STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	151565	A. BUILDING 00 B. WING	06/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
OMNI HOSPICE	3101 NORTH GREEN RIVER ROAD, SUITE 210 EVANSVILLE, IN 47715

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E 0000 Bldg. 00	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 418.113. Survey Dates: 5/31/2022-6/8/2022 Census: 22 At this Emergency Preparedness survey, OMNI Hospice, was found to have been in compliance with the Emergency Preparedness Requirements for Medicare Participating Providers and Suppliers at 42 CFR 418.113. QR completed 6/15/2022 A4	E 0000		
L 0000 Bldg. 00	This visit was for a Federal Recertification and State Re-licensure survey of a Provider. Survey Dates: 5/31/2022-6/3/2022 and 6/6/2022-6/8/2022 Census: 22 Facility: 009557	L 0000		
L 0578 Bldg. 00	418.60 INFECTION CONTROL The hospice must maintain and document an effective infection control program that protects patients, families, visitors, and hospice personnel by preventing and controlling infections and communicable			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (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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	diseases. Based on record review and interview, the agency failed to ensure an infection control and prevention plan was followed for all employees to ensure protection from communicable diseases for 3 of 10 employees. (MSW-1, RN-1, CNA-3, and MD-1) Findings include: 1. A revised 11/01/21 policy number 10.011 titled INFECTION CONTROL PLAN provided by the Executive Director (AS-1) on 6/7/2022 at 1:52 p.m. The policy indicated, but was not limited to, "PURPOSE: To enhance the safety and quality of patient care being provided by the agency ..." 2. A revised 6/1/2022 policy number 6.002 titled STAFF SCREENING, NEW HIRE, AND ANNUAL was provided by AS-1 on 6/7/2022 at 12:53 p.m. The policy indicated, but was not limited to, "PURPOSE: To establish a process to ensure appropriate staff screening prior to hire and annually thereafter ...PROCEDURE: ...B. TST Screening: (New Hire) New hires having no history of a positive (reactive) response to the TST are administered an initial TST. 1. If a new hire has documentation of a negative TST administered within the last 12 months, the director or designee will administer an initial TST and document results on the Employee Tuberculosis Screening Form. The previously documented test result, in conjunction with a TST administered by the director or designee, will demonstrate compliance with the 2-step method as per CDC guidelines. 2. If a new hire has no documentation of a TST, or the documentation is greater than 12 months, the director or designee will administer a second TST within 1-3 weeks	L 0578	On June 22, 2022, a mandatory staff meeting was held with all staff. The Executive Director provided education on Policy #10.011 Hospice Infection Control Plan and Policy #8.006 Staff screening: New Hire and Annual. On June 15, 2022, the Executive Director met with the Business Manager and provided education on Policy #8.006 Staff Screening: New Hire and Annual and Policy #8.009 Employee Medical File. On June 22, 2022, the Executive Director met with the Medical Director. The Executive Director educated him on Policy # 8.012 Medical Director/Associate Medical Director. The Executive Director has completed 100% audit on ail employee medical files and the Medical Director file. As of June 22, 2022, 100% of new employees and the Medical Director have had the initial TB test. Completion of the second TB test for all new staff and the Medical Director wilt be July 8, 2022. To ensure continued compliance, 100% of new employee medical files will be audited by the Executive Director or designee, for a minimum of 6 months or longer if 100% compliance is achieved for 3 consecutive months.	07/08/2022

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	from the initial TST (2-step method). Both results are documented on the Employee Tuberculosis Screening Form ..." 3. A 1/09/2017 policy number 3.004 titled PERSONNEL FILES was provided by AS-1 on 6/7/2022 at 1:43 p.m. The policy indicated, but was not limited to, "...2. The following items will be maintained in a medical file that is kept separate from the personnel file: a. TB test results..." 4. On 6/7/2022 at 10:55 a.m. the complete personnel record for employee MSW-1, hire date 11/29/2021, was provided by the Business Office Manager and Intake Coordinator (OS-1). The record evidenced documentation of only one Tuberculin Skin Test (TST). It failed to evidence the required TST 2-step method on an Employee Tuberculosis Form for new hires to the agency per agency policy. 5. On 6/7/2022 at 10:55 a.m. the complete personnel record for employee Registered Nurse Case Manager (RN-1), hire date 3/14/2022, was provided by the Business Office Manager and Intake Coordinator (OS-1). The record evidenced documentation of only one Tuberculin Skin Test (TST). It failed to evidence the required TST 2-step method on an Employee Tuberculosis Form for new hires to the agency per agency policy. 6. On 6/7/2022 at 10:55 a.m. the complete personnel record for employee Certified Nursing Assistant (CNA-3), hire date 1/10/2022, was provided by the Business Office Manager and Intake Coordinator (OS-1). The record evidenced documentation of only one Tuberculin Skin Test (TST). It failed to evidence the required TST 2-step method on an Employee Tuberculosis Form for new hires to the agency per agency policy.			

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	7. On 6/7/2022 at 10:55 a.m. the complete personnel record for employee Medical Director (MD-1), hire date 8/1/2021, was provided by the Business Office Manager and Intake Coordinator (OS-1). It failed to evidence the required TST screening for employees of the agency per agency policy. 8. During an interview with OS-1 on 6/7/2022 at 12:03 p.m. it was indicated that all new hires to the agency should have a 2 step TST per policy. OS-1 indicated that older employees should have at least one or annual risk assessments, but MD-1 sometimes was difficult to get requirements from to maintain compliance.			
L 0579 Bldg. 00	418.60(a) PREVENTION The hospice must follow accepted standards of practice to prevent the transmission of infections and communicable diseases, including the use of standard precautions. Based on observation, record review, and interview, the agency failed to follow infection control standards of practice for 1 of 3 home visit observations. (Patient 6) Findings include: 1. A revised 11/01/21 policy numbers 10.011titled Infection Control Plan was provided by the Executive Director (AS-1) on 6/7/2022 at 1:52 p.m. The policy indicated, but was not limited to, "PURPOSE: To enhance the safety and quality of patient care being provided by the agency ..." 2. A 2017 Elsevier Clinical eLearning Lesson titled Personal Hygiene: Bathing and Perineal Care training protocol for Home Health Aides was	L 0579	On June 22, 2022, a mandatory staff meeting was held with all staff. The Executive Director provided education to all staff on Policy #10.011 Hospice Infection Control Plan and on Policy #10.002 Hand Hygiene. The Hand Hygiene Job Aide was given to each employee. A sign-in sheet was used to document attendance. The Executive Director has observed 100% of the staff for compliance with hand hygiene and glove use, Infection control practices. To ensure ongoing compliance,	06/22/2022

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	provided by AS-2 on 6/7/22 at 1:46 p.m. The procedure/training protocol indicated, but was not limited to, "Introduction hygiene promotes comfort, safety, and health. The skin is the body's first line of defense against disease ...31. Clean the rectal area. Clean from the scrotum (front or top) to the anus (back or bottom). Rinse and dry well. 32. Remove the waterproof underpad. 33. Remove and discard the gloves. Practice hygiene. Put on clean gloves ..." 3. During a home visit on 12/9/2021 at 8:00 a.m. CNA-3 was observed giving a bed bath to patient 6. The hospice aide failed to change gloves after cleaning the patient's buttocks and anus then remove the underpad with new gloves and practice hand hygiene. CNA-3 failed to change gloves according to the procedure/training protocol of the Aide's competency checks. 4. During an interview on 6/2/2022 at 3:40 p.m. AS-1 indicated CNA-3 should have changed gloves after washing and drying patient 6's bottom and removing the underpad before moving forward with any other activity involving the patient.		the Executive Director or designee will observe and document using the Hospice Form Hand Hygiene/Glove Use Observation Tool, 3 random patient care staff per month for 3 months, or until 100% compliance is achieved for 3 consecutive months.	
L 0619 Bldg. 00	418.76(c)(5) COMPETENCY EVALUATION (5) The hospice must maintain documentation that demonstrates the requirements of this standard are being met. Based on record review and interview, the agency failed to ensure staff competency was completed for 1 of 10 records reviewed. (CNA-3) Findings include: 1. A 1/09/2017 policy number 3.004 titled	L 0619	On June 22, 2022, a mandatory staff meeting was held with all employees, A sign-in sheet was used to document attendance. Education was provided by the Executive Director on Policy #8.005 Employee Education and Development and Policy #8.004	06/22/2022

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	PERSONNEL FILES was provided by AS-1 on 6/7/2022 at 1:43 p.m. The policy indicated, but was not limited to, "...1. The Office Manager or designee will develop, keep and maintain the following items in personnel files at the clinical setting: ...f. Competency Assessments..." 2. A 10/01/2020 policy number 8.005 titled EMPLOYEE EDUCATION AND DEVELOPMENT was provided by AS-1 on 6/7/2022 at 12:24 p.m. The policy indicated, but was not limited to, "PURPOSE: To provide direction and guidance that will assure continuing education and development opportunities for all employees of LHC Group. To establish and maintain a mechanism for documenting completion of required training for regulating agencies ..." 3. On 6/7/2022 at 10:55 a.m. the complete personnel record for employee Certified Nursing Assistant (CNA-3), hire date 1/10/2022, was provided by the Business Office Manager and Intake Coordinator (OS-1). The record failed to evidence documentation of skills checks and an exam to demonstrate the aide's competency. 4. During an interview on 6/8/2022 at 10:01 a.m. AS-2 indicated CNA-3 had a preceptor who was doing skills check. That preceptor left the agency and didn't leave the competency check completed with the executive director. AS-1 indicated CNA-3 also had taken the competency exam but had yet to pass it in ITRAIN. AS-1 stated AS-2 was going to do skills checkoff that day and told OS-1 to get CNA-3 to complete competency exam immediately.		Evaluation and Competency Assessment. The Executive Director has completed a 100% audit on employee files and the competency forms for each staff. If applicable, and files for alt staff members brought into compliance. To ensure ongoing compliance, the Executive Director or designee, will perform a 100% audit of personnel files for compliance with employee competency requirements for a minimum of 6 months, or longer if 100% compliance is not achieved for at least 3 consecutive months.	
L 0661 Bldg. 00	418.100(g)(1) TRAINING (1) A hospice must provide orientation about the hospice philosophy to all employees and			

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	contracted staff who have patient and family contact. Based on record review and interview, the agency failed to ensure all staff had completed the required orientation to hospice philosophy for 2 of 10 records review. (MSW-1 and MD-1) Findings include: 1. A 10/01/2020 policy number 8.005 titled EMPLOYEE EDUCATION AND DEVELOPMENT was provided by AS-1 on 6/7/2022 at 12:24 p.m. The policy indicated, but was not limited to, "PURPOSE: To provide direction and guidance that will assure continuing education and development opportunities for all employees of LHC Group. To establish and maintain a mechanism for documenting completion of required training for regulating agencies ..." 2. A 08/01/18 policy number 8.012 titled MEDICAL DIRECTORS/ASSOCIATE MEDICAL DIRECTORS was provided by AS-1 on 6/7/2022 at 12:24 p.m. The policy indicated, but was not limited to, " ...PROCEDURE: ...7. All Medical Directors and Associate Medical Directors providing services under contract arrangement with the hospice provider, in addition to a signed and executed contract, must have the following: ...h. Signed Medical Director/Associate Medical Director Attestation indicating review of "Hospice Philosophy for Medical Directors", "Hospice Medical Director Guide", and the hospice provider policies and procedures. i. Initial and annual competency assessment/contract review ...". 3. A 2017 ITRAIN titled Hospice (Outpatient): 2022 Annual Mandatory Training was provided by AS-1 on 6/7/2022 at 12:53 p.m. The training	L 0661	On June 22, 2022, a mandatory staff meeting was held with all employees, A sign-in sheet was used to document attendance. Education was provided by the Executive Director on Policy #8.005 Employee Education and Development and Policy #8.004 Evaluation and Competency Assessment. The Executive Director has completed a 100% audit on employee files and the competency forms for each staff. If applicable, and files for alt staff members brought into compliance. To ensure ongoing compliance, the Executive Director or designee, will perform a 100% audit of personnel files for compliance with employee competency requirements for a minimum of 6 months, or longer if 100% compliance is not achieved for at least 3 consecutive months.	06/22/2022

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	indicated, but was not limited to, "EMPLOYEES (Non-Contractor) ALL Roles (Est Total 2.5 hrs) Code of Conduct & Ethics Attestation, Ethics, Compliance, HIPAA, *Introduction to Hospice Eligibility and Documentation, Fire Safety, HS Policy 15.022-Emergency Preparedness Plan ...Infection Control, Tuberculosis, & Bloodborne Pathogens ...CONTRACTORS ...Medical Directors (Contract Only) Complete Compliance training once they reach 120 hours of service for the year." 4. On 6/7/2022 at 10:55 a.m. the complete personnel record for employee MSW-1, hire date 11/29/2021, was provided by the Business Office Manager and Intake Coordinator (OS-1). It failed to evidence the required orientation to hospice per agency policy. 5. On 6/7/2022 at 10:55 a.m. the complete personnel record for employee Medical Director (MD-1), hire date 8/1/2021, was provided by the Business Office Manager and Intake Coordinator (OS-1). It failed to evidence the required orientation to hospice required per agency policy. 6. During an interview with OS-1 on 6/7/2022 at 12:03 p.m. it was indicated that all staff should have all their orientation completed with documentation in the personnel file as well as any annual or in-service trainings. OS-1 indicated that MD-1 doesn't really do ITRAIN and doesn't give copies of any continuing education completed to the office for the personnel file.			
L 0782 Bldg. 00	418.112(f) ORIENTATION AND TRAINING OF STAFF Hospice staff, in coordination with SNF/NF or ICF/IID facility staff, must assure orientation of such staff furnishing care to hospice patients in the hospice philosophy, including			

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	hospice policies and procedures regarding methods of comfort, pain control, symptom management, as well as principles about death and dying, individual responses to death, patient rights, appropriate forms, and record keeping requirements. Based on record review and interview, the agency failed to ensure hospice staff furnished orientation on hospice philosophy, policies and procedures regarding methods of comfort, pain control, symptom management, principles about death and dying at all skilled nursing or assisted living facilities that provide care to hospice patients for 2 of 2 active facilities, with the potential to affect all contracted facilities. (Entities 1 and 2) Findings include: 1. A 4/27/2022 contract titled NURSING FACILITY SERVICES AGREEMENT was copied by AD-1 on 5/11/2022 at 4:45 p.m. The contract indicated, but was not limited to, " ...3.3 Hospice Care Training. Hospice shall provide orientation and ongoing hospice care training to Facility's personnel as necessary to facilitate the provision of safe and effective care to Hospice Patients. Such orientation must include Hospice policies and procedures regarding methods of comfort, pain control and symptom management, as well as principles about death and dying, individual responses to death, patient rights, appropriate forms, and record keeping requirements." 2. During an interview on 6/2/2022 at 12:20 p.m. a facility nurse caring for patient 6 indicated that no training had been received by any hospice staff. 3. During an interview on 6/1/2022 at 9:45 a.m.	L 0782	On June 20, 2022, the Executive Director met with the Marketing Team and the Patient Care Manager, to discuss all agency contracts, active at all skilled nursing facilities. The Contract review included the in-services available to skilled nursing facilities with hospice contracts and in-services completed at each skilled nursing facility per nursing home agreement. Per nursing home agreement, all skilled nursing facility staff furnishing care to hospice patients will be trained in the hospice philosophy, including hospice policies and procedures, regarding methods of comfort, pain control, symptom management, as well as principals on death and dying, individual responses to death, patient rights, appropriate forms, and record keeping requirements. The Executive Director reviewed 100% of the skilled facility contracts. The Marketing Team will contact all skilled nursing facilities by June 30, 2022 and will set up appointments to meet and complete all required training. An updated list of appropriate in-services will be given to each	06/22/2022

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	Executive Director (AS-1) indicated he/she was unsure on how training was completed within the contracts for skilled nursing or assisted living facilities, but training was completed. AS-1 indicated the Patient Care Manager (AS-2) completed training regarding care and needs of the patient with facility staff when a patient was placed. AS-1 indicated being unsure if training provided by AS-2 was formal or documented and was unable to provide evidence of any training being completed at any facilities contracted with, including but not limited to, Entities 1 and 2.		skilled nursing facility. To ensure compliance, the Executive Director or designee, will review all contracts 90 days prior to contract renewal, to verify all required in-services have been completed. This audit will continue for a minimum of 6 months or until 100% compliant or longer if 100% compliance is not achieved for at least 3 consecutive months.	
L 0798 Bldg. 00	418.116 FEDERAL, STATE, LOCAL LAWS & REGULATIONS The hospice and its staff must operate and furnish services in compliance with all applicable Federal, State, and local laws and regulations related to the health and safety of patients. If State or local law provides for licensing of hospices, the hospice must be licensed. Based on record review and interview, the agency failed to have officials responsible for the day-to-day operations of the agency as officers on their application with the state for 1 of 1 hospice agency. (Entity 1). Findings include: 1. The Indiana Code (IC) 16-25-3-3 stated in Sec. 3. (a) An applicant shall submit an application for a hospice license or for approval of a hospice program on a form prescribed by the state department. (b) The applicant shall attach to the application evidence of the applicant's ability to comply with the minimum standards established for licensure under this article. (c) The application	L 0798	Hospice policy #6.001 Hospice Governing Body Responsibilities and Hospice Policy #6.005 Leadership Decision-Making Process identify that the Senior Management of the organization shall identify an individual, who is responsible for the day-to-day operations of the agency, Executive Director/Administrator position, and further identifies that the Executive Director, along with the Medical Director, and at lease one member of the hospice disciplinary group (RN Case Manager, Social Worker, and Chaplain) are the designated	06/22/2022

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	must contain the following information: (1) The applicant's name. (2) The type of hospice program the applicant will own or operate. (3) The location of the hospice program owned or operated by the applicant. (4) The name of the individual or individuals responsible for the day-to-day operation of the hospice program owned or operated by the applicant. 2. A revised 06/01/19 policy number 6.001 was provided by the Executive Director (AS-1) on 6/6/2022 at 8:46 a.m. The policy indicated, but was not limited to, "PURPOSE: To establish the authority and responsibilities for the governing body for planning of agency operations. POLICY: ...The governing body, as outlined by Senior Management, shall include the following: Executive Director, Agency Medical Director ..." 3. During entrance conference on 5/31/2022 at 9:40 a.m. the Executive Director could not name the individuals of the governing body but indicated the names of those that met for QAPI (Quality Assurance and Performance Improvement) quarterly. 4. Upon review of officer's names given to the state, AS-1 could not determine who those people were except they were corporate level people with LHC and had to speak with AS-1's supervisor to get clarification. 5. During an interview on 6/1/2022 at 10:57 a.m. AS-1 indicated the list of names given to the state was the LHC Group, Inc Officers but not the governing body of the OMNI hospice agency.		Governing Body of the Hospice Provider. This identification of the individual who is responsible for the day-to-day operations of the agency is documented via the Administrative Appointment form and notification provided to the State Agency, whenever there is a change in the designation. On 8/1/2021, the IN State licensure offices were provided with the notification of the assigned Executive Director as the individual identified to be responsible for "the day-to-day operations of the agency." Hospice Policy #6.001 Governing Body Responsibilities states in accordance with the Hospice Conditions of Participation 418.100(b), that the Hospice Governing Body is responsible for the full legal authority and responsibility for the management for the management of the hospice, the provision of all hospice services, its fiscal operations, and continuous quality assessment and performance improvement. The Hospice Governing Body will meet quarterly, according to Hospice Policy #6.001 and will maintain evidence of meetings including agenda, Governing Body Meeting Report, and subsequent Governing Body meeting minutes. The Governing Body met on 5/13/2022 to review Quarter 1 2022 and will	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	151565	A. BUILDING 00 B. WING	06/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
OMNI HOSPICE	3101 NORTH GREEN RIVER ROAD, SUITE 210 EVANSVILLE, IN 47715

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			meet again on 7/22/2022 to discuss and review Quarter 2 2022. All meeting minutes will be uploaded into the document management system. In order to ensure ongoing compliance with the Governing Board appointments and oversight, ongoing review of completion will occur Quarterly via the Executive Director or designee, the Hospice Regional QAPI Coordinator or designee. Any concerns related to compliance will be immediately reported to Senior Management.	