. Who is going to be respo	nsible	
		an investigation related to the			for numbers 1 and 2- The		
	patient's infections	. Employee A also indicated			Executive Director, Patient	care	
	the infection log sh	hould have been completed for			manager or designee is		
	infection control su	urveillance with the patient's			responsible for correcting th	е	
	information related	l to the infection.			deficiency.		
					4. By what date are you goi	ng to	
					have the deficiency corrected	ed?	
					September 18, 2020		

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		151544	B. WING		06/29	9/2020	
NAME OF	PROVIDER OR SUPPLIE	R		T ADDRESS, CITY, STATE, ZIP COD ARROWHEAD COURT	-		
HARBOR	R LIGHT HOSPICE			WN POINT, IN 46307			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX		NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPR	IATE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE	
0626	418.76(g)(2)						
		ASSIGNMENTS AND					
8ldg. 00	DUTIES						
		e provides services that are:					
		e interdisciplinary group.					
	(ii) Included in the	-					
		be performed under State					
	law by such hospice aide.						
	(iv) Consistent with the hospice aide training. Based on record review and interview, the hospice		L 0626	L626		09/18/2020	
		ide services included in the plan	L 0020	What is the deficiency? L62	06	09/18/2020	
	-	d by the interdisciplinary group		Hospice Aide Assignments			
		inical records reviewed. (#4)		duties CFR(s):418.76(g)(2)	and		
				Hospice aide provides serv	ices		
	The findings inclu	de:		that are (i) Ordered by the	1003		
	The mangs mera			interdisciplinary			
	Review of an agen	cy policy dated 4/1/14 titled		group(ii)Ordered by the			
	-	' stated, " Nursing care will be		interdisciplinary			
	-	ance with the patient's IDG		group(iii)Permitted to be			
		the supervision of a registered		performed under state law			
	nurse"			such hospice aide(iv)Consi	stent		
				with the hospice aide traini			
	Review of an agen	cy policy dated 4/1/14 titled		1. How are you going to corr	ect		
	"Care to Residents	of a SNF/NF [Skilled Nursing		the deficiency?			
	Facility/Nursing Facili	acility] or ICF/MR [Intermediate		What is the deficiency? L62	26		
		Iental Retardation]" stated, "		Hospice Aide Assignments			
	· · ·	ible for providing all Hospice		duties CFR(s):418.76(g)(2)			
		Provision of Hospice Aide		nurses and Aides will be edu			
	services"			on 9.22.01 Nursing services			
				9.12.01 IDG Care planning			
		iew on 6/25/2020 for patient #4		process, 9.13.01 Coordinatio			
		cy document titled "Physician's		patient care, 7.09.01 Care to)		
		re" for period 11/13/18 - 2/10/19		residents in a SNF/NF.			
		e patient was a resident at		2. How are you going to prev			
	-	ument indicated the hospice		the deficiency from recurring			
		e 2 visits per week for 13 weeks nd assistance with ADLs		future, even if already correct			
		living). Record review failed to		100% of all current/ active ne	evviy		
		ices were provided 2 times		admitted patients receiving			
	during the week of	-		hospice aides will have visit frequency audits to ensure a			

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

Event ID: QYKX11 Facility ID: 009088

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 151544		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		СОМ	(X3) DATE SURVEY COMPLETED 06/29/2020	
	PROVIDER OR SUPPLIE			1229 A	ADDRESS, CITY, STATE, ZIP C RROWHEAD COURT /N POINT, IN 46307	OD		
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A DEFICIENCY)	RECTION IOULD BE PPROPRIATE	(X5) COMPLETION DATE	
	Record review of a "Supplemental Ord and signed by the p the hospice aide vi per week effective to evidence aide se during the week of During an intervie employee A indica on 11/28/18 and th documentation of entered on the sche Employee A indica not provided since D and there was no entered on the sche by entity D. Emplo not ensure all care	In agency document titled ders from 12-29-18 to 2-9-19" obysician on 3/4/19 indicated sits were increased to 3 visits 12/30/18. Record review failed rvices were provided 3 times 512/30/18. W on 6/29/2020 at 11:11 a.m., ted the aide visit was refused ere was no clinical who refused the visit and who edule the visit was refused. atted the aide visit on 1/4/19 was care was performed by entity to documentation of who edule the care was performed byee A indicated the agency did on the aide care plan was agency did not request this			 visits are being met, ca are updated and the tar performed meet the ne patient. Monitoring will until the QAPI committed determines deficiency in corrected. 3. Who is going to be read for numbers 1 and 2- T Executive Director, Patter manager or designee is responsible for correcting deficiency. 4. By what date are you have the deficiency cor September 18, 2020 	sks being eds of the continue ee s esponsible he ient care s ng the u going to		
L 0671 Bldg. 00	findings is mainta patient. The clini correct clinical int the patient's atter staff. The clinica electronically. Based on record re failed to ensure co relation to the com patients who expen and 1 of 4 active c	RDS containing past and current ined for each hospice cal record must contain formation that is available to nding physician and hospice I record may be maintained view and interview, the hospice rrect clinical documentation, in prehensive assessment in 1 of 1 ienced pain and anxiety (#7), linical records requiring lab al sample of 10 records	L 00	571	L671 What is the deficiency Clinical Records CFR(418.104 – A clinical re containing past and c findings is maintained hospice patient. The o record must contain c	(s): cord urrent I for each clinical	09/18/2020	

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u>		(X3) DATE SURVEY COMPLETED	
		151544	B. WING		_	9/2020
NAME OF I	PROVIDER OR SUPPLIE	R		EET ADDRESS, CITY, STATE, ZIP	COD	
HARBOF	R LIGHT HOSPICE			9 ARROWHEAD COURT DWN POINT, IN 46307		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CO	DRRECTION	(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX		SHOULD BE APPROPRIATE	COMPLETIC
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG			DATE
				clinical information t		
	The findings inclu	de:		available to the patie		
	1 01 1 1			attending physician		
		eview for patient #7 on		hospice staff. The c		
		ced a document titled		record may be maint	ained	
		led visit" electronically signed		electronically.	4	
		n 1/28/2020. An area subtitled Monitoring" which had a		1. How are you going	to correct	
	-	Scales" which stated "Pain		the deficiency? What is the deficience		
		al 0 (0-10) Anxiety 03:14 am		clinical and clerical st	-	
		" An area subtitled "Physical \setminus		educated on L626 Ho		
		otion/ Behavior" stated "		Assignments and duti	-	
	-	"Another area subtitled "Visit		CFR(s):418.76(g)(2)		
		Ianagement" stated "Type of		11.02.01 Patient reco		
		[as needed] / Immediate Needs		and 11.13.1 Clinical		
		nsive: Emotion/ Behavior, Pain		Documentation.		
	-	Ianagement " Furthermore,		2. How are you going	to prevent	
	an area subtitled "I	Physical \ Pain Evaluation \ Pain		the deficiency from re		
	Assessment" stated	l, " Is pain an active		future, even if already	corrected?	
	problem for this pa	ttient?: 1. Yes " This		100% of all current pa	atients and	
		evidence consistent		new admissions recei	iving lab work	
		egards to anxiety and pain		will be monitored to e	nsure	
	comprehensive ass	essments.		consistent documenta		
				present for lab work.		
		iew evidenced a document titled		average daily census		
		Notes" which stated " Facility		monitored on a month	-	
	•	and stated pt [patient] is in		consistent past and c		
	-	Upon arrival patient was heard riving into the room. Facility		clinical records finding		
	e e	tated pt has currently been		and anxiety concerns	-	
		illigrams] of Dilaudid [narcotic		will continue until the committee determines		
		rate to severe pain] every hour		is corrected.	sueliciency	
		ivan [sedative used to relieve		3. Who is going to be	responsible	
		r as ordered. Facility nurse		for numbers 1 and 2-	•	
		are currently ineffective for pt		Executive Director, Pa		
		electronically signed by		manager or designee		
		/28/2020, at 5:28 AM.		responsible for correct		
		-		deficiency.	0	
	During an intervie	w on 6/29/2020, at 3:03 PM,		4. By what date are y	ou going to	
		owledged the inconsistencies		have the deficiency c		

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 151544	(X2) MULTIPLE A. BUILDING B. WING	construction 00	(X3) DATE SURVEY COMPLETED 06/29/2020		
NAME OF PROVIDER OR SUPPLIER HARBOR LIGHT HOSPICE			STREET ADDRESS, CITY, STATE, ZIP COD 1229 ARROWHEAD COURT CROWN POINT, IN 46307				
	1			1			
(X4) ID PREFIX TAG	(EACH DEFICIE	/ STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	E (X5) RIATE COMPLETION DATE		
	within the clinical	record and indicated the skilled educated on comprehensive		September 18, 2020			
	Person E stated "T night nurse wrote screaming from do on the pain/agitati to being comfortal review on 6/25/20 agency document 6/24/2020 which i monthly CBC (Co (Comprehensive M Dilantin (test to m medication) labs d	w on 6/29/2020, at 3:28 PM, 'heir [Harbor Light Hospice] she could hear the patient bwn the hallway but documented on chart a very low-end mark as ole and fine."2. Clinical record 20 for patient #5 evidenced an titled "Team Care Plan" dated ndicated the patient was to have mplete Blood Count), CMP Metabolic Panel) and Free onitor blood level of seizure trawn. The clinical record failed sults for March, April and May					
	employee A indica monthly labs since 1/31/2020 but ther clinical record. En	w on 6/29/2020 at 12:15 p.m., ated the patient was receiving e admission to hospice on re were not lab results in the apployee A indicated she received ts from entity B after lab results					
L 0674	418.104(a)(3) CONTENT						
Bldg. 00	[Each patient's re following:] (3) Responses to	ecord must include the o medications, symptom eatments, and services.					
	aide note failed to provided in 1 of 6	eview and interview, the hospice contain all the services discharged clinical records total of 10 clinical records	L 0674	L674 What is the deficiency? L67 Clinical Records CFR(s): 418.104(a)(3)– Each patient record must include the following (3) Responses to	's		

	R MEDICARE & MEDIC NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(V2) M		ONSTRUCTION	-	1B NO. 0938-039
	OF CORRECTION	IDENTIFICATION NUMBER	r í		<u>00</u>	(X3) DATE SURVEY COMPLETED	
IND FLAN	I OF CORRECTION	151544	A. BUILDING <u>00</u> B. WING			06/29/2020	
					ADDRESS CITY OT ATE 710 COD		
NAME OF	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD		
HARBO	R LIGHT HOSPICE				N POINT, IN 46307		
X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
REFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	1	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	The findings include	le:			medications, symptom		
	-				management, treatments, a	nd	
	The agency policy	dated April 1, 2014, policy			services.		
		itled "Patient Record Content"			1. How are you going to corre	act	
					the deficiency?	501	
	stated " Policy Hospice will provide an accurate and current patient record for every patient seen by Hospice. The record, whether						
					What is the deficiency? L67	4	
					Clinical Records CFR(s):		
	hard copy or in electronic form, will be made readily available on request by an appropriate authority. Purpose To ensure documentation of				418.104(a)(3)-		
					All nurses and aides will be		
				educated on L674 Clinical			
	patient status, servi	ices and outcomes			Records CFR(s): 418.104(a)	(3)	
	Procedure 1. hosp	pice will initiate and maintain an			policy 11.02.01 patient record	t	
	individual and accu	arate patient record containing			content, 11.03.01 hospice aid	le	
	past and current fir	idings for each patient			Documentation, 4.21.0 Hospi		
		ompliance with all federal/state			aide supervision.		
		ns. The record must contain			2. How are you going to prev	ent	
	-	ormation that is available to the			the deficiency from recurring		
		physician and Hospice staff.			future, even if already correct		
		maintained electronically.			100% of all admissions will b		
		standardized format for records.				-	
	-				audited to ensure authenticity		
		periodically reviewed and			accuracy. This audit will inclu		
	-	ary. 2. All entries must be			monitoring the care plan to e		
	-	plete and appropriately			it reflects the individual needs		
		Each patient record will contain			the patients identified in the in		
	U 1	plicable: Care/services			assessment. Monitoring the	care	1
		ce, including contracted staff			plan to ensure it reflects the		
	(evaluations, treatm	nents and progress notes).			individual needs of the patien	its	
	Date care/services	provided and staff/title who			identified in the admission cli	nical	
	provided care/servi	ices Responses to			note? Monitoring to ensure th	ie	
	medications, symp	tom management, treatments			aide supervisory section prop		
		atient/family response to			completed? Monitoring will	- ,	
	care/services"				continue until the QAPI com	nittee	
					determines deficiency is		
	The agency policy	with a revised date of			corrected.		
						aible	
		5, policy number 11.03.01, titled			3. Who is going to be respon-	SIDIG	
	· ·	cumentation" stated " Policy			for numbers 1 and 2- The		
	-	e accurate documentation of			Executive Director, Patient ca	are	
	-	ces. Purpose To provide			manager or designee is		
		he care performed by the			responsible for correcting the	;	
	Hospice Aide on e	ach visit Procedure 1. The	1		deficiency.		1

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	ENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 151544	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	COME	e survey pleted 9/2020
	PROVIDER OR SUPPLIE		1229 A	ADDRESS, CITY, STATE, ZIP COD ARROWHEAD COURT /N POINT, IN 46307		
(X4) ID PREFIX	(EACH DEFICIE)	' STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIEVING DIEOPMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROI DEFICIENCY)	DN BE PRIATE	(X5) COMPLETION
TAG	Hospice Aide will the patient on the a charting form designated RN [reg for reviewing the F This documentatio completion of each Clinical record rev start of care 5/9/19 document titled "P from 05-09-19 to 0 physician on 5/23/ Aid 05-09-19 2 x personal care and a [activities of daily Clinical record rev document titled "V [patient name] from This document ind visits. This docum 5-13-19 and indica "NA", perineal car movement as "NA assist with dressing lotion of patient's of apply deodorant as "NA", brush/comb "NA", and shower to evidence all resp documented. During an interview employee G indica and indicated she v	iew on 6/29/20, for patient #1, 9, evidenced an agency hysician's Orders/Plan of Care 08-06-19, dated and signed by the 19. This document stated " week x 13 weeks Provide assistance with ADLs	TAG	4. By what date are you go have the deficiency correct September 18, 2020	ing to	DATE

QYKX11 Facility ID: 009088

If continuation sheet

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PRINTED: 09/08/2020 FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES

	NT OF DEFICIENCIES OF CORRECTION	x1) provider/supplier/clia identification number 151544	JILDING NG	<u>00</u>	(3) DATE S COMPLI 06/29/2	ETED
	PROVIDER OR SUPPLI		1229 A	ADDRESS, CITY, STATE, ZIP COD RROWHEAD COURT /N POINT, IN 46307		
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE ENCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
_ 0679 Bldg. 00	and appropriatel accordance with accepted standa Based on record r agency failed to e clinical records in (#1) The findings inclu The agency policy number 11.02.01, stated " Policy accurate and currar patient seen by He Hospice will initia and accurate patien current findings fa compliance with a regulations" Clinical record re start of care 5/9/1 document titled ". and signed by em an area subtitled " which stated "Aid Supervision: Yes the Care Plan?: Y satisfied with care in service?: No hospice aide had n patient. The clini During an intervice employee A indic	be legible, clear, complete, y authenticated and dated in hospice policy and currently urds of practice. eview and interview, the hospice nsure the authenticity of all 1 of 10 clinical records reviewed.	579	L679 What is the deficiency? L679 Authentication CFR(s): 418.104(b)–All entries must be legible, clear, complete, and appropriately authenticated and dated in accordance with hospice policy and currently accepted standards of practice 1. How are you going to correct the deficiency? What is the deficiency? L679 Authentication CFR(s): 418.104(b)– All staff will be educated on L67 Authentication CFR(s): 418.104(b), policy 11.02.01 patie record content, and process for quality assurance review. 2. How are you going to prevent the deficiency from recurring in t future, even if already corrected 100% of all admissions will be audited during the QA process the ensure authenticity and accurac This will include reviewing if the care plan reflects the individual needs of the patient identified in the initial assessment, does the pare plan reflect the individual needs of the patients identified i the admission clinical note? Reviewing if the aide supervisor section was properly completed	ent the ? o y.	09/18/202

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	î î		ONSTRUCTION	. ,	TE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 151544	A. BU B. W	JILDING	00	-	APLETED 29/2020
	PROVIDER OR SUPPLIE			1229 A	ADDRESS, CITY, STATE, ZIP CO RROWHEAD COURT /N POINT, IN 46307	D	
(X4) ID PREFIX	SUMMARY	STATEMENT OF DEFICIENCIE		ID PREFIX	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SHC CROSS-REFERENCED TO THE AP	ECTION DULD BE	(X5) COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE AP DEFICIENCY)	PROPRIATE	DATE
	reviewed the plan aide.	of care with the home health			answered no if the Aide present). Monitoring will until the QAPI committe determines deficiency is corrected. Who is going to be resp numbers 1 and 2- The E Director, Patient care m designee is responsible correcting the deficiency By what date are you go have the deficiency corr September 18, 2020	continue e onsible for Executive anager or for /. Ding to	
. 0680 Bldg. 00	The clinical recorr information conta safeguarded aga use. The hospice the Department's health information 160 and 164. Based on observat interview, the hosp patient clinical rec unauthorized acces practice had the po The findings inclue The agency policy December 1, 2015 Title: Patient Con Patient records will in the office, All	F INFORMATION d, its contents and the ined therein must be inst loss or unauthorized must be in compliance with rules regarding personal n as set out at 45 CFR parts fon, record review, and bice agency failed to ensure all ords were safeguarded against as and / or use. This deficient tential to affect all patients. de: with a revised date of titled "Policy Number: 06.02.01 fidentiality" stated " 9. I not be left in unattended areas I patient records will be kept cabinets to minimize the	L 04	580	L680 What is the deficiency Protection of informati CFR(s) 418.104(C)The record, its contents an information contained must be safeguarded a loss or unauthorized u hospice must be in cou with the Departments r regarding personal hea information as set out parts 160 and 164. 1. How are you going to	on clinical d the therein tgainst se. The mpliance rules alth in 45CFR	09/18/2020

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	î î	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 151544	A. BUILDING B. WING	00	COMPLETED 06/29/2020
NAME OF 1	PROVIDER OR SUPPLIE	ER		TADDRESS, CITY, STATE, ZIP COD	
HARBOF	R LIGHT HOSPICE	1		ARROWHEAD COURT VN POINT, IN 46307	
(X4) ID	SUMMAR	Y STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTIO	N (X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP	BE COMPLETIO
TAG		OR LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	-	against unauthorized corruption,		What is the deficiency? L6	80
	damage and/or int	rusion"		Protection of information	
				CFR(s) 418.104(C)	
		1:03 a.m., Harbor Light Hospice		All staff have been educated	
		Mishawaka, IN was visited.		L680 Protection of informati	
		e of visit was employee G, I, and		CFR(s) 418.104(C) and pol	
		s made of the record room with		06.02.01 Patient Confidentia	ality &
		, light off, and no one present in om was observed to be filled		06.03.01 HIPAA Breach.	want
				2. How are you going to pre	
		binets with multiple banker boxes on top of the metal filing		the deficiency from recurring	-
		m failed to be locked to		future, even if already corre	
		ecords from unauthorized use.		Daily, during office hours, the medical room and workstati	
	saleguard cheft re	cords from unautionized use.			
	During an intervie	ew on 6/25/2020 at 11:05 a.m.,		will be audited to ensure pa records are safeguarded.	uent
	-	ated they don't have many		Monitoring will include is the	
		the occasional delivery person.		medical record room locked	
	visitors other than	the occasional derivery person.		there records outside of the	
				cabinets, is there any patier	
				information left in an unsecu	
				are or visible to those walking	
				the workstations? Monitorin	
				continue until the QAPI com	
				determines deficiency is	
				corrected.	
				3. Who is going to be respo	nsible
				for numbers 1 and 2- The	
				Executive Director, Patient	care
				manager or designee is	
				responsible for correcting th	e
				deficiency.	
				4. By what date are you goi	ng to
				have the deficiency corrected	ed?
				September 18, 2020	
0682	410 104(-)(4)				
0682	418.104(e)(1)				
Bldg. 00		R TRANSFER OF CARE			
Jug. 00		a patient is transferred to e/Medicaid-certified facility,			
		t forward, to the receiving			

	NT OF DEFICIENCIES	x1) provider/supplier/clia identification number 151544	A. BUILDI B. WING		СОМ 06/2	te survey pleted 29/2020
	PROVIDER OR SUPPLIE R LIGHT HOSPICE		12	REET ADDRESS, CITY, STATE, 229 ARROWHEAD COUR ROWN POINT, IN 46307		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	II PRE TA	FIX (EACH CORRECTIVE ACT CROSS-REFERENCED TO	TON SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
TAG	facility, a copy of- (i) The hospice di (ii) The patient's of Based on record re failed to forward th the hospice dischar transfer to another reviewed. (#4) The findings includ Review of an agen "Discharge Summa patient is transferre Medicare/Medicaid forward, to the record Hospice discharge Review of an agen Distribution for the 06-23-2020" on 6/2 was discharged fro Clinical record rev evidenced an agen "Charts/Clinical No by employee A wh transferred to anoth 1/29/19. Clinical re discharge summary During an interview employee B indica not completed and During an interview employee A indica discharge summary a signed copy. Employee Semi	scharge summary; and clinical record, if requested. view and interview, the agency he receiving facility a copy of rge summary after a patient's facility in 1 of 6 closed records de: cy policy dated 4/1/14 titled ary" stated, " If the care of a ed to another d-certified facility, Hospice will eiving facility; a copy of: The summary" cy document titled "Patient e period 01-01-2018 through 23/2020 evidenced patient #4 m the agency. iew on 6/25/2020 for patient #4 cy document titled otes" dated 1/29/19 completed ich indicated the patient was her hospice agency effective ecord review failed to evidence a	L 0682	L682 What is the deficient Discharge or trans CFR(s): 418.104(e) of the patient is trans facility, the hosping forward, to the read facility, a copy of discharge summan patients clinical read requested. 1. How are you go the deficiency? What is the deficient Discharge or trans CFR(s): 418.104(e) All nursing staff and be educated on L60 transfer of care CF (1) and policies 9.2 referral criteria, 9.2 criteria, and 9.29.00 Summary. 2. How are you go the deficiency from future, even if alread 100% of patients the transferred to anot have monitoring fo summaries printed that it was faxed to hospice. Monitoring until the QAPI com determines deficience corrected.	ency? L682 sfer of care)(1) If the care ansferred to d-certified ce must ceiving (i) hospice my(ii) The ecord if ing to correct ency? L682 sfer of care)(1) d office staff will 82 Discharge or FR(s): 418.104(e) 27.1 Transfer 28.01 Discharge 11 Discharge ing to prevent n recurring in the ady corrected? nat are her hospice will r discharge with verification o the receiving g will continue unittee	DATE 09/18/2020

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

Event ID: QYKX11 Facility ID: 009088

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	ND PLAN OF CORRECTION IDENTIFICATION NUMBER A.		(X2) MULTIPLE A. BUILDING B. WING	<u></u>		B NO. 0938-039 SURVEY ETED '2020
	PROVIDER OR SUPPLIE		1229	T ADDRESS, CITY, STATE, ZIP COD ARROWHEAD COURT WN POINT, IN 46307		
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
		rge summary since one was not		 3. Who is going to be response for numbers 1 and 2- The Executive Director, Patient car manager or designee is responsible for correcting the deficiency. 4. By what date are you going have the deficiency corrected September 18, 2020 	sible re g to	
L 0692 Bldg. 00	BIOLOGICALS (1) The interdisci review of the plan ability of the paties self-administer di patient in his or h (2) Patients receiprovides inpatient facility may only medications by th (i) A licensed nur health care profet their scope of pra- (ii) An employee State-approved t medication admin (iii) The patient, to interdisciplinary of Based on record re- agency failed to er was updated to inter- patient caregiver to medications, in 1 of	aving care in a hospice that t care directly in its own be administered the following individuals: se, physician, or other ssional in accordance with actice and State law; who has completed a raining program in histration; and upon approval by the group. eview and interview, the hospice usure the patient plan of care clude the capability of the to safely administer patient of 6 discharged clinical records total of 10 clinical records	L 0692	L692 What is the deficiency? L692 Biologicals CFR(s): 418.106(The interdisciplinary group, part of the review of the plan care, must determine the ability of the patient and/or family to safely self administ drugs and biologicals to the	(d)(1) as n of ter	09/18/2020

	R MEDICARE & MEDI					MB NO. 0938-03
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	î î	E CONSTRUCTION	<u>`</u>	E SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	<u>00</u>		PLETED
		151544	B. WING		06/2	9/2020
NAME OF	PROVIDER OR SUPPLIE	R		ET ADDRESS, CITY, STATE, ZIP COD		
TARBUI	R LIGHT HOSPICE		CRU	OWN POINT, IN 46307		_
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECT	ION	(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL	PREFIX	CROSS-REFERENCED TO THE APPR	D BE OPRIATE	COMPLETIC
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE
		with a revised date of		(2)Patients receiving car		
		4, policy number 08.10.01, titled		hospice that provides in		
	-	osal" stated " Policy Hospice		care directly in its own fa	acility	
	-	t/family/caregiver on policy and		may only be administere	d	
	procedures for the	management and disposal of		medication by the follow	ing	
	controlled drugs in	the patient's home. Purpose		individuals(i) A licensed	nurse,	
	To define appropri	ate management and disposal		physician, or other healt	h care	
	of controlled subst	ances Procedure 1. At the		professional in accordar	ice	
	time when control	led drugs are first ordered,		with their scope of pract	ice and	
	Hospice will: Pro-	vide a copy of the Hospice		state law(ii)An employee	who	
	written policies an	d procedures on the		has completed a		
	management and c	lisposal of controlled drugs to		State-approved training		
	-	nt representative and/or family.		program in medication		
	· · ·	ce policies and procedures for		administration and (iii)Th	ne	
	-	use and disposal of controlled		patient upon approval by		
		ent or representative and the		interdisciplinary team.		
		ge and manner that they		1. How are you going to c	orrect	
		re that these parties are		the deficiency?		
		g the safe use and disposal of		All nursing staff will be ed	ucated	
		Document in the patient's		on L692 Biologicals CFR(
	-	the written policies and		418.106(d)(1), policies 8.	-	
		naging controlled drugs was		Medication Disposal, 8.19		
	-	issed. 2. Hospice's medication		Medication Reconciliation		
	^	lisposal policies include:		Response to Adverse Dru	-	
	-	all medications out of reach of		Reactions and Medication	0	
		rsons with altered mental		8.12.01 Medication	LI1015,	
		er using a locked box to store		Administration, 9.15.01 Pl	an for	
		ions to prevent these		patient and family educati		
		being stolen or taken by anyone		2. How are you going to p		
	other than the patie					
	other than the path	-IIt		the deficiency from recurr	-	
	The econor neli-	dated April 1 2014 policy		future, even if already cor		
		dated April 1, 2014, policy		100% of all current/ active		
	number 08.19.01,			patients will be audited to	_	
		ted " Policy Hospice will		determine competency for		
	-	medications at time of		administration of medicati		
		an ongoing basis Procedure		management of controlled		
		sistered nurse] or LPN [licensed		substances. 100% of all n		
	-	/N [licensed vocational nurse]		admitted HOME patients		
		ations with the patient at each		the person responsible for		
	I visit to ensure und	erstanding of medication use.		administering medications	e ie	

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 151544	(X2) MULTIPLE C A. BUILDING B. WING	construction 00	COM	e survey pleted 9/2020
NAME OF	PROVIDER OR SUPPLIE	ËR	1229 /	TADDRESS, CITY, STATE, ZIP COD ARROWHEAD COURT		
HARBO	R LIGHT HOSPICE		CROV	VN POINT, IN 46307		
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	ION D BE OPRIATE	(X5) COMPLETIC DATE
	The review includ administration of a documented on ap EMR [electronic r medication tab" The agency policy number 08.15.01, Drug Reactions an Policy Hospice w actual or potential medication errors. be reported immed and Director/Mana medication errors variance/incident r reaction and medic compiled and anal [quality assessmer program." The agency policy December 30, 201 "Medication Adm To ensure that phy and that medication accurately to the c check all patient n ineffective drug th significant side effi contraindicated m problems to the ph assessed and reass medication r medication r medication n medication n medicat	es; side effects, storage and all medications. This review is propriate form or in Allscripts nedical record] system under the		identified through has cha will be audited to determin competency for administra medications and controller substances. This monitori continue until the QAPI co determines deficiency is corrected. 3. Who is going to be resp for numbers 1 and 2- The Executive Director, Patien manager or designee is responsible for correcting deficiency. 4. By what date are you go have the deficiency correct September 18, 2020	t care the	

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 06/29/2020 151544 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1229 ARROWHEAD COURT HARBOR LIGHT HOSPICE CROWN POINT, IN 46307 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE medication error or adverse drug reaction, the patient's physician is to be notified immediately. ... 11. The patient and family will be educated about potential adverse reactions and any other concerns. 12. Any unresolved, significant concerns about medications will be discussed by the nurse with the patient's physician and appropriate staff. ... 14. The IDG, as a part of the review of the plan of care, will determine initially and ongoing the ability of the patient/family/caregiver to safely self-administer drugs and biologicals to the patient in his/her home. The individualized IDG plan of care must identify if patient/family/caregiver and self administering drugs and biologicals. If the patient/family/caregiver is not capable of safely administering drugs and biologicals in the home, the issue will be addressed in the IDG care plan...." Clinical record review on 6/26/20 for patient #1, start of care 5/9/19, evidenced an agency document titled "Medication Status" which indicated the medication order for the patient. The patient medication list included (but was not limited to): Percocet [narcotic pain killer] By Mouth 10-325 mg [milligram] 1 tablet every 4 hours as needed, start date 4/19/19; Comfort Kit placed in home, started 5/16/19; Morphine Sulfate [narcotic pain reliever] By Mouth Solution 20mg / ml [milliliter] 5 - 10 milligram every 2 hours as needed by mouth or sublingual [under tongue], started 5/16/19; Ativan Injection Solution 2mg/ ml 0.5 - 1 milligram every 2 hours as needed by mouth or sublingual, started 5/16/19; Xanax [for anxiety] By Mouth tablet 0.5mg 1 tablet three times a day, start date 5/14/19; and Dilaudid [narcotic pain killer] By Mouth tablet 2mg 1-2 tablet every 4 hours as needed, started 5/10/19. QYKX11 Facility ID: 009088 Page 45 of 56 FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: If continuation sheet

09/08/2020

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 151544	(X2) MULTIPLE C A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 06/29/2020
NAME OF	PROVIDER OR SUPPLIE	ER		ADDRESS, CITY, STATE, ZIP C RROWHEAD COURT	COD
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	Clinical record rev	view evidenced an agency			
		Initial Visit - on 05-09-2019"			
		electronically signed by			
		document indicated the patient			
		d medications appropriately and			
		d for Xanax [for anxiety] and			
		pain reliever]. This document			
	-	verbal medication instructions			
		patient and patient caregiver			
	-	vere reconciled without issue			
	and there were no	dosage errors.			
	Clinical record rev	view evidenced an agency			
	document titled "C	Charts/Clinical Notes" dated			
	5/10/19 and electr	onically signed by employee L.			
	This document sta	ted " During the last hospital			
	-	ving percocet alternating with			
		as working well for the pain, 5			
		out of percocet and began			
		ng 14 - 16 x a day and was			
		e dilaudid" The medication			
		e medication of dilaudid should			
	•	en over 6 times daily. There			
		he skilled nurse educated the			
		egiver on the medication error			
		ne primary physician was			
	notified of the exc	ess administration of dilaudid.			
		view evidenced an agency Routine Visit - on 05-10-2019"			
		ically signed by employee L on			
		ument indicated the patient had			
		ngoing education and bain regimen. The document			
	-	ly/patient caregiver needed			
		and reinforcement of pain			
		ument indicated the patient			
		d the medications appropriately,			
		eeded for percocet and dilaudid,			
		ver needed reinforcement for			
	ine patient caregiv	er needed rennforcement 101	1	1	1

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 151544	(X2) MULTIPLE A. BUILDING B. WING	E CONSTRUCTION B 00	COM	te survey 1pleted 29/2020
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_		Y STATEMENT OF DEFICIENCIE	ID			(¥5)
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		ion, and the medications were				
	document titled "C entry dated 5/10/1 employee L. This [patient] is out of 1 admission nurse to was called to Encl staff to call in 3 da	view evidenced an agency Charts/Clinical Notes" with one 9 and electronically signed by entry stated " She said pt Percocet but has deluded, call to o check on status Percocet ara along with Xanax, asked dr ays supply to local [name of p/u [pick up] and take for my				
	document titled " dated and electrom 5/13/19. This doc needed ongoing ea pain regimen, the needed ongoing ea pain regimen, pair and patient was ur document indicate the medications ap provided on perco schedule was set u the medications w the patient caregiv	view evidenced an agency Routine visit - on 05-13-2019" ically signed by employee L on ument indicated the patient ducation and reinforcement of family/pcg [patient/caregiver] ducation and reinforcement of a reported by patient caregiver hable to provide details. This ad the patient caregiver managed opropriately, education was cet, dilaudid dosages and a up. This document indicated ere reconciled without issue and yer demonstrated understanding and needed reinforcement.				
	document titled "C entry dated 5/13/1 employee L. This , DIL [daughter in tablets at a time w q [every] 4 hrs [ho bottle is 1 tab. No	view evidenced an agency Charts/Clinical Notes" with an 9 and electronically signed by document stated " [Person G] law] had been giving percocet 2 hen the order is 1 tab 10/325mg purs], and is written on the med ted that in her writing down the d a 8 hr lapse in pain				

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZOD HARBOR LIGHT HOSPICE 1229 ARROWHEAD COURT CROWN POINT, IN 46307 COUNT TO PERCIENCE IP BERENX REGULATORY OR LSC DENTIFYING INFORMATION TAG IP REGULATORY OR LSC DENTIFYING INFORMATION IP		NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 151544	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	COM	te survey ipleted 29/2020
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PRETX (EACI DEFICIENCY MUST BE PRECEDED BY FULL TAG PRETX Description COMPLET TAG TAG REGULTIONY OR LSC IDENTIFYING INFORMATION to give alternating pain meds of percocet and diluadid q 2 hrs until she is comfortable Narcotics were counted P is having pain in her abdomen, lower left chest, lungs are clear but diminished in all lobes. She is alternating percocet with diluadid, DL says the pain scenes to be increasing quickly" Clinical record review evidenced an agency document titled " Oncall/Unscheduled visit - on 05-14-2019" dated and electronically signed by employee L on 5/14/19. This document indicated the pain was well controlled with the current Plan of Care, patient needed ongoing education and reinforcement of pain regimen, fmainly/peg needed ongoing education and reinforcement of pain regimen, the DIL main caregiver was given a form adjusted for the abilities to understand, she needed reinforcement and additional teaching for better control of the patient's pain. The document indicated the patient's were reclucated, the patient caregiver managed medications appropriately, they were reducated on percocet and dilaudid administration schedule, the patient caregiver demonstrated understanding by verbalization and the patient darpetiver needed reinforcement, the medication was reconciled without issue and the skilled nurse reinforced giving pain medication. Image: Clinical Notes Image: Clinical Notes Image: Clinical Notes Clinical record review evidenced an agency document titled "Charts/Clinical Notes" with an entry dated and signed by employee L on 51/4/19, This set ty stated"	HARBOF	R LIGHT HOSPICE		CROW	N POINT, IN 46307		
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ally increase in ner anxiely over lise of pain		-					

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 151544	(X2) MULTIPLE CO A. BUILDING B. WING	DNSTRUCTION 00	(X3) DATE COMPL 06/29/	ETED
NAME OF	PROVIDER OR SUPPLI	ER		ADDRESS, CITY, STATE, ZIP CO RROWHEAD COURT)D	
HARBOI	R LIGHT HOSPICE	Ē		N POINT, IN 46307		
(X4) ID PREFIX		Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF	OULD BE	(X5) COMPLETIO
TAG		DR LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE
		curity Prn [as needed] visit				
	-	l, educating main caregiver				
		v to give meds for good pain				
		ore direction due to giving				
		set up a schedule that she can				
		has the sign out sheets but				
		on that sheet to know what she				
		n she could give again, also				
		raking her to give her				
	medication"					
	Clinical record rev	view evidenced an agency				
	document titled ".	Routine visit - on 05-15-2019"				
	dated and electron	ically signed by employee J on				
	5/15/19. This doc	ument indicated the patient				
	caregiver manage	d mediations appropriately, the				
	patient was unable	e to manage medications,				
	medications were	reconciled without issue, and				
	there were no dos	age errors.				
		view evidenced an agency				
		Charts/Clinical Notes" with an				
		nployee M, timed 08:01:30a with				
	an effective date of	of 5/15/19. This document stated				
	Ũ	ed call from pt's [patients]				
		person G], stating that the pt has				
		c today. Pt is now				
		her head hanging back, mouth				
	· ·	l not open her eyes. [Person G]				
		at the pt's mouth is open, she				
		not swallow any of her PM				
	medications, as th	ey are still in her mouth"				
	Clinical record rev	view evidenced an				
	interdisciplinary g	group note titled "Charts/Clinical				
		/19 and electronically signed by				
		document indicated she was				
		st pain meds for comfort, that				
		bus teaching on pain meds with				
		iver, [person G], and that the				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 151544	(X2) MULTIPLE A. BUILDING B. WING	COMPL	(X3) DATE SURVEY COMPLETED 06/29/2020	
NAME OF	PROVIDER OR SUPPLIE	ËR		T ADDRESS, CITY, STATE, ZII ARROWHEAD COURT	P COD	
HARBO	R LIGHT HOSPICE	1	CRO	WN POINT, IN 46307		
(X4) ID PREFIX		Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO) CROSS-REFERENCED TO TH	N SHOULD BE	(X5) COMPLETIO
TAG	REGULATORY C	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY		DATE
	anxiety periods as	be using pain medicine for comfort. There was no nange to the patient's care plan.				
	document titled " 05-16-2019" dated employee N on 5/ the patient was let manages medication	view evidenced an agency Oncall/Unscheduled visit - on and electronically signed by 16/19. This document indicated hargic, the patient caregiver ons appropriately, the reconciled without issue, and age errors.				
	document titled "C had an entry dated by employee N. T said her pills were held them in mout mouth swabs fridge and they sai will come by fed e	view evidenced an agency Charts/Clinical Notes" which 5/16/19 electronically signed This entry stated " [Person G] still in her mouth due to she h but she got them out. Left Asked if there is a comfort kit in id no but we have been told it ex. Hospice nurse [employee N] and no comfort kit has been d.				
	document titled " 05-16-2019" dated employee O on 5/ patient caregiver r appropriately, taug patient caregiver r	view evidenced an agency Oncall/Unscheduled visit - on l and electronically signed by 16/19. This document indicated nanages medications ght about comfort kit briefly, needs reinforcement, ciled without issue, and no				
	document titled "C entry dated 5/16/1 employee O. This	view evidenced an agency Charts/Clinical Notes" with an 9 electronically signed by 9 document stated " Family 8 can be crushed or to change				

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 151544	(X2) MULTIPLE CC A. BUILDING B. WING	COMPL	(X3) DATE SURVEY COMPLETED 06/29/2020		
NAME OF PROVIDER OR SUPPLIER HARBOR LIGHT HOSPICE			STREET ADDRESS, CITY, STATE, ZIP COD 1229 ARROWHEAD COURT CROWN POINT, IN 46307				
(X4) ID PREFIX		Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR	D BE	(X5) COMPLETIO	
TAG	delivery. Talked v states Ambien, Xa remoron [sic], Per recommend dc [di agreement, not rec talking with [persa any of her meds o time due to swallc of what to do at th with other family tomorrow. Comfc arrive by Saturday Clinical record rev document titled ". 05-17-2019" dated employee L on 5/7 pain was well con patient needs ongo reinforcement of p ongoing education regimen, changes adjusting medicati and to see nurses of the physician was caregiver managed re-education was of dilaudid, xanax to verbal instructions and patient caregir understanding by needed reinforcem reconciled withou Clinical record rev document titled "C entry dated and el- L on 5/17/19. Thi narcotics sheets ha	view evidenced an agency Oncall/Unscheduled visit - on d and electronically signed by 17/19. This document indicated trolled with current plan of care, bing education and bain regimen, family/pcg needed and reinforcement of pain necessary, daughter in law was ions as they spoke about today notes. This document indicated not contacted that the patient d medications appropriately, done on the use of percocet, reduce use of pain medication, s were given to patient caregiver ver demonstrated verbalization, patient caregiver nent, and medications were	TAG	DEFICIENCY)		DATE	

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-039 **CENTERS FOR MEDICARE & MEDICAID SERVICES** STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 06/29/2020 151544 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1229 ARROWHEAD COURT HARBOR LIGHT HOSPICE CROWN POINT, IN 46307 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE documenting them. [Person G] and I are working on reducing pain mediation and managing her anxiety better. ... 4. Supporting [person G] who is managing the medications and pt's care. Roxanol [morphine - narcotic pain killer] was ordered for local pharmacy so family would have it/they are aware. ... Spoke with [person G] about give [sic] a pain me every 4 hours, give 1 percocet or 1-2 dilaudid, and use 1/2 Xanax for anxiety ([person G] said that the Xanax makes her sleepy so we are trying to reduce with good effect) more scheduled during the day. ... Lock box was dropped off, RNCM [registered nurse case manager] has the second key. Comfort pak to come Saturday, family is aware to refrigerate when it come/under lock [sic]." Clinical record review evidenced an agency document titled "... Routine visit - on 05-20-2019" dated and electronically signed by employee L on 5/20/19. This document indicated the patient caregiver managed medications appropriately, refills were needed and will be delivered, no medications were taught this visit, and medications were reconciled without issue. Clinical record review evidenced an agency document titled "Charts/Clinical Notes" with an entry dated and electronically signed by employee L on 5/20/19. This entry stated "... 1. Several meds were ordered today. [Person G] continued to give pt the max of pain med that she could have, resulting in decreased amt [amount] of percocet and dilaudid. ... She continues to take percocet 10/325 and 2 hours later alternating meds, dilaudid 2mg 2 tabs, Xanax 0.5 bid, ambien at night to help sleep. ... Pt has some unusual behaviors, moves around room during the nights, mild confusion, hx [history] of strong drug use (addicted ?). Continue to teach about medication QYKX11 Facility ID: 009088 Page 52 of 56 FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: If continuation sheet

09/08/2020

PRINTED:

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 151544		IDENTIFICATION NUMBER	(X2) MULTIPLE CO A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/29/2020			
NAME OF PROVIDER OR SUPPLIER HARBOR LIGHT HOSPICE			STREET ADDRESS, CITY, STATE, ZIP COD 1229 ARROWHEAD COURT CROWN POINT, IN 46307				
(X4) ID PREFIX		Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL)	O BE	(X5) COMPLETIO	
TAG		OR LSC IDENTIFYING INFORMATION ing, usage. Narcotic counts at	TAG	CROSS-REFERENCED TO THE APPRO DEFICIENCY)		DATE	
	document titled ". dated and electrom 5/23/19. This doc contact was requir been going well an dilaudid and perce the maximum and was attempted, 12 attempt was made had been sent for no refills remained percocet counted the shapes and many of imprints were unru- find the morphine was educated on u medications only an all medications had dosages and minin delivered. This do patient caregiver r appropriately, pati- medications, refill [narcotic pain medi- taught, medication issue, and there w Clinical record rev document titled ". 05-25-2019" dated employee P on 5/2 the patient caregive appropriately, the taught, the patient	view evidenced an agency Routine visit - on 05-23-2019" ically signed by employee J on ument indicated no physician red, person G stated things have nd pain regimen of alternating boet had been effective using bount available, count of narcotics dilaudid tablets remained, an to reorder from Enclara, script 180 tablets and 90 were sent but d. The document indicated ablets were of 2 different of the tablets were soiled and eadable, person G was unable to concentrate bottle, person G tilizing the as needed when asked for by the patient, d been signed out at maximum num amount of time since being boument indicated that the nanaged medications ent was unable to manage needed for hydromorphone dication], no medications were as were reconciled without ere no dosage errors. view evidenced an agency Oncall/Unscheduled visit - on d and electronically signed by 26/19. This document indicated verbalization, and medications ithout an issue					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 151544	(X2) MULTIPLE CC A. BUILDING B. WING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 06/29/2020		
NAME OF PROVIDER OR SUPPLIER HARBOR LIGHT HOSPICE			STREET ADDRESS, CITY, STATE, ZIP COD 1229 ARROWHEAD COURT CROWN POINT, IN 46307				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APF DEFICIENCY)	JLD BE COMPLETIO		
	document titled "C entry dated and ele P on 5/26/19. Thi unable to located I narcotic count; DI the morphine, they pointing to Haldol Ativan is not in th need of additional Ativan half-tabs re kit. Family re-edu of life symptoms, logs, with understa Clinical record rev document titled " 05-26-2019" dated employee Q on 5/2 no physician conta caregiver managed there is a history of verbal and written patient caregiver a reinforcement, me problems were ide dosage errors. Clinical record rev document titled "C entry dated and ele Q on 5/26/19. Thi Numerous family arguing over the o numerous doses w daughter-in-law pa 2 Tabs q3*. Last o 5:00 p.m. until Su	view evidenced an agency Charts/Clinical Notes" with an ectronically signed by employee s document stated " Family liquid Ativan during this writer's L [person G] stated other than y only had one bottle of liquid, in comfort kit. Family maintains e refrigerator Pt is not in anxiolytics at this time, and 5 emain in lock box from comfort acated on safety/fall risk with end medication use and narcotic anding verbalized" view evidenced an agency Oncall/Unscheduled visit - on d and electronically signed by 26/19. This document indicated act was required, the patient d the medications appropriately, of substance abuse in the home, instructions were given to the and the caregiver needed dications were reconciled and entified, and there was no view evidenced an agency Charts/Clinical Notes" with an ectronically signed by employee is document stated " members present and each ther. Med count was done and vere not recorded. Per atient rec'd [received] Percocet, dose recorded was Saturday @ nday afternoon at 3:00. Pt's. present and unbeknownst to					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 151544			A. E	AULTIPLE CO BUILDING VING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 06/29/2020	
	PROVIDER OR SUPPLIEF	R.		1229 AF	NDDRESS, CITY, STATE, ZIP COI RROWHEAD COURT N POINT, IN 46307)	
			-				(775)
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PREFIX	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOU		(X5) COMPLETIO
TAG		R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APP DEFICIENCY)	ROPRIATE	DATE
into	daughter-in-law and			ind			Diffe
	-	nost of the conversation. He					
		outside and began asking					
		and sharing his anger					
	regarding the rest of the family. This writer						
	encouraged him to discuss situation with his family as this writer could offer him no more						
	family as this writer could offer him no more information, He became angrier and stated						
	"everyone in the house needs to be drug tested						
	and arrested for stealing meds from my dying						
		was encouraged to talk to his					
		r was unable to help him"					
	family as this write						
	Clinical record revi expired on 5/27/19.	ew evidenced the patient					
	of care was ever up difficulty swallowin and administration prn visits made due concerns. During an interview employee G indicat found to be incomp medications they w social worker and d	ew failed to evidence the plan dated to include the patient's ng, the medication education concerns, and the numerous to pain and neurological / on 6/26/20 at 3:51 p.m., ed if the daughter in law was etent with administering ould notify the whole team, octor. Employee G also id not see anything in the					
		ency administrator was					
	employee G indicat notified, but it was	y on 6/26/20 at 4:06 p.m., ed that the physician was not clarified if the physician patient's medication issues or ng.					
		on 6/26/20 at 4:09 p.m., ed when bottles of patient's					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES		(IB NO. 0938-039
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 151544	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		(X3) DATE SURVEY COMPLETED 06/29/2020		
	NAME OF PROVIDER OR SUPPLIER HARBOR LIGHT HOSPICE			1229 A	ADDRESS, CITY, STATE, ZIP COD RROWHEAD COURT N POINT, IN 46307		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE	(X5) COMPLETION DATE
	morphine and ativan come up missing this should be reported to the physician and a care plan meeting should be set up.						

QYKX11 Facility ID: 009088