STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 151599		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY  COMPLETED  10/01/2020			
	PROVIDER OR SUPPLIER	LIATIVE CARE - INDIANA LLC	STREET ADDRESS, CITY, STATE, ZIP COD 11550 N MERIDIAN STREET, SUITE 375 CARMEL, IN 46032				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE		
L 0000 Bldg. 00	This visit was for a	Federal Complaint survey of a	L 0000	L 000 This Plan of Correction constitutes PREMIER HOSPIC	·F		
	Deemed Hospice pr Survey Dates: 09/3 CCN: 151599 Facility: 007409 Complaint #: IN00 Deficiencies related complaint were cite Records Reviewed:	ovider.  0 to 10/01/2020  337284: Substantiated.  I and unrelated to the d.		& PALLIATIVE CARE - INDIAI LLC's written allegation of compliance for the deficiencies cited. However, submission of Plan of Correction is not an admission that a deficiency exi or that one was cited correctly. This Plan of Correction is submitted to meet requirement established by state and/or fee law.	NA  s this ists ts		
L 0515 Bldg. 00	(4) Choose his or  Based on record reversal failed to ensure pating to choose his conference of 4 interviews conference.  1. Review of the age "Hospice Election of a section titled "Rig physician" which in have a right to choose oversee my care	her attending physician;  view and interview, the agency ents were informed of their or her attending physician in 3 ducted. (Patients #1, 3, 9)  gency's document titled of Benefit Statement" revealed that to choose an attending idicated "I understand that I use my attending physician to	L 0515	L 515 418.52(c)(4) RIGHTS OF THE PATIENT [The patient has a right to the following:] (4) Choose his or he attending physician. How are you going to correct the deficiency? If already corrected, include the following steps and state dat of correction. From 10/8/20-10/9/20, all Community Liaison staff were In-serviced on the following Premier Hospice & Palliative CCHAP Hospice Policy and Procedure Manual, 2020 polici	er t e Care		

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

TITLE

(X6) DATE

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

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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 00 COMPLETED B. WING 10/01/2020 151599 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 11550 N MERIDIAN STREET, SUITE 375 PREMIER HOSPICE & PALLIATIVE CARE - INDIANA LLC CARMEL, IN 46032 (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 contained the patient rights, a section on page 14 and rules: titled "Decision Making - You have the right to", 1.ADMISSION CRITERIA AND indicated the patient has the right to choose their PROCESS- INDIANA, Policy No. attending physician and other health care providers and communicate with these providers. 2.HOSPICE ELECTION STATEMENT, Policy No. 1-031; 3. Review of the agency's active client roster and 3.§418.52 Condition of discharge report that was provided on 09/30/2020, Participation: Patient's Rights. revealed 25 out of 30 active client roster and 20 Involved staff acknowledged this out of 27 discharged patients had the hospice in-service re-training in writing. medical director as their primary physician. Organization policies set forth that the patient has the right to be 4. The family member for patient #1 was informed of his or her rights, and interviewed on 09/30/20 at 9:20 a.m., and indicated the hospice shall protect and while the patient was at the hospital, a hospice promote the exercise of these liaison visited and was told that they could not rights. The patient has the right to use their own MD and had to use the hospice choose his or her attending Medical Director, as well as what they could and physician and to have this person could not do, would "get rid" of the patient's involved in their medical care in all medications and provide only comfort hospice settings as long as the medications, no emergency room visits, no attending physician, in turn, reaching to their primary care physician, and they undertakes to provide care for the could only reach out to the hospice physician. patient. 5. The family member for patient #3 was How are you going to prevent interviewed on 10/01/20 at 9:40 a.m., and indicated the deficiency from recurring in during their admission, they were not provided the future, even if already with an option to keep their primary care corrected? physician but was instructed that the Medical 1.100% focused chart audit for Director would be their primary physician while on 90 days on Admissions, then

6. The family member for patient #9 was interviewed on 09/30/2020 at 4:43 p.m., and indicated during their admission, they were not provided with an option to keep their primary care physician. When asked about the consents that were signed indicating their understanding of patient rights and if these rights were explained in

full detail, the family member indicated the person

to ensure patients were informed they have the right to choose their attending physician, as evidenced by patient or representative placing their initials next to the statement "YOU HAVE THE RIGHT TO: choose your attending physician.." education on Page 14 of the Patient Hospice Admission

ongoing, 10% review each quarter

service.

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 10/01/2020 151599 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 11550 N MERIDIAN STREET, SUITE 375 PREMIER HOSPICE & PALLIATIVE CARE - INDIANA LLC CARMEL, IN 46032 (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 who had them sign the admission documents Booklet. Nurses shall securely reviewed "main topics", told them where to sign, submit a copy of the initialed page gave them "stuff to read" and was told they to the office for chart attachments. couldn't see their primary care physician. Nurses shall report any Complaints related to Liaison 7. During an interview on 09/30/2020 at 4:55 p.m., misinformation/misunderstanding and when queried if patients are allowed to to the agency Administrator who choose their own physician for hospice services, will interview the beneficiary and/or the Administrator stated patients could "elect caregivers; who-ever, 100% their choice." 2.Patient Care Managers/Designee(s) shall phone 8. The above findings were reviewed with the survey all new Admissions to Regional Director of Compliance, Director of verify patient/representative Nursing, Patient Care Manager of the understanding of education on Bloomington Branch, and Administrator on Patient's Rights including patient's 10/01/2020 at 1:20 p.m.. in which they responded right to choose their attending that the patients/ caregivers signed the consents physician; upon admission, therefore, they knew they had a 3. Thresholds for focused audits choice. When asked how certain they were that and phone surveys are 100% with their clinicians and liaisons were thoroughly evidence patients/representatives reviewing patient rights and consents upon were informed and understood admission when 3 out of 4 people indicated they their right to choose their were told they must use the Medical Director, attending physician. If threshold they had no other response. not met, Patient Care Managers will re-educate involved staff, progressively, involving human resources for discipline, if needed. Who is going to be responsible for prevention above: i.e., director, supervisor, etc.? Patient Care Managers (PCMs) are responsible for audits, surveys and staff correction. PCMs will be overseen by Director(s) of Clinical Services (DCS) who report to the Administrator. The Administrator shall report Focus audit and Patient survey results to the QAPI Committee and then the Governing

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CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED 151599 B. WING 10/01/2020

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP COD 11550 N MERIDIAN STREET, SUITE 375

PREMIER HOSPICE & PALLIATIVE CARE - INDIANA LLC			CARMEL, IN 46032			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	III PRE	FIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETION DATE		
L 0525 Bldg. 00	418.54(c)(1) CONTENT OF COMPREHENSIVE ASSESSMENT The comprehensive assessment must take into consideration the following factors: (1) The nature and condition causing admission (including the presence or lack of objective data and subjective complaints).  Based on record review and interview, the agency failed to ensure comprehensive assessments were complete and included assessments of bruising, location of diminished breath sounds, past medical histories/ medication use of anti-seizure, anti-anxiety, muscle relaxant, and pain medications, as well as ensuring wound measurements were accurate for 2 of 3 records reviewed. (Patient #1, 2) Findings include:  1. Review of an agency's policy titled	L 0525	Body for three consecutive quarters.  By what date are you going to have the deficiency corrected? 10/30/20.  Liaisons completed re-education by 10/9/20. Nurses completed education on their role in compliance by 10/30/20. By no later than 10/30/20, the organization will have implemented 100% Focus audits and Surveys.  L 525 18.54(c)(1) CONTENT OF COMPREHENSIVE ASSESSMENT  The comprehensive assessment must take into consideration the following factors:  (1) The nature and condition causing admission (including the presence or lack of objective data and subjective complaints).  How are you going to correct the deficiency? If already corrected, include the	10/30/2020		

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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>			COMPLETED	
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				CTREET	ADDRESS CITY STATE ZID COD		
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DDEMIE	D LICEDICE & DALL	LIATIVE CADE INDIANALIC			N MERIDIAN STREET, SUITE 3	175	
PREMIE	R HUSPICE & PALI	LIATIVE CARE - INDIANA LLC		CARIVIE	EL, IN 46032		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX			COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	-	DATE
	"Comprehensive Assessment Policy No. 1-014.1"				following steps and state dat	e	
	dated 5/11/20, indicated " 1. During the				of correction.		
	comprehensive asse	essment, all baseline data and			From 10/14/20-10/30/20, all		
	other relevant infor	mation will be documented in			Registered Nurses were		
	the patient's clinical	l record B 2.			In-serviced on the following		
	Restlessness, anxiet	ty 4. Skin Integrity E.			Premier Hospice & Palliative C	Care	
	Alleviating and exa	cerbating factors for physical			CHAP Hospice Policy and		
	symptoms. F. Curr	rent treatment and patient			Procedure Manual, 2020 polic	ies,	
	response to that trea	atment. I. A physical			and wound assessment and c	are	
	assessment, includi	ng skin N. Patients past			guidelines:		
	and present medical and psychiatric history				1.COMPREHENSIVE		
	including any pertinent diagnosis and any				ASSESSMENT, Policy No. 1-0	)14	
	co-morbid conditions "				2.PAIN ASSESSMENT, Poli	су	
					No. 1-018;		
	2. According to an	article titled "Table 2,			3.WOUND CARE, Policy No		
	[National Pressure	Ulcer Staging System] at			2-035.A;		
	https://www.ncbi.nl	lm.nik.gov, described a deep			4.SKIN AND WOUNDCARE		
	tissue injury as a "p	ressure-related injury to			QUICK REFERENCE/GUIDELINE;		
	subcutaneous tissue	es under intact skin Initially,			National Pressure Ulcer Advis	ory	
	these lesions have to	he appearance of a deep			Panel (NPUAP) Staging Syste	m.	
	bruise purple or 1	naroon localized area of			Involved staff acknowledged th	nis	
	discolored intact sk	in or blood-filled blister due to			in-service re-training in writing		
	damage of underlyi	ng soft tissue from pressure			Organization policies set forth	that	
	and/ or sheer." A S	tage 2 pressure wound is			complete comprehensive		
	described as a "part	ial thickness loss or dermis			assessment includes		
	presenting as a shal	low open ulcer with a red, pink			assessments of bruising, locat	ion	
		slough. May also present as			of diminished breath sounds,		
	an intact or open/ru	ptured serum-filled blister.			acceptable pain range, past		
		or dry shallow ulcer without			medication histories/medicatio	n	
	slough or bruising."	' A Stage 3 pressure wound is			use of anti-seizure, anti-anxiet	y,	
		thickness tissue loss.			muscle relaxant, as well as		
	Subcutaneous fat m	ay be visible, but bone,			ensuring wound measurement	:S	
		re not exposed. Slough may			are accurate and wounds are		
	_	not obscure the depth of			staged according to the NPUA	P	
		clude undermining and			Staging System. The hospice		
		e 4 pressure wound is			conduct and document in writi	•	
		hickness tissue loss; extensive			patient-specific comprehensive	e	
		sposed bone, tendon or			assessment that identifies the		
		eschar may be present on some			patient's need for hospice care	,	
	parts of the wound	bed. Often includes			and services, and the patient's	;	

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had a diagnosis of an anxiety disorder. On 9/1,

need for a bowel regimen, esp.

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 10/01/2020 151599 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 11550 N MERIDIAN STREET, SUITE 375 PREMIER HOSPICE & PALLIATIVE CARE - INDIANA LLC CARMEL, IN 46032 (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 the note indicated the patient had a deep tissue when the patient is prescribed injury to the right heel possibly measuring 2.6 x 5 opioids. cm (centimeters), a wound to the right trochanter 2.D. Nature and condition measuring 2 x 0.8 x 0.1 cm, left heel measuring was causing admission described as an unstageable deep tissue injury 3.E. Alleviating and measuring 2.5 x 6 cm, Stage IV left trochanter exacerbating factors for physical measured 3.5 x 3.5 x 0.4 cm on 8/28/20. During the symptoms patient's stay, the patient had critical labs and 1. Effectiveness drug therapy refused further treatment and hospice was 2. Unwanted side and toxic effects presented. 3. Drug interactions (actual or potential) Review of the plan of care for the benefit period of 4. Duplicate drug therapy 09/10/20 to 12/8/20. The medication list on the F. Current treatment and patient plan of care indicated the patient was prescribed response to that treatment and taking Alprazolam (Xanax) 0.5 mg (milligrams) G. An assessment of the patient's every 6 hours as needed for anxiety, Baclofen 20 response to palliative treatment mg twice a day for muscle relaxant, levetiracetam H. An assessment of the patient's 500 mg and Vimpat 100 mg twice a day for well-being, comfort and dignity seizures, and Norco 5 mg-325 mg tablet every 6 throughout the dying process. hours as needed for pain. I. A physical assessment, including blood pressure, Review of the start of care comprehensive temperature, pulse, respiration, assessment dated 9/10/20, failed to include an skin, and other relevant data acceptable pain range. The assessment failed to related to pertinent physical include any information/ assessment of the findings and the patient's terminal patient's need for anti-anxiety medication, muscle illness relaxant, anti-seizure medication, pain medication, J. Imminence of death right heel and right trochanter. Review of the K. Patient's functional status wound assessment indicated the patient had a including, but not limited to, the stage 3 wound to the left greater trochanter that degree of self-care and the amount measured 10 (L) x 8.5 (W) x 0.5 (D) centimeters and level of assistance needed (cm); the sacral wound was stage 4 wound that L. Patient's cognitive status measured 18 x 25 x 1.5 cm; and a stage 2 wound to including the ability to understand the left heel that measured 7.6 x 7.6 x 0.1 cm. The and participate in his or her own narrative note indicated the right heel was care Complication and risk factors unblancheable and boggy. The wound that affect care planning assessment failed to include a full assessment M. Complication and risk factors with measurements of the right heel, failed to that affect care planning, including identify the left heel accurately according to drug diversion professional wound standards; failed to be N. Patient's past and present

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 10/01/2020 151599 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 11550 N MERIDIAN STREET, SUITE 375 PREMIER HOSPICE & PALLIATIVE CARE - INDIANA LLC CARMEL, IN 46032 (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 consistent with the patient's stay at the facility medical, psychiatric history, and failed to be consistent with ongoing pertinent diagnosis, co-morbid assessments as evidenced by the following: conditions O. Name and address of the Review of the updated comprehensive patient's attending physician assessment dated 9/14/20, indicated the left P. Name of hospital, other trochanter measured 3.5 x 5 x 1 cm, the sacral agencies, persons involved in the wound measured 8.5 x 9 x 3 cm, and the left heel past & present care of the patient measured 4 x 3.5 x 0 cm. Q. An evaluation of the home environment and assessment of Review of the updated comprehensive emergency preparedness assessment dated 9/23/20, indicated the left R. Presence of any Advance trochanter measured 5 x 5 x 0.5 cm, the sacral Directives for care and/or wound measured 5 x 9 x 1.5 cm, and the left heel discussions with patient and measured 5 x 6 x 0.1 cm. family/caregiver regarding the withholding/withdrawal of During an interview on 9/30/20 at 5:00 p.m., when resuscitative services or treatment asked about the inconsistent measurements of the S. Equipment presently in home patient wounds, the Patient Care Manager and potentially needed by patient acknowledged the discrepancy. T. Review of current and related past medications, including During an interview on 10/1/20 at 9:14 a.m., the prescription and over-the-counter patient's caregiver stated the patient had been on medications, supplements, herbal Xanax for years for anxiety and the patient had remedies, alternative treatments, horrible dysreflexia, which caused his legs to allergy history and other spasm, and did have pain and discomfort, and medication information utilized the Baclofen routinely and Norco as U. Patient and family/caregiver needed. support systems and the care the family/caregiver is available, 5. The above findings were reviewed with the capable, and willing to provide, Regional Director of Compliance, Director of including applicable strengths of Nursing, Patient Care Manager of the patient, physical, psychosocial, Bloomington Branch, and Administrator on and/or spiritual resources available 10/01/2020 at 1:20 p.m., in which no further V. The patient's psychosocial information or documentation was provided. status, including emotional barriers to treatment, cognitive limitations, memory and orientation, family relationships,

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social history, source and adequacy of environmental and

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

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 151599		(X2) MULTIPLE C A. BUILDING B. WING	construction <u>00</u>	(X3) DATE SURVEY COMPLETED 10/01/2020	
	ROVIDER OR SUPPLIE	R LIATIVE CARE - INDIANA LLC	11550	ADDRESS, CITY, STATE, ZIP COD N MERIDIAN STREET, SUITE ( IEL, IN 46032	375
(X4) ID PREFIX TAG	(EACH DEFICIEN	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)	(X5) COMPLETION DATE
				other resources, coping mechanisms, and the patient's and family/caregiver's reaction illness.  W. An assessment of the patie and family/caregiver's spiritual orientation, including, as appropriate, any involvement religious group such as a chur or synagogue or a support group such as Alcoholics Anonymou and spiritual concerns or need such as despair, suffering, guetc.  X. Involvement of family/caregineighbors, and/or other individuals/organizations, incluinvolvement in any support group. An assessment of the need volunteer services to offer supor respite to the patient and family/caregiver  Z. A bereavement assessment the needs of the patient's family and other individuals  AA. Laboratory results  BB. Medical, alcohol, and other drug history  CC. TB screening  DD. Specific, individualized paneeds/problems pertinent to the hospice care being provided EE. Past medical and surgical care, including dates of onset/exacerbation  FF. The patient's and family/caregiver's educational needs, abilities, motivation, ar readiness to learn.  GG. The need for referrals an	ent's I in a rch pup is ds ds ditt, giver, dding pups I for poort  at of illy  er  atient ne

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

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	TOF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA DEFICIES (X1) PROVIDER/SUPPLIER	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 10/01/2020
	ROVIDER OR SUPPLIER R HOSPICE & PALLIATIVE CARE - INDIANA LLC	11550 1	ADDRESS, CITY, STATE, ZIP COD N MERIDIAN STREET, SUITE 3 EL, IN 46032	375
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	5.112
			further evaluation by approprial health professionals  1. The assessment should determine: Probable prognosis six (6) months or less; Patient problems and needs related to terminal illness; Patient goals related to the terminal illness. During each wound care visit, nurse to review prior wound assessment, note significant discrepancies from prior to cur wound assessment, communit to manager and to the physicia and resolve discrepancy in the medical record documentation. Wound care will be evaluated reviewed at least weekly in response to treatment. All wou care will be performed in accordance with physician ordand practice standards. The physician will be updated regarding a patient's wound ston an ongoing basis. The organization will notify the physician immediately if there signs and symptoms of wound deterioration, including infections significant bleeding, or enlargement. If there is no improvement in a wound after weeks of a treatment, the physician will be consulted to determine if a change in wound care is appropriate.  How are you going to prevent the deficiency from recurring	d sof of the creent cate ann, see and and and and are donn, two and and and are donn, and are donners ar
			the future, even if already	

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Z26G11

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If continuation sheet Page 10 of 148

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

PRINTED: 11/20/2020 FORM APPROVED OMB NO. 0938-039

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 151599		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY  COMPLETED  10/01/2020	
	ROVIDER OR SUPPLIE	R LIATIVE CARE - INDIANA LLC	11550	ADDRESS, CITY, STATE, ZIP COD N MERIDIAN STREET, SUITE ( EL, IN 46032	375	
(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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
				corrected?  1.100% focused chart audit 90 days on Admissions, then ongoing, 10% each quarter to ensure nursing comprehensiv assessment;  2.100% focused wound care audit for 90 days on all Wound care patients, then ongoing, 1 each quarter to ensure pressulcer assessment according to NPUAC Staging System;  3.Threshold for focused audit 100% compliance with comprehensive assessment awound staging. If threshold not met, Patient Care Managers vire-educate involved staff, progressively, involving huma resources for work plans, if needed.  Who is going to be responsi for prevention above: i.e., director, supervisor, etc.?  Patient Care Managers (PCM are responsible for audits and correction. PCMs will be oversiby Director(s) of Clinical Servi (DCS) who report to the Administrator. The Administra shall report Focus audit result the QAPI Committee and ther Governing Body for three consecutive quarters.  By what date are you going thave the deficiency corrected 10/30/20.	e e e d 00% ure o its is nd ot vill n ble ls) staff seen ces tor s to o the	
i l			I	Nurses completed re-education	''' ~ y	

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

Event ID:

Z26G11

Facility ID: 007409

If continuation sheet

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 151599	A. BUILDING B. WING	00	10/01/2020		
	PROVIDER OR SUPPLIE	R LIATIVE CARE - INDIANA LLC	STREET ADDRESS, CITY, STATE, ZIP COD 11550 N MERIDIAN STREET, SUITE 375 CARMEL, IN 46032				
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	418.54(d) UPDATE OF COL ASSESSMENT The update of the assessment must hospice interdisci collaboration with physician, if any) that have taken p assessment. It m the patient's progoutcomes, as well patient's response update must be a as the condition on less frequently. Based on record refailed to ensure the assessment include information on the toward desired out.	MPREHENSIVE e comprehensive to be accomplished by the		L 533 418.54(d) UPDATE OF COMPREHENSIVE ASSESSMENT The update of the comprehense assessment must be accomplished by the hospice interdisciplinary group (in collaboration with the individua attending physician, if any) and	DATE  10/30/2020  sive		
	Comprehensive As dated 5/11/20, indivisit, the Case Mar evaluate the patien	gency policy titled "Ongoing sessment Policy No. 1-015.1" cated " During each home mager or other discipline will traccording to the problems are initial assessment and		must consider changes that hat taken place since the initial assessment. It must include information on the patient's progress toward desired outcomes, as well as a reassessment of the patient's	ave		

PRINTED: 11/20/2020

STATEMENT OF DEPICEINCHS AND PLAN OF CORRECTION DESTRECT ADON NUMBER 151599  NAME OF PROVIDER OR SUPPLIER PREMIER HOSPICE & PALLIATIVE CARE - INDIANA LLC  (X4) ID SLAMMARY STATIMINAT OF DEPICENCE: PREMIER (EACH DEPICENCY MUST BE PRECEDED BY FULL TAG  REGIOLATION OR INSTERMENTIAN OF OPENCINNEL! Education Process Policy No. 2-025.1-3" dated 5/11/20, indicated " Procedure 6 the patient and family/ caregiver will receive verbal, and as appropriate, written instructions on: B. The patient's disease process C. The medical regimen D. Medication amanagement and administration G. Prescribed treatments 7. Documentation of patient and family/ caregiver will receive verbal, and the patient's and family caregiver will receive verbal, and as appropriate, will be patient's response to the teaching, including level of understanding and the ability to repeat or demonstrate what was taught. C. Describing any additional learning needs not currently met 11. The patient's and family/caregiver's knowledge, skills, and behaviors will be assessed during hospice visits. Re-education, when appropriate, will be provided 3. Review of an agency policy titled "Pain Management Education Policy No. 2-020.1" dated 5/11/20, indicated " 3. Documentation of patient and family/ caregiver instruction and understanding in the clinical record will include: A. Information taught B. Patient and family/ caregiver understanding C. Response to teaching"  4. Review of an agency policy titled "Pain assessment Policy No. 1-018.1" dated 5/11/20, indicated " Pain assessments will be appropriate to the patient's gead and will be documented to facilitate regular reassessment and follow-up by clinicians 2 the following in-depth pain assessment Policy No. 1-018.1" dated 5/11/20, indicated " Pain assessment and follow-up by clinicians 2 the following in-depth pain assessment Policy No. 1-018.1" dated 5/11/20, indicated " Pain assessments will be appropriate to the patient's gead and will be document		T OF HEALTH AND HUI R MEDICARE & MEDIC	OMB NO. 0938-039					
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Documentation of patient and family/ caregiver education will consist of: A. Describing what was taught to the patient B. Describing the patient's response to the teaching, including level of understanding and the ability to repeat or demonstrate what was taught. C. Describing any additional learning needs not currently met 11.  The patient's and family/caregiver's knowledge, skills, and behaviors will be assessed during hospice visits. Re-education, when appropriate, will be provided "  3. Review of an agency policy titled "Pain Management Education Policy No. 2-026.1" dated 5/11/20, indicated " 3. Documentation of patient and family/ caregiver instruction and understanding in the clinical record will include: A. Information taught B. Patient and family/ caregiver understanding C. Response to teaching"  4. Review of an agency policy titled "Pain assessment Policy No. 1-018.1" dated 5/11/20, indicated " assessment will be appropriate to the patient's age and will be documented to facilitate regular reassessment and follow-up by  The following Premier Hospice & Palliative Care CHAP Hospice & Palliative Care		regimen D. Medica	ation management and		corrected, include the			
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was taught to the patient B. Describing the patient's response to the teaching, including level of understanding and the ability to repeat or demonstrate what was taught. C. Describing any additional learning needs not currently met 11.  The patient's and family/caregiver's knowledge, skills, and behaviors will be assessed during hospice visits. Re-education, when appropriate, will be provided "  3. Review of an agency policy titled "Pain Management Education Policy No. 2-026.1" dated 5/11/20, indicated " 3. Documentation of patient and family/ caregiver instruction and understanding in the clinical record will include:  4. Review of an agency policy titled "Pain Liferation taught B. Patient and family/ caregiver understanding C. Response to teaching"  4. Review of an agency policy titled "Pain assessment Policy No. 1-018.1" dated 5/11/20, indicated " Pain assessments will be appropriate to the patient's age and will be documented to facilitate regular reassessment and follow-up by  Nursing staff were In-serviced on the following Premier Hospice & Palliative Care CHAP Hospice Charp Pall		Documentation of p	patient and family/ caregiver		of correction.			
patient's response to the teaching, including level of understanding and the ability to repeat or demonstrate what was taught. C. Describing any additional learning needs not currently met 11.  The patient's and family/caregiver's knowledge, skills, and behaviors will be assessed during hospice visits. Re-education, when appropriate, will be provided"  3. Review of an agency policy titled "Pain Management Education Policy No. 2-026.1" dated 5/11/20, indicated " 3. Documentation of patient and family/ caregiver instruction and understanding in the clinical record will include:  A. Information taught B. Patient and family/ caregiver understanding C. Response to teaching"  4. Review of an agency policy titled "Pain assessment Policy No. 1-018.1" dated 5/11/20, indicated " Pain assessments will be appropriate to the patient's age and will be documented to facilitate regular reassessment and follow-up by  the following Premier Hospice & Palliative Care CHAP Hospice Policy and Procedure Manual, 2020 policies and wound assessment guidelines: 1.0NGOING COMPREHENSIVE ASSESSMENT, Policy No. 1-015; 1.PATIENT EDUCATION PROCESS, Policy No. 2-025; 2.PAIN MANAGEMENT EDUCATION, Policy No. 2-026; 3.PAIN ASSESSMENT, Policy No. 1-018; 4. WOUND CARE, Policy No. 2-035.A; 5.SKIN AND WOUNDCARE QUICK REFERENCE/GUIDELINE; National Pressure Ulcer Advisory Panel (NPUAP) Staging System. Involved staff acknowledged this in-service re-training in writing: Organization policies set forth the		education will cons	ist of: A. Describing what		From 10/14/20-10/30/2	0, all		
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will be provided "  ASSESSMENT, Policy No. 1-015; 1.PATIENT EDUCATION PROCESS, Policy No. 2-025; 2.PAIN MANAGEMENT 5/11/20, indicated " 3. Documentation of patient and family/ caregiver instruction and understanding in the clinical record will include: A. Information taught B. Patient and family/ caregiver understanding C. Response to teaching "  ASSESSMENT, Policy No. 2-025; 2.PAIN MANAGEMENT EDUCATION, Policy No. 2-026; 3.PAIN ASSESSMENT, Policy No. 1-018; 4.WOUND CARE, Policy No. 2-035.A; 5.SKIN AND WOUNDCARE QUICK REFERENCE/GUIDELINE; National Pressure Ulcer Advisory Panel (NPUAP) Staging System. Involved staff acknowledged this in-service re-training in writing: Organization policies set forth the		skills, and behavior	s will be assessed during		_			
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"  5.SKIN AND WOUNDCARE QUICK REFERENCE/GUIDELINE;  4. Review of an agency policy titled "Pain assessment Policy No. 1-018.1" dated 5/11/20, indicated " Pain assessments will be appropriate to the patient's age and will be documented to facilitate regular reassessment and follow-up by  5.SKIN AND WOUNDCARE QUICK REFERENCE/GUIDELINE; National Pressure Ulcer Advisory Panel (NPUAP) Staging System. Involved staff acknowledged this in-service re-training in writing: Organization policies set forth the						•		
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to the patient's age and will be documented to facilitate regular reassessment and follow-up by in-service re-training in writing: Organization policies set forth the								
facilitate regular reassessment and follow-up by  Organization policies set forth the						•		
					_	-		

assessment information will be obtained whenever

include a medication history, presence of common

possible: ... G. Pain management history, to

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to the comprehensive assessment

includes accurate and consistent

information on the patient's

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 10/01/2020 151599 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 11550 N MERIDIAN STREET, SUITE 375 PREMIER HOSPICE & PALLIATIVE CARE - INDIANA LLC CARMEL, IN 46032 (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 barriers to reporting pain and using analgesics, symptoms, progress toward past interventions and response ... I. The desired outcomes, and patient's patient's pain goal, including pain intensity goals response to care. The ongoing related to function, activities, and quality of life ... comprehensive assessment will Pain Management ... 2. Non-pharmacological be updated as frequently as the interventions will be considered for the treatment condition of the patient warrants. of pain ... 4. Patient and family / caregiver Each visit, the nurse will education will focus on the use and side effects of assess/data collect for: analgesic and/ or adjuvant medications, expected 1.A. Pain, including the responses to therapy, and the importance of origin, location, duration, severity, administering medications according to prescribed and relief measures dosage and frequency." 2.B. Symptoms such as, nausea, vomiting, respiratory 5. According to an article titled "Table 2, distress, patient's response to [National Pressure Ulcer Staging System] at care https://www.ncbi.nlm.nik.gov, described a deep 3.C. Factors that alleviate or tissue injury as a "pressure-related injury to exacerbate physical symptoms subcutaneous tissues under intact skin.. Initially, 4.D. Current treatment these lesions have the appearance of a deep related to the identified symptoms bruise ... purple or maroon localized area of and the patient's response discolored intact skin or blood-filled blister due to 5.E. Vital signs appropriate damage of underlying soft tissue from pressure to the patient's condition and/ or sheer." A Stage 2 pressure wound is 6.F. Breath sounds described as a "partial thickness loss or dermis 7.G. Skin integrity presenting as a shallow open ulcer with a red, pink 8.H. Bowel sounds, wound bed without slough. May also present as elimination (urinary and bowel) an intact or open/ruptured serum-filled blister. 9.I. Mental status Presents as a shiny or dry shallow ulcer without 10.J. Appetite/diet, nutritional slough or bruising." A Stage 3 pressure wound is status described as a "full thickness tissue loss. 11.K. Functional status Subcutaneous fat may be visible, but bone, 12.L. Safety/home tendon, or muscle are not exposed. Slough may environment be present but does not obscure the depth of 13.M. Patient and tissue loss. May include undermining and family/caregiver support tunneling." A Stage 4 pressure wound is 14.N. Progress toward described as a full thickness tissue loss; extensive hospice goals and patient needs destruction; with exposed bone, tendon or and problems muscle. Slough or eschar may be present on some 15.O. Compliance with parts of the wound bed. Often includes treatments and medication undermining and tunneling. An Unstageable regimen

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		r ´			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u> COMPLETED			TED	
		151599	B. WING 10/01/2020				2020
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	S.			N MERIDIAN STREET, SUITE 3	375	
PREMIE	R HOSPICE & PALI	LIATIVE CARE - INDIANA LLC	CARMEL, IN 46032				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	1	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	wound is described	as a "full thickness tissue loss			16.[Narcotic Counts includ	ding	
	in which actual dep	th of the ulcer is completely			Quantity of medication used si	ince	
		(yellow, tan, gray, green, or			last count and Reason is a		
		har (tan, brown or black) in the			required ongoing assessment]		
		nough slough and/ or eschar			17.P. The need for an		
	_	se the base of the wound, the			alternative setting or level of c	are	
	true depth and stage	e cannot be determined "			18.Ongoing comprehensiv	ve	
					assessments should focus on		
		article titled "Assessment and			progress toward goals:		
	Documentation of F				19.A. Patient's response t	o l	
		t.org/Internal/events/Nursing			care		
	_Home/Assessment_and_Documentation_Pressu				20.B. Changes in patient		
	re_Ulcers%20_0110719_Color.pdf described				condition, level of deterioration	۱	
	-	a "process by which the			21.C. Changes in patient		
		vered by new epithelium, this			diagnoses/prognosis		
	begins when the wo				22.D. Changes in the		
	-	Γhe tissue is pink, almost			patient's care environment or		
		urs on top of healthy			support systems		
	-	Slough is described as "the			23.E. Well-being		
	-	zed yellowish tissue is			24.F. Comfort		
		ned by an accumulation of			25.G. Dignity throughout t	he	
		t be confused with the			dying process		
		lecrotic tissue is described as			26.Based on the		
		g dead tissue. The wound may			assessments, the plan of		
		d black. Dead connective			care—including problems, nee	eds,	
		ray. The presence of dead			goals, and outcomes—will be		
	tissue in a wound pr	revents healing."			reviewed and updated by the		
		10			interdisciplinary group membe	rs	
		ord for patient #1, start of care			responsible for the case.		
		ed and included a plan of care			Change/verbal orders will be		
		od of 8/6/20 to 10/4/20. The			entered immediately and		
		d, but was not limited to, goals			forwarded to the physician.		
		caregivers are knowledgeable			Patients and family/caregivers		
		pice plan of care for patient			receive information regarding		
	pt/cg (patient/ careg				and the management of pain a		
		dications, uses, and side			integral part of hospice care. T		
		ication and administer			patient and family/caregiver w	ill	
		cribed as evidenced by no			receive verbal or written		
		n medication error, narcotic			instructions, as appropriate,		
	counts will be corre	ect each visit through next			regarding:		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u>			ETED
		151599	B. WI	ING		10/01/	/2020
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	t			N MERIDIAN STREET, SUITE 3	875	
PREMIE	R HOSPICE & PALI	LIATIVE CARE - INDIANA LLC			EL, IN 46032	,, 0	
	THOSE ISE AT ALI			O, a civil			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	-	nxiety/ agitation/ restlessness			1.A. The pain process		
		th use prn [as needed]			2.B. The risk for pain		
	_	ed through next benefit period			3.C. The pain assessmer	nt	
		r will be able to verbalize			process		
	measures to promot				4.D. The importance of		
		n the terminal patient through			effective pain management		
	next benefit period	···· ·			5.E. Methods for pain		
	Daview of 41 - 0/7/2	O.IDC (intendiacialiname)			management, when identified	as	
		0 IDG (interdisciplinary group) ducation provided were safety			part of treatment	-f	
		-			6.F. Potential limitations	OI .	
	and comfort medication. Narcotic count indicated:				pain management modalities		
	Norco 12 tabs (tablets), Roxanol 30 ml (milliliters), and Lorazepam 10 tabs. Patient and/or caregiver				7.G. Side effects of pain treatment		
	•	ropriate use, use of side rails				nt	
		tration, and dexamethasone			8.Documentation of patie and family/caregiver instruction		
		patients pharmacy. Review of			and understanding in the clinic		
		visit note dated 8/7/20			record will include: A. Specific		
	_	nterventions/ goals achieved			information taught; B. Patient		
	-	ent and safety. The updated			family/caregiver specific	and	
		essment/ skilled nursing visit			understanding; C. Response to	0	
	-	ence the patient's/ caregiver			teaching; D. Additional learnin		
		e goals related to the specific			needs. Nurses will document	-	
		s educated and patient/			and symptom assessments ar		
		ding of each medication and			reassessments as required. W		
	_	nderstanding/ verbalization of			pain is identified, a more		
		te comfort related to			comprehensive pain assessme	ent	
	respiratory system.				will be completed. Pain		
					assessments facilitate		
	Review of the 8/8/2	0 IDG note indicated "N/A" to			reassessment and follow-up.		
	education provided.	Narcotic count indicated:			During wound care visits, nurs	e to	
	Norco 12 tabs, Mor	phine (Roxanol) 30 ml, and			review prior wound assessme		
	Lorazepam 20 tabs.	Patient and/ or caregiver			note significant discrepancies		
	understand the appr	opriate use of side rails and			prior to current wound		
	returns demonstration	on. Respirations even but			assessment, communicate to		
	slightly labored at r	est at times and the patient			manager and to the physician,	and	
		tervention, no edema, and			resolve discrepancy in the me	dical	
	DME (durable med	ical equipment) concerns.			record documentation. Wound		
	Review of the skille	ed nursing visit note dated			care will be evaluated and		
	8/8/20 indicated the	only interventions/ goals			reviewed at least weekly. All		
	achieved was pain r	nanagement and safety. The	l		wound care will be performed	in	

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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 00 COMPLETED B. WING 10/01/2020 151599 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 11550 N MERIDIAN STREET, SUITE 375 PREMIER HOSPICE & PALLIATIVE CARE - INDIANA LLC CARMEL, IN 46032 (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 updated comprehensive assessment/ skilled accordance with physician orders nursing visit notes failed to evidence the and practice standards. The patient's/ caregiver progress towards the goals physician will be updated related to the specific medication that was regarding a patient's wound status educated and patient/ caregiver understanding of on an ongoing basis. The each medication and progress towards organization will notify the understanding/verbalization of measures to physician immediately if there are promote comfort related to respiratory system. signs and symptoms of wound The clinical record also failed to evidence the deterioration, including infection, accuracy of the narcotic count/ if Lorazepam was significant bleeding, or ordered the previous day or if there was a enlargement. If there is no miscount due to previous days count indicated 10 improvement in a wound after two tabs. weeks of a treatment, the physician will be consulted to Review of the 8/9/20 IDG note indicated "N/A" to determine if a change in wound education provided. Narcotic count indicated: care is appropriate. Norco 12 tabs, Morphine (Roxanol) 29.5 ml, and Lorazepam 20 tabs. Patient and/ or caregiver How are you going to prevent understand the appropriate use of side rails and the deficiency from recurring in returns demonstration. Over the counter eye the future, even if already drops used and spouse instructed on hospice not corrected? delivering medications. Review of the skilled 1.100% focused chart audit for nursing visit note dated 8/9/20 indicated the only 90 days on Update of interventions/ goals achieved was pain Comprehensive Assessment prior management and safety. The updated to each Interdisciplinary Group comprehensive assessment/ skilled nursing visit Meeting/IDG, then ongoing, 10% notes failed to evidence the patient's/ caregiver each quarter to ensure update to progress towards the goals related to the specific the comprehensive assessment; medication that was educated and patient/ 2.100% focused wound care caregiver understanding of each medication and audit for 90 days on all Wound progress towards understanding/verbalization of care patients, then ongoing, 10% measures to promote comfort related to each quarter to ensure pressure respiratory system. The visit note also failed to ulcer assessment according to

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evidence an assessment of when the patient used

Review of the 8/10/20 IDG note indicated the

education provided was on safety and comfort

medication. Narcotic count indicated: Norco 12

tabs, Roxanol 28 ml, Lorazepam 21 tabs. Patient

the Roxanol and reason for use.

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NPUAC Staging System;

re-educate involved staff,

3. Threshold for focused audits is 100% compliance with update to

comprehensive assessment and

wound staging. If threshold not

met, Patient Care Managers will

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			URVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	A. BUILDING 00 COMPLETED			TED
		151599	B. WING 10/01/2020			2020	
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	t .			N MERIDIAN STREET, SUITE 3	375	
PREMIER	R HOSPICE & PALI	LIATIVE CARE - INDIANA LLC			EL, IN 46032	- <del>-</del>	
	· · · · · · · · · · · · · · · · ·		1		, T	ı	
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	+	TAG			DATE
		nderstand the appropriate use			progressively, involving huma	n	
		urns demonstration. Shortness			resources for work plans, if		
		e. Concerns and request for a			needed.		
		ent's bed. Review of the skilled			M/ha ia gaing ta ha gaaga a ""	hla	
	nursing visit note in interventions/ goals				Who is going to be responsi	nie	
	management and sa	_			for prevention above: i.e.,		
	_	essment/ skilled nursing visit			director, supervisor, etc.? Patient Care Managers (PCM:	c)	
		ence the patient's/ caregiver			are responsible for audits and	<i>'</i>	
		e goals related to the specific			correction. PCMs will be overs		
		-			by Director(s) of Clinical Servi		
	medication that was educated and patient/ caregiver understanding of each medication and				(DCS) who report to the	003	
	progress towards understanding/ verbalization of				Administrator. The Administra	tor	
	measures to promote comfort related to				shall report Focus audit result		
		The visit note also failed to			the QAPI Committee and then		
		nent of when the patient used			Governing Body for three	i uic	
		e accuracy of the narcotic			consecutive quarters.		
		oam was counted at 20 tabs on			denocedante quartere.		
	8/9/20.				By what date are you going t	to	
					have the deficiency correcte		
	Review of the 8/13/	20 IDG note indicated the			10/30/20.		
	education provided	were safety and comfort			Nurses completed re-education	n by	
	_	ic count indicated: Norco 12			10/30/20. By no later than	, l	
		l, Lorazepam 20 tabs. Patient			10/30/20, the organization will		
		nderstand the appropriate use			have implemented 100% Focu		
		urns demonstration. Shortness			audits on Update of		
		e. Spouse requests a bariatric			Comprehensive Assessment	orior	
	bed extender and w	as advised that it was not			to each IDG and Wounds ong		
	available. Review	of the skilled nursing visit note					
	1	nterventions/ goals achieved					
		ent and safety. The updated					
	_	essment/ skilled nursing visit					
		ence the patient's/ caregiver					
		e goals related to the specific					
		s educated and patient/					
		ding of each medication and					
		nderstanding/ verbalization of					
		e comfort related to					
		The visit note also failed to					
	evidence an assessn	nent of when the patient used					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>			COMPLETED	
		151599	B. W	NG		10/01/	2020
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	t .			N MERIDIAN STREET, SUITE 3	75	
PREMIER	R HOSPICE & PALL	LIATIVE CARE - INDIANA LLC			EL, IN 46032	7.5	
TIXLIVIILI	THOSI ICE & FALI	LIATIVE CARE - INDIANA LLC		CARIVIL	.L, IIV 40032		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	ГЕ	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	the Lorazepam.						
	Review of the 8/17/	20 IDG note indicated the					
	education provided	were safety and comfort					
	medication. Narcot	ic count indicated: Norco 12					
	tabs, Roxanol 28 m	l, Lorazepam 21 tabs. No falls					
	and caregiver under	stands the appropriate use of					
	side rails and return	s demonstration. The patient					
	had tachycardia wit	h an irregular heart rate of					
	140-160, new order	for cardizem 120 mg daily was					
	called into the phare	macy. No shortness of breath					
	above baseline. Review of the skilled nursing						
	visit note indicated the only interventions/ goals						
	achieved was pain r	nanagement and safety. The					
	updated comprehen	sive assessment/ skilled					
	nursing visit notes f	ailed to evidence the					
	patient's/ caregiver	progress towards the goals					
		ic medication that was					
	_	t/ caregiver understanding of					
	each medication and	d progress towards					
		palization of measures to					
		lated to respiratory system.					
	-	Cailed to evidence an accurate					
		Lorazepam was counted at 20					
	tabs on 8/13/20.	1					
	8. The clinical reco	ord for patient #2, start of care					
		ved and included start of care					
		essment dated 9/10/20, failed					
	•	table pain range. Review of					
	_	ent indicated the patient had a					
		e left greater trochanter that					
	-	ength] x 8.5 (W) [width] x 0.5 (D)					
		(cm), with $\leq 25$ % (less than 25					
		tissue and 51-75% necrotic					
		ound was stage 4 wound that					
		1.5 cm, depth description					
		kness wound with 25 - 50 %					
		0% necrotic tissue slough; and					
		the left heel that measured 7.6					

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	ETED
		151599	B. WI	NG		10/01	/2020
NAME OF I	PROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP COD		
					N MERIDIAN STREET, SUITE 3	375	
PREMIE	R HOSPICE & PAL	LIATIVE CARE - INDIANA LLC		CARME	EL, IN 46032		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	BROWINEDIS BLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	T-	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	16	DATE
		th description indicated a partial					
	_	ith 100% epithelialization and					
		sue slough and eschar. The					
		narrative note indicated the patient had a right					
		s non-blanchable and boggy					
	but unopened.	263					
	1						
	Review of the plan	of care for the benefit period of					
	_	The medication list indicated					
		scribed Xanax 0.5 mg every 6					
	hours as needed for anxiety, Baclofen 20 mg tablets 2 times daily for muscle relaxant,  Lorazepam 1 mg tablet every 4 hours as needed for anxiety, agitation, and restlessness, Norco 5 mg - 325 mg tablet 1 every 6 hours as needed for						
		concentrate 100 mg/ 5 ml (20					
		n give 0.25 ml every 4 hours as					
		air hunger. The interventions					
	_	ce nurse to obtain blood sugar					
	_	atient/ caregiver at each visit,					
		3 pressure ulcers (located at					
		sacral, and left heel), hospice					
		in level and report changes in					
	_	ian, and failed to evidence a					
		cceptable level of pain. The					
	_	ed only two orders to instruct:					
	_	ch visit and to educate patient/					
	-	se and safety at each visit. No					
		ruction was indicated in the					
	plan of care.						
	•						
	Review of the skille	ed nursing visit note dated					
		ut was not limited to, the					
		ded: "Assessed pain level					
	using appropriate pain scale hospice comfort kit						
	reviewed and is intact with current expiration						
	dates instructed patient/ caregiver regarding						
	use of comfort kit Instructed patient/ caregiver						
		Reinforced nurse's					
		ng safety " The narcotic					

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	` ′		NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPL	
		151599	B. W	ING		10/01/	/2020
NAME OF T	DROLUDED OF CURRY TO		-	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	<b>{</b>		11550 N	N MERIDIAN STREET, SUITE 3	375	
PREMIEI	R HOSPICE & PALI	LIATIVE CARE - INDIANA LLC		CARME	EL, IN 46032		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		ve note indicated "Norco 2,					
		e] meds [medications] still at					
		als met indicated "Patient/					
		proper use of comfort kit" which					
		th the narcotic count in the					
		Interventions not provided					
		ab as ordered Not applicable ich was inconsistent with the					
	goals met of "Patient verbalizes tolerance to lab procedure." The note also indicated a goal met of						
	"Patient/ caregiver verbalizes understanding of						
		ares related to fall awareness"					
		iled to evidence the specific					
	education that was provided. The note failed to evidence an assessment of the right heel.						
	evidence un assessi	ment of the right need.					
	Review of the 9/12/	20 IDG note indicated the					
	narcotic count as fo	llows: the morphine was not					
	in the home, Loraze	epam 30 tabs, Xanax 33 tabs,					
	and Norco 2 tabs. I	Review of the skilled nursing					
	visit note dated 9/12	2/20 indicated the patient's					
	repeat pain assessm	ent "N/A - Patient was at or					
	below their accepta	ble level for pain during the					
	initial pain assessm	ent" and the visit note failed to					
		gar assessment. The					
	_	ded indicated "Hospice					
		ed and is intact with current					
	1 -	structed patient/ caregiver					
		mfort kit. The interventions					
		on safety measures					
		instructions regarding safety."					
	The note failed to in	-					
		nat was taught from the					
		ote also indicated a goal met of					
		verbalizes understanding of					
		ares related to fall awareness"					
	but the visit note failed to evidence the specific						
	education that was provided. The assessment						
		nce an assessment of the right					
	heel.						

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 151599		DNSTRUCTION 00	(X3) DATE SURVEY COMPLETED 10/01/2020	
	PROVIDER OR SUPPLIER  R HOSPICE & PALLIATIVE CARE - INDIANA	11550 1	ADDRESS, CITY, STATE, ZIP COD N MERIDIAN STREET, SUITE EL, IN 46032	≣ 375	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE  (EACH DEFICIENCY MUST BE PRECEDED BY FUR  REGULATORY OR LSC IDENTIFYING INFORMAT		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP DEFICIENCY)	E COMPLETION	
	Review of the skilled nursing visit note dated 9/13/20, the interventions provided indicated "Hospice comfort kit reviewed and is intact wit current expiration dates, instructed patient/ caregiver regarding use of comfort kit. The interventions indicated. The interventions also stated " 10. Provide venous [stasis ulcer] wound care per orders" when the patient does n have stasis ulcers but pressure ulcers. Other interventions revealed "Instructed patient/ caregiver on wound care Instructed patient/ caregiver in performing wound care including proper disposal of used wound supplies Instructed patient/ caregiver in preventative skin care Instructed patient/ caregiver regarding proper nutrition including calories/ protein intal necessary to promote wound healing Identific sources of pressure " when the plan of care failed to be updated to include these instruction education. Other interventions include: "Instruon safety measures Reinforced nurse's instructions regarding safety." The note failed to indicate the specific medications and what was taught from the comfort kit. The note also indicated a goal met of "Patient/ caregiver verbalizes understanding of proper safety measures related to fall awareness" but the visit note failed to evidence the specific education the was provided. The assessment note failed to evidence an assessment of the right heel and the visit note failed to evidence a blood sugar assessment.  Review of the 9/14/20 IDG note indicated the narcotic count as follows: the morphine was not in the home, Lorazepam 30 tabs, Xanax 30 tabs Norco 1 tab. Review of the skilled nursing visit note dated 9/14/20 indicated the patient's repeat pain assessment "N/A - Patient was at or below pain assessment "N/A - Patient was at or below	n ke ed s/ act to to to s, t t t t			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 151599		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 10/01/2020	
	PROVIDER OR SUPPLIER	LIATIVE CARE - INDIANA LLC	11550	ADDRESS, CITY, STATE, ZIP COD N MERIDIAN STREET, SUITE EL, IN 46032	375
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	
1AG	their acceptable lever pain assessment. Indicated "Hospice intact with current of patient/ caregiver rewhen the narrative and "Comfort meds pharmacy today." Or revealed " 10. Prowound care per order not have stasis ulcevisit note failed to it about the use of hydrote failed to evide heel.  Review of a physici indicated the hospicusing verbal pain sechanges in pain lever effectiveness of promote failed to evide the hospicusing verbal pain sechanges in pain lever effectiveness of promote failed to 19/16/20, indicated to 19/16/20, indicated to 19/14/20. The Integration at stage 3 and 4 zero to stage 2 pressidentified the patier include an assessment indicated quadriplegic with the wound assessment indicated quadriplegic with a large amount with a large amount with a large amount indicated and indicated the patient indicated quadriplegic with the wound assessment indicated the patient in the	el for pain during the initial The interventions provided comfort kit reviewed and is expiration dates, instructed garding use of comfort kit" note indicated Norco: 2 tabs being PU [picked up] from Other interventions provided ovide venous [stasis ulcer] ers " when the patient does are but pressure ulcers. The include any documentation drocodone. The assessment ince an assessment of the right  an order dated 9/16/20, the nurse to monitor pain level tale each visit and to report the tel to the physician, monitor Norco and prin morphine.  And nursing visit note dated the last bowel movement was 9/14/20 visit note indicated the last bowel movement was 9/14/20 visit note indicated the last bowel movement was 19/14/20 visit note indicated the last bowel moveme	TAG	DETICIENC!!	DATE

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Facility ID: 007409

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		151599	B. W	ING		10/01/	/2020
		l .		CTDEET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIER	8			NDRESS, CITY, STATE, ZIP COD N MERIDIAN STREET, SUITE 3	75	
DDEMIE	D HUCDICE & DVI I	LIATIVE CARE - INDIANA LLC		1		113	
FREIVIIE	R HUSPICE & PALI	LIATIVE CARE - INDIANA LLC		CARIVIE	EL, IN 46032		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		tic eschar tissue, the sacral					
	_	4 but described as a					
		ue injury with a moderate					
	_	drainage and a strong odor					
		otic slough and eschar tissue,					
		a stage 2 but described as a					
		ue injury with 75-100%					
	_	sue, soft black necrotic tissue					
	and 0-25% necrotic slough tissue. The wound						
	identification and assessments failed to be						
	consistent and accurate according to the wound assessment websites. The assessment note failed						
		ssment of the right heel. The					
	narrative note indicated the patient was having						
	episodes of a fixed stare without identifying this						
	_	e incident. The narrative					
	_	t was out of Norco and the					
		the left arm on 9/15/20. The					
		ndicate if the physician was					
		and drainage of the wounds					
	_	e. The interventions provided					
	_	comfort kit reviewed and is					
		expiration dates, instructed					
	1 .	egarding use of comfort kit.					
		1 9/17/20 indicated the narcotic					
	-	pleted due to multiple family					
		ne and the caregiver was					
	unconnortable getti	ng the medications out.					
	Review of the skills	ed nursing visit note dated					
		ne patient was confused and					
		oes not significantly affect the					
		s repeat pain assessment "N/A					
		below their acceptable level for					
		-					
	pain during the initial pain assessment" but the narrative note indicated the clinician gave the						
	patient lorazepam and hydrocodone due to the						
	patient lorazepain and hydrocodone due to the patient being confused speaking in nonsensical						
		ing. The note indicated the					
		' and notified the physician,					
	Patient was active	and notified the physician,					

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		151599	B. WI	NG		10/01	/2020
				_	_		
NAME OF I	PROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP COD		
					N MERIDIAN STREET, SUITE 3	375	
PREMIE	R HOSPICE & PAL	LIATIVE CARE - INDIANA LLC		CARME	EL, IN 46032		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	T-	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	IE	DATE
		e medications, and only					
		edications/ scheduled					
		zepam. The narcotic count					
	_	note indicated Hydrocodone					
		Lorazepam 29. The count failed					
	to include the patie	-					
	l to morado uno panto						
	Review of the 9/19	0/20 IDG note indicated the					
		illows: Morphine is not in the					
		22 tab, Xanax 11 tabs, Norco 45					
	tabs. Review of the skilled nursing visit note						
		ntegumentary section					
		atient had zero pressure ulcers					
	when the patient has wounds to bilateral heels, left trochanter and sacrum, the patient was alert						
		xiety does not affect the					
		s worst pain level in the last 24					
		1-10 (with 10 being the worse					
		arrently has no pain, the					
	- '	assessment "N/A - Patient					
		ir acceptable level for pain					
		in assessment". The IDG					
	-	he morphine was inconsistent					
		-					
		ount on 9/18, the inconsistent					
		om 25 tabs on 9/18 to current					
		identify an assessment of the					
		vel due to 7 Lorazepam tabs					
		evious day. The assessment					
		nce an assessment of the right					
	heel.						
	Daview - £41 - 0/20	20 IDG note indicated the					
		llows: Morphine is not in the					
		nsistent from 9/18/20.					
	_	Xanax 11 tabs, Norco 42 tabs.					
	Review of the skilled nursing visit note dated						
	9/20/20, indicated the patient did not have anxiety						
	that significantly affected him/ her, the pain						
		ed to indicate the patient has					
	no pain or pain doe	s not interfere with activity or					

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	· ′		NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	UILDING	00	COMPL	
		151599	B. W	ING		10/01	/2020
NAME OF I	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP COD	•	
				11550 N	N MERIDIAN STREET, SUITE 3	375	
PREMIE	R HOSPICE & PAL	LIATIVE CARE - INDIANA LLC		CARME	EL, IN 46032		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY		DATE
		repeat pain assessment attent was at or below their					
		pain during the initial pain					
	_	narrative note indicated the					
		prn (as needed) Norco was					
		ng their pain. The visit note					
	_	assessment of the patient					
		vel due to the use of the					
	narcotics. The assessment note failed to evidence						
	an assessment of the right heel.						
	Review of the skille	ed nursing visit note dated					
	9/21/20, indicated the patient did not have anxiety						
	that significantly affected him/ her, the pain						
	assessment continued to indicate the patient has						
	no pain or pain doe	s not interfere with activity or					
	movement and the	repeat pain assessment					
	indicated "N/A - Pa	tient was at or below their					
	acceptable level for	pain during the initial pain					
	assessment." The l	eft trochanter wound					
	assessment indicate	ed the depth description was					
	_	atient had a large amount of					
		vith a strong odor, the sacral					
	wound assessment	-					
	_	ensive with a strong odor, and					
		ed to be a stage 2 but the					
		vas described as necrotic. The					
		in the narrative indicated					
	·	ken within 24 hours),					
	_	nk, Roxanol 29 ml, and Xanax					
		ailed to include an assessment					
	_	ty and pain due to the use of					
		assessment note failed to					
	evidence an assessment of the right heel.						
	Review of the skilled nursing visit note dated						
	9/23/20, indicated the patient did not have anxiety						
		fected him/ her, the pain					
		ed to indicate the patient has					
		s not interfere with activity or					

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	AND PLAN OF CORRECTION  AND PLAN OF CORRECTION  151599		instruction 00	(X3) DATE SURVEY  COMPLETED  10/01/2020	
	PROVIDER OR SUPPLIER R HOSPICE & PALLIATIVE CARE - INDIANA LLC	11550 N	ADDRESS, CITY, STATE, ZIP COD N MERIDIAN STREET, SUITE 3 EL, IN 46032	375	
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE	
	movement and the repeat pain assessment indicated "N/A - Patient was at or below their acceptable level for pain during the initial pain assessment." The left heel continued to be a stage 2 but the depth description was described as necrotic with a measurement of 5 x 6 x 0.1 cm. The wound identification and assessments failed to be consistent and accurate according to the wound assessment websites. The assessment note failed to evidence an assessment of the right heel. The narcotic count within the narrative note indicated Norco 26 (9 tabs taken within 48 hours), Lorazepam 9 (12 tabs taken in 72 hours in conjunction with Xanax), Roxanol (Morphine) 30 ml, and Xanax 7 (4 tabs taken in 72 hours in conjunction with Lorazepam). The caregiver requested refills on the Xanax and Lorazepam. The visit note failed to evidence a comprehensive assessment of the patient's use of pain and anti-anxiety medications.  Review of the skilled nursing visit note dated 9/25/20, indicated the patient did not have anxiety that significantly affected him/ her, the pain assessment continued to indicate the patient has no pain or pain does not interfere with activity or movement and the repeat pain assessment indicated "N/A - Patient was at or below their acceptable level for pain during the initial pain assessment." The left heel continued to be a stage 2 but the depth description was described as necrotic without a measurement. The wound identification and assessments failed to be consistent and accurate according to the wound assessment websites. The assessment note failed to evidence an assessment of the right heel. The narcotic count within the narrative note indicated Lorazepam 33 tabs, Xanax 60 tabs, Roxanol 30 ml, and Norco 21 tabs. The visit note failed to evidence a comprehensive assessment of the				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 151599		r í	JILDING	nstruction <u>00</u>	(X3) DATE : COMPL 10/01/	ETED		
		ROVIDER OR SUPPLIER	LIATIVE CARE - INDIANA LLC		11550 N	DDRESS, CITY, STATE, ZIP COD I MERIDIAN STREET, SUITE 3 L, IN 46032	75	
	(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE  CY MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
		Review of the skilled 9/28/20, indicated that significantly af assessment continuous no pain or pain does movement and their indicated "N/A - Paracceptable level for assessment." The lastage 2 but the dept as necrotic without identification and acconsistent and accurassessment websites to evidence an assessment websites to evidence an assessment websites to increase Baclofernarcotic count with Lorazepam 21 tabs conjunction with Xataken in 72 hours in Roxanol 30 ml, and 72 hours). The narprovided was safety there was instructio comfort kit, instruction of the sk proper positioning, hydration and nutrit surfaces. These into consistent with the failed to evidence a the patient's use of predications.  Review of the skilled assessment working assessment with the failed to evidence a the patient's use of predications.	and anti-anxiety medications.  In and anti-anxiety  In anxiety  In anxiety					

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STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	ETED
		151599	B. WI	NG		10/01/	/2020
				CED DEET A	ADDRESS OF A STATE OF SOR		
NAME OF P	ROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD	75	
DDEMIE	DIJOCDICE & DALL	HATIVE CADE INDIANALIC			N MERIDIAN STREET, SUITE 3	0/5	
PREMIE	R HUSPICE & PALI	LIATIVE CARE - INDIANA LLC		CARIVIE	EL, IN 46032		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	that significantly af	fected him/ her, the pain					
	assessment continue	ed to indicate the patient has					
	no pain or pain doe	s not interfere with activity or					
		repeat pain assessment					
	indicated "N/A - Pa	tient was at or below their					
	-	pain during the initial pain					
		eft heel wound assessment					
		ement of 5.5 x 6.5 x 0.1 cm,					
	continued to be a st						
	-	cribed as necrotic. The					
		n and assessments failed to be					
		rate according to the wound					
	assessment websites and the sacral wound						
	measurements of tunneling and undermining						
	failed to be consiste						
		sessment note failed to					
		nent of the right heel. The					
		ated the patient's muscle					
	_	ning and orders were received					
		n to four times a day. The					
		in the narrative note indicated					
		Xanax 41 tabs 8 tabs taken in					
		etion with Lorazepam), Roxanol					
	· · · · · · · · · · · · · · · · · · ·	1 tabs. The narrative note					
		provided was safety. The					
		ated there was instruction					
		f the comfort kit, instruction					
		aspection of the skin, ag proper positioning,					
	•	te hydration and nutrition, and					
		nces. These interventions					
		ent with the narrative note.					
		to evidence a comprehensive					
		atient's use of pain and					
	anti-anxiety medications.						
	8 During an interv	riew on 9/30/20 at 4:55 p.m., the					
	_	d that the agency did not					
	provide "comfort ki						
	Provide connect Ki						

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PRINTED: 11/20/2020 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES					OMB NO. 0938-039	
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 151599		(X2) MULTIPLE C A. BUILDING B. WING	construction 00	(X3) DATE SURVEY COMPLETED 10/01/2020		
	PROVIDER OR SUPPLIER	LIATIVE CARE - INDIANA LLC	11550	CADDRESS, CITY, STATE, ZIP COD N MERIDIAN STREET, SUITE ( MEL, IN 46032	375	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
L 0544 Bldg. 00	9. The above finding Regional Director of Nursing, Patient Ca Bloomington Branch 10/01/2020 at 1:20 stated that the assess indicating there work medication was work needed to be any further patient was taking in Director of Nursing description and stage appropriate.  418.56(b) PLAN OF CARE The hospice must and the primary careducation and traithospice as appropriate and the primary careducation and traithospice as appropriate identified in the plant Based on record reversible for identified in the pla	ngs were reviewed with the f Compliance, Director of re Manager of the h, and Administrator on p.m., the Director of Nursing sment was accurate in ald be no pain or anxiety if riking and did not feel that there rther assessments since the nedications as prescribed. The indicated he felt the ting of wounds were  ensure that each patient are giver(s) receive ning provided by the oriate to their the care and services an of care.  riew and interview, the agency to notes contained specific to patients and family their response for 2 of 3  Patient #1, 2)  ency policy titled "Patient Policy No. 2-025.1-3" dated Procedure 6 the caregiver will receive verbal, written instructions on: B. the process C. The medical titon management and	L 0544	L 544 418.56(b) PLAN OF CAThe hospice must ensure that each patient and the primary of giver(s) receive education and training provided by the hospicappropriate to their responsible for the care and services identing the plan of care.  How are you going to correct the deficiency? If already corrected, include the following steps and state day correction.  From 10/14/20-10/9/20, all Nutwere In-serviced on the follow Premier Hospice & Palliative (correction).	ARE 10/30/2020 to care do ce as illities tiffied et te urses ving	
	administration G	Prescribed treatments 7.		CHAP Hospice Policy and		

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Documentation of patient and family/ caregiver

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Procedure Manual, 2020 policies:

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 10/01/2020 151599 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 11550 N MERIDIAN STREET, SUITE 375 PREMIER HOSPICE & PALLIATIVE CARE - INDIANA LLC CARMEL, IN 46032 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE education will consist of: A. Describing what 1.PATIENT EDUCATION was taught to the patient ... B. Describing the PROCESS, Policy No. 2-025; patient's response to the teaching, including level 2.PAIN MANAGEMENT of understanding and the ability to repeat or EDUCATION, Policy No. 2-026; demonstrate what was taught. C. Describing any 3.BASIC HOME SAFETY. additional learning needs not currently met ... 11. Policy No. 2-048. The patient's and family/ caregiver's knowledge, Involved staff acknowledged this skills, and behaviors will be assessed during in-service re-training in writing: Organization policies set forth the hospice visits. Re-education, when appropriate, will be provided .... " organization shall ensure visit notes contain specific details of 2. Review of an agency policy titled "Pain education to patients and family Management Education Policy No. 2-026.1" dated members along with their 5/11/20, indicated " ... 3. Documentation of patient response. Patients and and family/ caregiver instruction and family/caregivers will receive understanding in the clinical record will include: information regarding pain and the A. Information taught B. Patient and family/ management of pain as an integral caregiver understanding C. Response to teaching part of hospice care. The patient .... " and family/caregiver will receive verbal or written instructions, as 3. Review of clinical record #1, Election date of appropriate, regarding: 08/06/2020, included a plan of care for the benefit 1.A. The pain process period of 08/06/2020 to 10/04/2020, with orders to 2.B. The risk for pain instruct medication "indications, uses, side effects 3.C. The pain assessment of each medication prior to administration .... " The plan of care revealed that the patient was 4.D. The importance of prescribed approximately 23 medications. effective pain management 5.E. Methods for pain Review of a skilled nursing visit note dated 08/07, management, when identified as 08/08, 08/09, 08/10, 08/13/20, failed to evidence part of treatment any instructions or education in regards to the 6.F. Potential limitations of patient medications. pain management modalities 7.G. Side effects of pain Review of a skilled nursing visit note dated treatment 08/17/20, indicated the patient was placed on 8.Documentation of patient cardizem 120 mg daily. The visit note failed to and family/caregiver instruction evidence any education about the new medication and understanding in the clinical nor any instruction or education of the patient's record will include: A. Specific prescribed medications. information taught; B. Patient and family/caregiver specific

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 151599		A. B	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 10/01/2020		
	ROVIDER OR SUPPLIEF	R LIATIVE CARE - INDIANA LLC		11550 1	ADDRESS, CITY, STATE, ZIP COD N MERIDIAN STREET, SUITE ( EL, IN 46032	375	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	(X5) COMPLETION
TAG		R LSC IDENTIFYING INFORMATION v on 9/30/20 at 4:55 p.m., when		TAG	understanding; C. Response t		DATE
	_	aregivers should have a copy			teaching; D. Additional learnin		
	-	rofile, the Administrator stated			needs. Nurses will document	-	
	_	on profile should be printed out			and symptom assessments a	•	
	and given to the pat	-			reassessments as required. V		
					pain is identified, a more		
	During an interview	v on 10/01/20 at 9:20 a.m., when			comprehensive pain assessm	ent	
	-	provided them with a			will be completed. Pain		
		cating instruction or provided			assessments will facilitate reg	ular	
	any verbal educatio				reassessment and follow-up b		
	medications, the car	regiver indicated they were			clinicians. Patients receive	•	
	only provided a sma	all handwritten note which			information regarding basic ho	ome	
	indicated for the mo	orphine, 0.5 ml (milliliters) to be			safety in the <i>Patient Hospice</i>		
	given every hour ar	nd Ativan, 1 tab every hour			Admission Booklet, page 29,		
	then 2 tabs 0.5 mg (milligram), which was a new				including:		
	dose but there was some confusion on the exact				1. Fire response including Ox	ygen	
	dosage. The caregi	ver indicated she was not			Safety		
	provided any educa	tion on the medication and felt			2. Electrical safety		
	that both medication	ns given multiple times in an			3. Environmental and mobility		
	hour resulted in the	ir loved ones death.			safety		
					4. Bathroom safety		
	_	were reviewed with the			1.Documentation of patie	ent :	
	_	of Compliance, Director of			and family/caregiver instruction		
	Nursing, Patient Ca				the clinical record will include:		
		ch, and Administrator on			2.A. Specific Information		
		p.m., in which no further			taught		
	information or docu	imentation was provided.			3.B. Adaptations made to	)	
					the environment		
		eal record #2, Election date of			4.C. Patient and		
		plan of care for the benefit			family/caregiver understanding	-	
		to 12/8/2020, with only two			5.D. Return demonstration		
		afety measures each visit and			in use of equipment, if approp		
	_	family on oxygen use and			6.E. Response to teachir	ıg	
	•	No other orders of instruction			7.F. Additional learning		
	was indicated in the	e pian oi care.			needs		
					1.	-4	
					How are you going to prever		
					the deficiency from recurring	iu	
					the future, even if already		
			1		corrected?		1

Z26G11

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

PRINTED: 11/20/2020 FORM APPROVED OMB NO. 0938-039

CENTERS FOR MEDICARE & MEDICAID SERVICES ON						
STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 151599		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  00		(X3) DATE SURVEY COMPLETED		
		B. WING		10/01/2020		
NAME OF PROVIDER OR SUPPLIER PREMIER HOSPICE & PALLIATIVE CARE - INDIANA LLC		STREET ADDRESS, CITY, STATE, ZIP COD 11550 N MERIDIAN STREET, SUITE 375 CARMEL, IN 46032				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX TAG		CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PREFIX (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI		ATE COMPLETION DATE	
				1.100% Focused chart audit 90 days on Admissions, then ongoing, 10% review each quito ensure specific patient education and response is charted; 2.100% focused audit prior each Interdisciplinary Group Meeting/IDG, then ongoing, 1 each quarter to ensure specific patient education and response charted; 3.Threshold for focused audit prior each quarter to ensure specific patient education and response charted; 3.Threshold for focused audit 100% compliance with documentation of patient and caregiver education. If threshold for the motion met, Patient Care Manage will re-educate involved staff, progressively, involving human resources for work plans, if needed.  Who is going to be responsific for prevention above: i.e., director, supervisor, etc.? Patient Care Managers (PCM are responsible for audits and correction. PCMs will be oversible by Director(s) of Clinical Servit (DCS) who report to the Administrator. The Administration shall report Focus audit result the QAPI Committee and ther Governing Body for three consecutive quarters.  By what date are you going the part the deficiency corrected.	to  0% ic se is dits is old ers an  ible ds) d staff seen ices ator ds to n the	
				have the deficiency correcte	ar	

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10/30/20.

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Nurses completed re-education by

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES							FORM APPROVED OMB NO. 0938-039	
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 151599		IDENTIFICATION NUMBER	(X2) MULTIPLE CO A. BUILDING B. WING		NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 10/01/2020		
	PROVIDER OR SUPPLIEI	R LIATIVE CARE - INDIANA LLC		11550 N	DDRESS, CITY, STATE, ZIP COD MERIDIAN STREET, SUITE 3 L, IN 46032	375		
(X4) ID PREFIX TAG	(EACH DEFICIEN	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		ID EFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
L 0546 Bldg. 00	418.56(c)(1) CONTENT OF PLAN OF CARE [The plan of care must include all services necessary for the palliation and management of the terminal illness and related conditions, including the following:] (1) Interventions to manage pain and symptoms.  Based on record review and interview, the Interdisciplinary Group (IDG) failed to ensure the plan of care included interventions for 1 of 1 active record reviewed. (Patient #2)  Finding include:  Review of an agency's policy titled "Prioritizing Patient Problems/ Needs Policy No. 1-033.1" dated 5/11/20, indicated " A written, individualized plan of care will be established within 48 hours of hospice benefit election to assist with identification and prioritization of patient immediate problems/ needs"  The clinical record for patient #2, Election date 9/10/20, included history and physical from an entity dated 8/14/20, which stated the patient has a history of C6 spinal cord injury after a motor vehicle accident in 2002 that resulted in the				10/30/20. By no later than 10/30/20, the organization will have implemented 100% Focu audits on documentation of education at Admission and P to each IDG.	no later than e organization will ented 100% Focus cumentation of Admission and Prior		
			L 0546		services necessary for the	AN OF CARE  le plan of care must include all vices necessary for the liation and management of the minal illness and related nditions, including the lowing:  Interventions to manage pain d symptoms.  Interventions to manage pain d symptoms.  In a symptom		

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patient becoming a paraplegic, has sacral/ischial

and heel wounds. The patient was admitted prior

to this hospitalization for sepsis related to wound

infections. The patient underwent debridement

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Policy No. 1-013;

1.INITIAL ASSESSMENT,

2.THE PLAN OF CARE-

INDIANA, Policy No. 9-017;

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING 00		00	COMPLETED	
		151599	B. WING			10/01	/2020
1.0.000			<u> </u>	CTREET	ADDRESS CITY STATE ZID COD		
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP COD N MERIDIAN STREET, SUITE 3	375	
PREMIER HOSPICE & PALLIATIVE CARE - INDIANA LLC					EL, IN 46032	J1 J	
			1		-L, 114 T0002		1
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID PROVIDER'S PLAN OF CORRECTION  DD FFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		CROSS-REFERENCED TO THE APPROPRIATE		TE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG			DATE
	· ·	py. The patient returned to			1.PRIORITIZING PATIENT		
	-	unresponsiveness and fever.			PROBLEMS/NEEDS, Policy N	NO.	
	The patient was treated again for recurrent sepsis and ended up having 3 seizures during their				1-033.		
	-	g 3 seizures during their			Policy sets forth that the		
	hospital stay.			Interdisciplinary Group (IDG) shall			
	The clinical mass == 1	also contained notes from a			ensure the plan of care includ		
		also contained notes from a			interventions for symptom cor		
	_	lity that the patient was sent to			This includes pain manageme	ent,	
	-	of device that decreases air			anxiety management,		
	` · ·	and to help it heal), IV			interventions for seizure and		
	•	iotics for sepsis, and seizures.			muscle relaxant therapy,		
		-			interventions to prevent skin		
	A 9/5/20 note indicated the patient's sacral wound increased in size from 7 to 10 cm due to loose				breakdown/infection, and interventions for education of	tha	
						urie	
	stools, causing further infection to the sacral				patient of risks while taking	rod	
	wound. The note also indicated the patient had a diagnosis of an anxiety disorder. On 9/1, the note				narcotics.The hospice register nurse will complete an initial	eu	
	indicated the patient has a deep tissue injury to				assessment utilizing scales/ra	tina	
	the right heel possibly measuring 2.6 x 5 cm, a				tools to assess for problems a	-	
		trochanter measuring 2 x 0.8 x			to establish a baseline status		
	_	easuring was described as an			each symptom rated. Items	OI .	
		ssue injury measuring 2.5 x 6			assessed may include, but are	a not	
		ochanter measured 3.5 x 3.5 x 0.4			limited to, the following:	3 1101	
_		the patient's stay, the patient			1.A. Pain assessment		
	-	d refused further treatment and			2.B. Vital signs		
	hospice was presented.				3.C. Fatigue, drowsiness	;	
					4.D. Nausea, appetite	•	
	Review of the start of care comprehensive				5.E. Depression, anxiety		
	assessment dated 9/10/20, the narrative note				6.F. Shortness of breath		
		ad been hospitalized x2 for			7.G. Well-being		
	sepsis related to the wounds and during the last			8.The admitting		ed	
	-	patient had 3 seizures and the			nurse will determine the patier		
	•	to 6 beers daily. The note			and caregiver's primary conce		
	indicated the patient had a Stage 4 sacral ulcer,				goals and immediate care nee		
	stage 3 left hip ulcer, stage 2 left heel ulcer and the				Nurses will document teaching		
	right heel was unblancheable and boggy. The				and interventions performed d	_	
	note went on to state the patient wore waffle				all visits in accordance with th	_	
	boots and the patient was incontinent of bowel				plan of care. A written		
	and bladder.				individualized patient and		
and onder.				family/caregiver plan of care v	vill he		

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		COMPLETED			
1515		151599	B. WING			10/01/2020		
				STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF PROVIDER OR SUPPLIER					N MERIDIAN STREET, SUITE 3	875		
PREMIER HOSPICE & PALLIATIVE CARE - INDIANA LLC				CARMEL, IN 46032				
1 I CLIVIIL		-		O/ II IIVIL	1			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG		5.111		
	^	of care for the benefit period of			established. The care provided			
		The medication list on the			the patient must be in accorda			
	_	ed the patient was prescribed			with the plan of care. The plan			
	and taking alprazolam 0.5 mg every 6 hours as				care will include orders for care.			
	needed for anxiety, Baclofen 20 mg twice a day for			The plan of care will be based on				
	muscle relaxant, levetiracetam 500 mg and Vimpat				the initial, comprehensive and			
		for seizures, and Norco 5			ongoing comprehensive			
		every 6 hours as needed for			assessments performed by			
		are revealed only two orders to			members of the interdisciplina	-		
		sures each visit and to			group and will be reviewed on	а		
	_	nily on oxygen use and safety			regular basis but no less than			
	at each visit. No other orders of instruction was				every fifteen (15) days. This p			
	_	n of care. The goals included,			will focus on identified problen	ns,		
	but limited to, the patient/ caregiver will				goals, and interventions. The			
	understand the pain scale. The plan of care failed				patient and family/caregiver will be			
	to interventions for pain management, patient's				encouraged to participate in the			
	anxiety, muscle relaxant, seizures, interventions to				development of and continued			
	prevent any further skin breakdown/ infection,				updating of the plan of care ar			
	and interventions to education the patient of				will be advised of any changes to			
	consuming alcohol while taking narcotics.				the plan of care. A written,			
	D : 10/1/20 : 0.14				individualized plan of care will	be		
	During an interview on 10/1/20 at 9:14 a.m., the				established to assist with			
	patient's caregiver stated the patient had been on				identification and prioritization	ΟT		
	Xanax for years for anxiety and the patient had				patient immediate problems/needs. The plan of care			
	horrible dysreflexia, which caused his legs to					care		
	spasm, and does have pain and discomfort, and				should include:			
	utilizes the Baclofen routinely and Norco as				A. Patient and family/caregive	I		
	needed.				needs (prioritized) 9.B. Goals			
	The above findings	wara raviawad with the						
	The above findings were reviewed with the Regional Director of Compliance, Director of				10.C. Dates problems identified/onset			
	Nursing, Patient Care Manager of the				D. Resolution dates			
	Bloomington Branch, and Administrator on				D. Nesolution dates			
	10/01/2020 at 1:20 p.m., in which the team had no				How are you going to preven	nt		
	further information or documentation to provide.				the deficiency from recurring			
		provide.			the future, even if already	,		
					corrected?			
					1.100% Focused chart audit	for		
					90 days on Admissions, then			
					ongoing 10% review each gua	arter		

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

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 00 COMPLETED B. WING 10/01/2020				
		151599	B. WI			10/01/	ZUZU
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
	> HU6DICE & DVI I	LIATIVE CARE - INDIANA LLC			N MERIDIAN STREET, SUITE 3 EL, IN 46032	3/5	
FNEIVIIE	THOSFICE & FALL	LIATIVE CARE - INDIANA LLC			-L, IIN 40032		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION DATE
					to ensure appropriate symptor	n	
					control interventions and respo		
					are charted;		
					2.100% Focused audit prior	to	
					each Interdisciplinary Group	20/	
					Meeting/IDG, then ongoing, 10 each quarter to ensure approp		
					symptom control interventions		
					response are charted;		
					3.Threshold for focused aud		
					100% compliance with plan of		
					care that includes intervention		
					symptom control. If threshold r		
					met, Patient Care Managers w re-educate involved staff,	/111	
					progressively, involving human	,	
					resources for work plans, if		
					needed.		
					Miles to make at 1		
					Who is going to be responsit for prevention above: i.e.,	oie	
					director, supervisor, etc.?		
					Patient Care Managers (PCMs	s)	
					are responsible for audits and	,	
					correction. PCMs will be overs	een	
					by Director(s) of Clinical Service	ces	
					(DCS) who report to the		
					Administrator. The Administrate shall report Focus audit results		
					the QAPI Committee and then		
					Governing Body for three		
					consecutive quarters.		
					By what date are you going t		
					have the deficiency corrected 10/30/20.	a?	
					Nurses completed re-educatio	n bv	
					10/30/20. By no later than	,	
					10/30/20, the organization will		
					have implemented 100% Focu	ıs	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	JLTIPLE C	ONSTRUCTION	X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPLETED	
		151599	B. WI	NG		10/01/2020	
				STREET	ADDRESS, CITY, STATE, ZIP COD	<u>.                                    </u>	
NAME OF I	PROVIDER OR SUPPLIEI	R			N MERIDIAN STREET, SUITE 3	375	
PREMIE	R HOSPICE & PAL	LIATIVE CARE - INDIANA LLC			EL, IN 46032		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	ON (X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETIC	ON
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE	
					audits on symptom control		
					interventions at Admission and	d	
					Prior to each IDG.		
1 0540	440.50(.)(0)						
L 0548	418.56(c)(3)	AN OF CARE					
Dida 00	CONTENT OF PL						
Bldg. 00	· ·	must include all services					
	1	palliation and management less and related conditions,					
	including the follo						
	_	<b>-</b>					
	(3) Measurable outcomes anticipated from implementing and coordinating the plan of						
	care.	r doordinating the plan of					
	Garo.		L 05	548	L 548 [The plan of care must	10/30/20	20
	Based on record rev	view and interview, the		740	include all services necessary		<i>J</i> 20
		roup (IDG) failed to ensure the			the palliation and managemen		
		ed measurable goals for 1 of 1			the terminal illness and related		
	active record review	_			conditions, including the		
					following:]		
	Finding include:				(3) Measurable outcomes		
					anticipated from implementing	յ and	
	The clinical record	for patient #2, Election date			coordinating the plan of care.4	18	
	·	istory and physicals from an			418.56(c)(3) CONTENT OF P	LAN	
	1 -	0, which stated the patient had			OF CARE		
		nal cord injury after a motor			How are you going to correc	t	
		2002 that resulted in the			the deficiency? If already		
	-	paraplegic, had sacral/ischial			corrected, include the		
		The patient was admitted prior			following steps and state da	te	
	-	on for sepsis related to wound			of correction.		
	_	ient underwent debridement			From 10/14/20-10/30/20, all		
		py. The patient returned to unresponsiveness and fever.			Nurses were In-serviced on the	le	
	_	ated again for recurrent sepsis			following Premier Hospice &	,	
	_	ng 3 seizures during their			Palliative Care CHAP Hospice Policy and Procedure Manual		
	hospital stay.	ig 5 seizures during then			2020 policies:	,	
	nospitai stay.				1.INITIAL ASSESSMENT,		
	The clinical record	also contained notes from a			Policy No. 1-013;		
		lity that the patient was sent to			2.THE PLAN OF CARE-		
		n for wound treatment with a			INDIANA, Policy No. 9-017;		

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CENTERS FOR MEDICARE & MEDICAID SERVICES					OMB NO. 0938-039	
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED	
		151599	B. WING		10/01/2020	
	PROVIDER OR SUPPLIER	LIATIVE CARE - INDIANA LLC	11550	ADDRESS, CITY, STATE, ZIP COD N MERIDIAN STREET, SUITE:	375	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		(X5)	
PREFIX		ICY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		
TAG	`	R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE	
1710		of device that decreases air	mo	3.PRIORITIZING PATIENT	Ditte	
	` **	and to help it heal), IV		PROBLEMS/NEEDS, Policy I	No.	
		iotics for sepsis, and seizures.		1-033.	NO.	
		-				
		ated the patient's sacral wound		Policy sets forth that the		
		om 7 to 10 cm (centimeters) due		Interdisciplinary Group (IDG)	I	
		sing further infection to the		ensure the plan of care includ	I	
		note also indicated the patient		patient specific, measurable g	joals	
	_	an anxiety disorder. On 9/1/20,		and outcomes. This includes		
		he patient had a deep tissue		measurable goals for pain and		
		eel possibly measuring 2.6 x 5		anxiety management, seizure		
	· ·	right trochanter measuring 2 x		control, dysreflexia, preventio		
		eel measuring was described as		skin breakdown/infection, and		
		p tissue injury measuring 2.5 x		education for patient and		
		trochanter measured 3.5 x 3.5 x		caregivers on risks, including		
		During the patient's stay, the		narcotic interactions. The hos	pice	
	patient had critical	labs and refused further		registered nurse will complete	e an	
	treatment and hosp	ice was presented.		initial assessment utilizing		
				scales/rating tools to assess f	or	
	Review of the start	of care comprehensive		problems and to establish a		
	assessment dated 9	0/10/20, the narrative note		baseline status of each symptom	tom	
	stated the patient ha	ad been hospitalized x2 for		rated. Items assessed may		
	sepsis related to the	wounds and during the last		include, but are not limited to,	the	
	hospitalization, the	patient had 3 seizures and the		following:		
		to 6 beers daily. The note		1.A. Pain assessment		
	_	at had a Stage 4 sacral ulcer,		2.B. Vital signs		
	_	er, stage 2 left heel ulcer, and		3.C. Fatigue, drowsiness	5	
		inblancheable and boggy. The		4.D. Nausea, appetite		
	_	te the patient wore waffle		5.E. Depression, anxiety		
		nt was incontinent of bowel		6.F. Shortness of breath		
		ain assessment failed to		7.G. Well-being		
		able pain range/ goal		8.The admitting registere	ed	
	established by the p			nurse will determine the patie		
				and caregiver's primary conce		
	Review of the plan	of care for the benefit period of		goals and immediate care nee	I	
	_	). The medication list on the		Nurses will document teachin		
		ed the patient was prescribed		and interventions performed of	<u> </u>	
		am 0.5 mg (milligrams) every 6		all visits in accordance with th	I	
		anxiety, Baclofen 20 mg twice		plan of care. A written		
		laxant, levetiracetam 500 mg		individualized natient and		

and Vimpat 100 mg twice a day for seizures, and

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family/caregiver plan of care will be

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 151599		JILDING	instruction 00	(X3) DATE S COMPL 10/01/	ETED		
		ROVIDER OR SUPPLIER	LIATIVE CARE - INDIANA LLC	11550 N	ADDRESS, CITY, STATE, ZIP COD N MERIDIAN STREET, SUITE 3 EL, IN 46032	75	
	(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	Ē	(X5) COMPLETION DATE
	IAU	Norco 5 mg-325 mg for pain. The plan of orders to instruct: sate of educate patient of safety at each visit. Were indicated in the care failed to include measurable goal and goals in regards to the muscle relaxant, seing breakdown of infection caregiver understand narcotics.  During an interview patient's caregiver samax for years for horrible dysreflexia spasm, and does have utilizes the Baclofer needed.  The above findings Regional Director of Nursing, Patient Care Bloomington Brance 10/01/2020 at 1:20	g tablet every 6 hours as needed of care revealed only two afety measures each visit and amily on oxygen use and No other orders of instruction e plan of care. The plan of the an acceptable pain range as and failed to include measurable the patient's wounds, anxiety, zures, to prevent further skin on and goals for patient/ding of mixing alcohol with and the patient had been on anxiety and the patient had, which caused his legs to the pain and discomfort, and an routinely and Norco as were reviewed with the of Compliance, Director of	IAU	established. The care provided the patient must be in accorda with the plan of care. The plan care will include orders for care. The plan of care will be based the initial, comprehensive and ongoing comprehensive assessments performed by members of the interdisciplinate group and will be reviewed on regular basis but no less than every fifteen (15) days. This plan will focus on identified problem goals, and interventions. The patient and family/caregiver with encouraged to participate in the development of and continued updating of the plan of care and will be advised of any changes the plan of care. A written, individualized plan of care will established to assist with identification and prioritization patient immediate problems/needs. The plan of care should include:  A. Patient and family/caregiver needs (prioritized)  9.B. Goals  10.C. Dates problems identified/onset  D. Resolution dates  How are you going to preventhe deficiency from recurring the future, even if already corrected?  1.100% Focused chart audit 90 days on Admissions, then ongoing, 10% review each quantical care will each plan of care and the plan of care will established to assist with identification and prioritization patient immediate problems/needs. The plan of care will established to assist with identification and prioritization patient immediate problems/needs (prioritized)  9.B. Goals  10.C. Dates problems identified/onset  D. Resolution dates	nce of e. on  Ty a an as, II be e d to be of are	DATE

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

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 10/01/2020	
151500 R WING 10/01/2020	
10/01/2020	
STREET ADDRESS, CITY, STATE, ZIP COD	
NAME OF PROVIDER OR SUPPLIER  11550 N MERIDIAN STREET, SUITE 375	
PREMIER HOSPICE & PALLIATIVE CARE - INDIANA LLC CARMEL, IN 46032	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID PROVIDER'S PLAN OF CORRECTION (X5)	
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	ON
TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE	
to ensure measurable goals are	
included in the plan of care; 1.100% Focused audit prior to	
each Interdisciplinary Group	
Meeting/IDG, then ongoing, 10%	
each quarter to ensure appropriate	
measurable goals are included in	
the plan of care update;	
2.Threshold for focused audits is	
100% compliance with plan of	
care that includes interventions for	
symptom control. If threshold not	
met, Patient Care Managers will	
re-educate involved staff, progressively, involving human	
resources for work plans, if	
needed.	
Who is going to be responsible	
for prevention above: i.e.,	
director, supervisor, etc.?	
Patient Care Managers (PCMs)  are responsible for audits and staff	
correction. PCMs will be overseen	
by Director(s) of Clinical Services	
(DCS) who report to the	
Administrator. The Administrator	
shall report Focus audit results to	
the QAPI Committee and then the	
Governing Body for three	
consecutive quarters.	
By what date are you going to	
have the deficiency corrected?	
10/30/20.	
Nurses completed re-education by	
10/30/20. By no later than	
10/30/20, the organization will	
have implemented 100% Focus	

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					(X3) DATE SURVEY	
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	î î			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 00 COMPLETED			
		151599	B. WING		10/01/2020	
		<u> </u>	<del></del>			
NAME OF F	PROVIDER OR SUPPLIEF	₹		ADDRESS, CITY, STATE, ZIP COD	7-	
				N MERIDIAN STREET, SUITE 3	3/5	
PREMIE	R HOSPICE & PAL	LIATIVE CARE - INDIANA LLC	CARM	EL, IN 46032		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	DROUDERIC DV 131 OF CORRESPON	(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION	
TAG	`	R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE	
				goals at Admission and Prior t	to	
				each IDG.		
				Cush ibe.		
L 0553	418.56(d)					
	REVIEW OF THE	PLAN OF CARE				
Bldg. 00	A revised plan of					
5.ag. 00	· ·	he patient's updated				
		ssessment and must note				
	! ·					
		ress toward outcomes and				
	goals specified in	ше ріап оі саге.	1.0553	L 550 440 50/ 1) DEL //E1/ 05	THE 10/20/2020	
	D 1 1	. 11.4 . 4 IDC	L 0553	<b>L 553</b> 418.56(d) REVIEW OF	THE 10/30/2020	
		view and interview, the IDG		PLAN OF CARE		
		Group) failed to ensure the		A revised plan of care must		
		included the patient's		include information from the		
		tcomes and goals as specific		patient's updated comprehens		
	_	for 2 of 3 records reviewed.		assessment and must note the	e	
	(Patient #1, 2)			patient's progress toward		
				outcomes and goals specified	in	
	Findings include:			the plan of care.		
				How are you going to correc	t	
	1. Review of an ag			the deficiency? If already		
		Group Meeting Policy No.		corrected, include the		
	1-036.1) dated 5/11	/20, indicated " Each patient's		following steps and state da	te	
		updated utilizing the results		of correction.		
	from the ongoing co	omprehensive assessment		From 10/14/20-10/30/20, all		
		interdisciplinary group		Nursing staff were In-serviced	on	
	meeting plan of car	e update form will be used for		the following Premier Hospice	. &	
	update of the patien	nt and family/ caregiver It		Palliative Care CHAP Hospice		
		response to treatment and		Policy and Procedure Manual		
		geted outcomes, with may		2020 policies and rules:		
		acotherapeutic effectiveness of		1.PRIORITIZING PATIENT		
		ment outcomes. B. An		PROBLEMS/NEEDS, Policy N	No.	
	' '	e in symptoms or acuity 2.		1-033;		
		3. Condition of skin/ presence/		2.MONITORING PATIENT'S	3	
		lcers H. Plan for changes in		RESPONSE/REPORTING TO		
	treatments or proce	_		PHYSICIAN, Policy No. 1-010		
	a caments of proce	aures.		3.ONGOING	′,	
	2 The clinical roos	ord for patient #1, start of care		COMPREHENSIVE		
	ı z. ine cimicai fecc	na ioi paucii #1. Stait 01 Caic	1	I CONFREDENSIVE	1	

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8/6/20, was reviewed and included a plan of care

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ASSESSMENT, Policy No. 1-015.

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		, and the second	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  00		(X3) DATE SURVEY  COMPLETED	
		151599	B. WING		10/01/2020	
	PROVIDER OR SUPPLIER	LIATIVE CARE - INDIANA LLC	11550	ADDRESS, CITY, STATE, ZIP COD N MERIDIAN STREET, SUITE 37 EL, IN 46032	75	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION	
TAG	<del> </del>	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
	_	od of 8/6/20 to 10/4/20. The		Involved staff acknowledged thi	s	
		ed goals of "Patient, family,		in-service re-training in writing:		
	_	vledgeable and involved in		Organization policies set forth the		
		e for patient pt/cg (patient/		the IDG (Interdisciplinary Group	•	
		palize understanding of		shall ensure the revised plan of		
		nd side effects of each		care includes the patient's		
		ninister medications as		progress toward outcomes and		
	_	nced by no adverse effects		goals as specified in the plan of		
		ror, narcotic counts will be		care update. Clinicians will		
		rough next benefit period.		monitor, document, and report t	he	
	Patient/ Caregiver will understand the numeric			patient's response to care and		
	pain scale, how to manage pain and report changes to hospice. Pt [Patient] will rate pain at			treatment provided on each		
				hospice visit in IDG coordination	٦.	
		end of each nursing visit by		Progress of goals will be		
		cations as ordered throughout		measured at regular intervals a	nd	
	_	mfort medications will be given		updated on the plan of care.		
		will have an effective bowel		Clinicians will establish and		
		videnced by] pt having a BM		maintain ongoing communication		
		at least every 3 days		with the patient's physician and		
		period. Pt will be free of s/s		the hospice Medical Director to		
		ns] constipation. Pt will be free		ensure responsive medical care		
	_	ea/ vomiting] by the end of the		the patient. A revised plan of ca		
		through next benefit period.		must include information from the		
		restlessness will be managed		patient's updated comprehensive	re	
	_	eded] lorazepam as ordered		assessment and must note the		
	_	t period. Patient will rate		patient's progress toward	4	
		less by the end of each nursing		outcomes and goals as specifie	u	
	_	enefit. Patient will maintain ction and within constraints of		in the plan of care. IDG		
	_	ea rating of 5/10 or less rest by		Discussion shall note patient		
		sing visit through next benefit		progress toward wound		
		spiratory status will be		healing/wound goals, increased use of symptom control		
	_	rt as possible AEB no		medications, identify lack of		
		ounds, discolored sputum r/t		symptom assessment and relat	ed	
		ed productive cough or		goals, patient changes in status		
		ortness of air] throughout		and implement updated goals a		
	_	ient/ caregiver will be able to		interventions for actively dying	iiu	
	•	to promote comfort related to		patients.		
		in the terminal patient through		How are you going to prevent		
	I respiratory system i	m are terminar patient unough	1	I HOW are you going to prevent	1	

next benefit period. Pt will wear oxygen as

Z26G11

the deficiency from recurring in

PRINTED: 11/20/2020 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES					OMB NO. 0938-039	
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED	
		151599	B. WING		10/01/2020	
			-	TARRESON COMMANDE SUR COR		
NAME OF	PROVIDER OR SUPPLIEF	8		T ADDRESS, CITY, STATE, ZIP COD O N MERIDIAN STREET, SUITE :	275	
DDEMIE		LIATIVE CARE - INDIANA LLC		MEL, IN 46032	373	
FINEIVIIE	. HOSFICE & FALI	LIATIVE CARE - INDIANA LLC	CARI	VIEL, IN 40032		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
	_	xt benefit period. Patient will		the future, even if already		
	demonstrate oxyger	n saturation to patient's		corrected?		
	optimal level through	gh benefit period. Patient will		1.100% Focused audit prior	· to	
	have safety needs n	net AEB no falls or injury		each Interdisciplinary Group		
	throughout benefit	period. Patient/ caregiver		Meeting/IDG, then ongoing, 1	0%	
	understand the risks	s and benefits of side rail use		each quarter to ensure update	es	
	through next benefi	t period. Patient needs will be		and progress toward measura	able	
	met throughout the	next benefit period Patient		goals is included in plan of ca	re	
	will receive persona	al care and hygiene, including		update;		
	other activities of d	aily living to their optimal level		2.Threshold for focused aud	dits is	
	AEB remaining odd	or free, having a neat/ clean		100% compliance with plan of	f	
	appearance through	next benefit period. Patient/		care that includes updates an	ıd	
Caregiver understand the risk and benefits of side			progress toward measurable			
	rail use through nex	kt benefit period."		goals. If threshold not met, Pa	atient	
				Care Managers will re-educat	ie e	
	Review of the agen	cy's document titled 8/19/20		involved staff, progressively,		
	Hospice IDG Comp	orehensive Assessment and		involving human resources fo	r work	
	Plan of Care Update	e for patient #1, included IDG		plans, if needed.		
	notes from skilled r	nursing visits. The Plan of Care				
	Update failed to evi	idence the patient's/ caregiver		Who is going to be responsi	ble	
	progress towards al	l goals listed on the plan of		for prevention above: i.e.,		
	care, as well as the	specific medication that was		director, supervisor, etc.?		
	educated as evidence	ced by the following:		Patient Care Managers (PCM	is)	
				are responsible for audits and	staff	
	The 8/7/20 IDG not	te indicated the education		correction. PCMs will be over	seen	
	provided were safet	ty and comfort medication.		by Director(s) of Clinical Servi	ices	
	Narcotic count indi	cated: Norco 12, Roxanol 30		(DCS) who report to the		
	ml, and Lorazepam	10. No falls. Patient and/ or		Administrator. The Administra	ator	
		d the appropriate use, use of		shall report Focus audit result	ts to	
		ns demonstration, and		the QAPI Committee and ther		
	dexamethasone was	s called into the patients		Governing Body for three		
		of the skilled nursing visit note		consecutive quarters.		
		nterventions/ goals achieved		· ·		
	was pain manageme	_		By what date are you going	to	
		-		have the deficiency correcte		
	The 8/8/20 IDG not	te indicated "N/A" to education		10/30/20.		
	provided. Narcotic	count indicated: Norco 12,		Nurses completed re-education	on by	
	_	l) 30 ml, and Lorazepam 20. No		10/30/20. By no later than	<b>,</b>	
		r caregiver understand the		10/30/20, the organization wil	1	
		side rails and returns		have implemented 100% Foc		
	1 ** *		1	' " " " " " " " " " " " " " " " " " " "	I	

i ´		X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		UILDING	00	COMPLE	
		151599	B. W	ING		10/01/2	:020
NAME OF D	DROVIDED OD STIDDLIEE			STREET A	ADDRESS, CITY, STATE, ZIP COD	•	
	PROVIDER OR SUPPLIEF			11550 N	N MERIDIAN STREET, SUITE 3	375	
PREMIER	R HOSPICE & PALI	LIATIVE CARE - INDIANA LLC		CARME	EL, IN 46032		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		spirations even but slightly			audits on progress toward pat		
		nes and the patient denied a			measurable goals Prior to eac	h	
		on, no edema, and DME			IDG.		
	l '	quipment) concerns. Review of visit note indicated the only					
	interventions/ goals						
	management and sa						
	management and sa	nory.					
	The 8/9/20 IDG not	te indicated "N/A" to education					
	provided. Narcotic	count indicated: Norco 12,					
	Morphine (Roxanol	l) 29.5 ml, and Lorazepam 20.					
	No falls. Patient and	d/ or caregiver understand the					
		ide rails and returns					
		er the counter eye drops used					
	_	ed on hospice not delivering					
		ew of the skilled nursing visit					
		only interventions/ goals					
	achieved was pain i	nanagement and safety.					
	The 8/10/20 IDG no	ote indicated the education					
	provided were safet	ty and comfort medication.					
	Narcotic count indi	cated: Norco 12, Roxanol 28					
	ml, Lorazepam 21.	No falls. Patient and/ or					
	_	d the appropriate use of side					
		monstration. Shortness of					
		Concerns and request for a					
		ent's bed. Review of the skilled					
	nursing visit note in	-					
	interventions/ goals						
	management and sa	itety.					
	The 8/13/20 IDG no	ote indicated the education					
		ty and comfort medication.					
	1 ^	cated: Norco 12, Roxanol 28					
		No falls. Patient and/ or					
	_	d the appropriate use of side					
		monstration. Shortness of					
	breath at baseline.	Spouse requests a bariatric					
	bed extender and w	as advised that it was not					
	available. Review	of the skilled nursing visit note					

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Event ID:

Z26G11 Facility ID: 007409

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY
AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00	COMPLETED
151599 B. WING	10/01/2020
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CO.  AASSO ALMEDIDIAN OFFEET, OL	
PREMIER HOSPICE & PALLIATIVE CARE - INDIANA LLC  11550 N MERIDIAN STREET, SU CARMEL, IN 46032	UITE 3/5
(X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID PROVIDER'S PLAN OF CORRE	ection (X5)
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP	OULD BE COMPLETION
TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY)	DATE
indicated the only interventions/ goals achieved	
was pain management and safety.	
The 8/17/20 IDG note indicated the education	
provided was on safety and comfort medication.	
Narcotic count indicated: Norco 12, Roxanol 28	
ml, Lorazepam 21. No falls. and/ or caregiver	
understand the appropriate use of side rails and	
returns demonstration. The patient had	
tachycardia with an irregular heart rate of 140-160, new order for cardizem 120 mg daily was called	
into the pharmacy. No shortness of breath above	
baseline. Review of the skilled nursing visit note	
indicated the only interventions/ goals achieved	
was pain management and safety.	
3. The clinical record for patient #2, start of care	
9/10/20, was reviewed and included a plan of care	
for the benefit period of 9/10/20 to 12/8/20. The medication list indicated the patient was	
prescribed Xanax 0.5 mg every 6 hours as needed	
for anxiety, Baclofen 20 mg tables 2 times daily for	
muscle relaxant, Lorazepam 1 mg tablet every 4	
hours as needed for anxiety, agitation, and	
restlessness, Norco 5 mg - 325 mg tablet 1 every 6	
hours as needed for pain, and Morphine	
concentrate 100 mg/ 5 ml (20 mg/ml) oral solution	
give 0.25 ml every 4 hours as needed for pain or	
air hunger. The interventions indicated the	
hospice nurse to obtain blood sugar readings from the patient/ caregiver at each visit, wound	
treatment to 3 pressure ulcers (located at the left	
trochanter, sacral, and left heal), and failed to	
evidence a goal of what is an acceptable level of	
pain.	
Review of the comprehensive assessment dated	
9/10/20, failed to include an acceptable pain range.  Review of the wound assessment indicated the	
patient had a stage 3 wound to the left greater	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILD	DING	00	COMPL	ETED
		151599	B. WING			10/01/	/2020
		l .	S'	TDEET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIER	₹			N MERIDIAN STREET, SUITE 3	275	
DDEMIE		LIATIVE CARE - INDIANA LLC			EL, IN 46032	013	
FINEIVIIEI		LIATIVE CARE - INDIANA LLC		ANVIE	.L, IN 40032		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	II	D	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PRE	EFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	T.	AG	DEFICIENCY)		DATE
		sured 10 (L) x 8.5 (W) x 0.5 (D)					
		vith < 25 % granulation tissue					
		ic tissue; the sacral wound was					
	_	measured 18 x 25 x 1.5 cm,					
		dicated a full thickness					
		% necrosis and 26 - 50%					
		gh; and a stage 2 wound to					
		easured 7.6 x 7.6 x 0.1 cm, depth					
		d a partial thickness wound					
	_	alization and 0-25 % necrotic					
	tissue slough and es	schar.					
	D : C4 1:11						
		ed nursing visit note dated					
		), the interventions provided					
		d patient/ caregiver on wound					
	_	atient/ caregiver in performing					
		ng proper disposal of used					
		nstructed patient/ caregiver in are Instructed patient/					
	1 ~	proper nutrition including					
		ake necessary to promote					
	_	lentified sources of pressure					
	_	failed to be updated to include					
	these interventions	-					
		or these interventions.					
	measurable gould it	2 mos mor omono.					
	Review of the 9/16/	/20 Hospice IDG					
		sessment and Plan of Care					
		Director note indicated the					
		ageable wound on the right					
		fle boots, which failed to be					
		emprehensive nursing					
		DG note made by the Patient					
		not by the patient's case					
		"See Admission Note" versus					
	_	on in regards to the patient					
		gress or lack there of with the					
		ment. The note failed to					
	include if any other	interventions were offered to					
	1	ds to pressure relieving					

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Event ID:

Z26G11 Facility ID: 007409

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 00 COMPLETED  B. WING 10/01/2020				ETED
		151599	B. W	ING		10/01/	/2020
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	8			N MERIDIAN STREET, SUITE 3	75	
PREMIE	R HOSPICE & PALI	LIATIVE CARE - INDIANA LLC			EL, IN 46032	. •	
	T		1	<u> </u>			
(X4) ID		STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5)
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL		TAG	CROSS-REFERENCED TO THE APPROPRIADEFICIENCY)	ΓE	COMPLETION DATE
IAU		R LSC IDENTIFYING INFORMATION ar readings, and reason for	+	IAG			DATE
		in the home and any other					
	education that needs to be provided to the patient and their caregiver.						
	Review of the skille	ed nursing visit note dated					
		he last bowel movement was					
		9/14/20 visit note indicated					
		umentary assessment indicated					
	_	re ulcers, but only identified					
	one at stage 3 and 4	, and inaccurately indicated					
	zero to stage 2 pres	sure ulcers. The visit note					
	identified the patient is a diabetic but failed to include an assessment of blood sugars, the						
	patient's repeat pain	assessment "N/A - Patient					
	was at or below the	ir acceptable level for pain					
	during the initial pa	in assessment", the functional					
	assessment indicate	ed the patient was a					
	quadriplegic with th	ne patient is a paraplegic, the					
	wound assessment	indicated the left trochanter is					
		ected deep tissue injury with a					
		rulent draining with a strong					
		necrotic slough tissue and					
		schar tissue, the sacral wound					
	1	cribed as a suspected deep					
		moderate amount of purulent					
	_	ng odor with 0-25% of necrotic					
	_	issue, and the left heel is a					
		ed as a suspected deep tissue					
		% epithelialization tissue, soft					
		e and 0-25% necrotic slough					
	tissue. The wound						
		to be consistent and accurate					
		ound assessment websites.					
		indicated the patient was					
		a fixed stare without					
		possible seizure incident.					
		ated the patient was out of					
	_	ent had pain in the left arm on					
	9/15/20. The visit i	note failed to indicate if the					

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Event ID:

Z26G11 Facility ID: 007409

If continuation sheet Page 48 of 148

	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER 151599	(X2) MULTIPLE CC A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 10/01/2020
	PROVIDER OR SUPPLIER R HOSPICE & PALLIATIVE CARE - INDIANA LLC	11550 1	ADDRESS, CITY, STATE, ZIP COD N MERIDIAN STREET, SUITE 3 EL, IN 46032	75
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
	physician was notified of the odor and drainage of the wounds and possible seizure. The interventions provided indicated "Hospice comfort kit reviewed and is intact with current expiration dates, instructed patient/ caregiver regarding use of comfort kit. The IDG note dated 9/17/20 indicated the narcotic count was not completed due to multiple family members in the home and the caregiver was uncomfortable getting the medications out.  Review of the skilled nursing visit note dated 9/18/20 indicated the patient was confused and lethargic, anxiety does not significantly affect the patient, the patient's repeat pain assessment "N/A - Patient was at or below their acceptable level for pain during the initial pain assessment" but the narrative note indicated the clinician gave the patient lorazepam and hydrocodone due to the patient being confused speaking in nonsensical sentences and wincing. The note indicated the patient was "active" and notified the physician, discontinued routine medications, and only ordered comfort medications/ scheduled Morphine and Lorazepam. The narcotic count within the narrative note indicated Hydrocodone 25, Roxanol 30 ml, Lorazepam 29. The count failed to include the patient's Xanax.  Review of the 9/19/20 IDG note indicated the narcotic count as follows: Morphine is not in the home. Lorazepam 22 tab, Xanax 11 tabs, Norco 45 tabs. Review of the skilled nursing visit note dated 9/19/20, the Integumentary section indicated that the patient had zero pressure ulcers, the patient was alert and oriented x3, anxiety does not affect the patient, the patient's worst pain level in the last 24 hours, on a scale of 1-10 (with 10 being the worse pain) was a 6 but currently has no pain, the patient's repeat pain assessment			

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Event ID:

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Facility ID: 007409

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	ETED
		151599	B. WI	NG		10/01/	2020
				CTDEET A	DDDECC CITY CTATE ZID COD		
NAME OF F	ROVIDER OR SUPPLIEF	2			ADDRESS, CITY, STATE, ZIP COD N MERIDIAN STREET, SUITE 3	75	
DDEMIE	P HOSDICE & DAI	LIATIVE CARE - INDIANA LLC			EL, IN 46032	113	
FINEIVIIEI	THOSPICE & FAL	LIATIVE CARE - INDIANA LLC	_	CARIVIL	.E., IN 40032		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		at or below their acceptable					
	-	g the initial pain assessment".					
		ount for the morphine was					
		e narcotic count on 9/18, the					
	inconsistent number of Norco from 25 tabs on						
	9/18 to current 45 tab, and failed to identify an						
	assessment of the patient's anxiety level due to 7						
	Lorazepam tabs being used from previous day.						
	Review of the 9/20/	20 IDG note indicated the					
		llows: Morphine is not in the					
	home which is inco	nsistent from 9/18/20.					
	Lorazepam 21 tabs,	Xanax 11 tabs, Norco 42 tabs.					
	Review of the skille	ed nursing visit note dated					
	9/20/20, indicated t	he patient did not have anxiety					
	that significantly af	fected him/ her, the pain					
	assessment continu	ed to indicate the patient has					
	no pain or pain doe	s not interfere with activity or					
		repeat pain assessment					
		tient was at or below their					
	-	pain during the initial pain					
		narrative note indicated the					
		prn Norco was effective in					
		n. The visit note failed to					
		ent of the patient anxiety and					
	pain level due to the	e use of the narcotics.					
	Review of the skills	ed nursing visit note dated					
		he patient did not have anxiety					
	· ·	fected him/ her, the pain					
		ed to indicate the patient has					
		s not interfere with activity or					
		repeat pain assessment					
		tient was at or below their					
		pain during the initial pain					
	_	eft trochanter wound					
		ed the depth description was					
		atient had a large amount of					
	_	vith a strong odor, the sacral					
	wound assessment						
		-	1				

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Event ID: Z26G11 Facility ID: 007409

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	LETED
		151599	B. WI	NG		10/01	/2020
			1	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIE	R			N MERIDIAN STREET, SUITE	375	
PREMIE	R HOSPICE & PAL	LIATIVE CARE - INDIANA LLC			EL, IN 46032		
(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	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY)		DATE
	_	tensive with a strong odor, and					
		ued to be a stage 2 but the					
	depth description was described as necrotic. The narcotic count within the narrative indicated						
		ken within 24 hours),					
		ank, Roxanol 29 ml, and Xanax					
		failed to include an assessment					
	_	ety and pain level due to the use					
	of the narcotics.						
	Review of the skill	ed nursing visit note dated					
		the patient did not have anxiety					
		ffected him/ her, the pain					
	1 -	ed to indicate the patient has					
		es not interfere with activity or					
		repeat pain assessment					
		atient was at or below their					
		r pain during the initial pain					
		left trochanter wound					
	assessment indicate	ed the depth description was					
		patient had a large amount of					
	_	with a strong odor, the wound					
		ated 5 x 5 x 0.5 cm with <2 cm					
	undermining (0.5 c	m at 12 - 3 o'clock, 3 - 6 at					
	I - '	ock, and 9-12 at o'clock) and 1					1
		9-12 o'clock. The sacral wound					
	_	ed the depth description was					
		a strong odor, with < 2 cm					1
		at 12 - 3 o'clock, 3 - 6 at o'clock,					
	I - '	9-12 at o'clock) and 1 cm of					
	tunneling at 9-12 o	'clock. The left heel continued					
	to be a stage 2 but t	the depth description was					
	described as necrot	tic with a measurement of 5 x 6					1
	x 0.1 cm. The wou	and identification and					
	assessments failed	to be consistent and accurate					
	according to the wo	ound assessment websites.					1
	The narcotic count	within the narrative note					
	indicated Norco 26	(9 tabs taken within 48 hours),					
	Lorazepam 9 (12 ta	abs taken in 72 hours in					
	conjunction with X	(anax), Roxanol (Morphine) 30					

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Event ID:

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Facility ID: 007409

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 151599		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		X3) DATE SURVEY COMPLETED 10/01/2020		
	PROVIDER OR SUPPLIER	LIATIVE CARE - INDIANA LLC		11550 N	NDDRESS, CITY, STATE, ZIP COD NMERIDIAN STREET, SUITE 3 EL, IN 46032	75	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	ΓE	(X5) COMPLETION
TAG	ml, and Xanax 7 (4 conjunction with Lorequested refills on The visit note failed assessment of the panti-anxiety medical.  Review of the skilled 9/25/20, indicated that significantly af assessment continuous no pain or pain does movement and the residuated "N/A - Palacceptable level for assessment." The lassessment indicated extensive and the purulent drainage we epithelialization, 76 and 0-25% Necrotical assessment failed to measurement but in cm at 12 - 3 o'clock and 9-12 at o'clock) wound assessment indicated with slough and esceptable as wound remained to be a standard or continued to be a standard or continued to be a standard or the narcotic count of the narcotic count of the narcotic count of the marcotic count of the marcotic count of the service or the narcotic count of the service of the marcotic count of the marcotic count of the service of the marcotic count of the service of the marcotic count of the marcotic count of the service of the marcotic count of the marc	tabs taken in 72 hours in brazepam). The caregiver the Xanax and Lorazepam. It to evidence a comprehensive attent's use of pain and attent's pain dictate the patient has a not interfere with activity or repeat pain assessment attent was at or below their pain during the initial pain left trochanter wound at the depth description was attent had a large amount of with moderate odor, <25 % (3-100% Necrotic tissue slough at tissue eschar. The avoidence a wound actuded <2 cm undermining (2 and no tunneling. The sacral indicated the depth densive with moderate odor, ion 0-25% of necrotic tissue than. The assessment failed to measurement but included < 2 cm at 12 - 3 o'clock, 3 - 6 at ck, and 9-12 at o'clock) and 2 (2-12 o'clock. The left heel		TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)		DATE

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

Event ID: Z26G11 Facility ID: 007409

If continuation sheet Page 52 of 148

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	ETED
		151599	B. WI	NG		10/01/	2020
			<u> </u>	CTDEET A	ADDRESS SITV STATE ZIR COD		
NAME OF P	ROVIDER OR SUPPLIER	₹			ADDRESS, CITY, STATE, ZIP COD N MERIDIAN STREET, SUITE 3	75	
DDEMIE		LIATIVE CARE - INDIANA LLC			EL, IN 46032	173	
PREMIER	THOSPICE & PALI	LIATIVE CARE - INDIANA LLC		CARIVIE	EL, IN 40032		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		Norco 21 tabs. The visit note					
		comprehensive assessment of					
	-	pain and anti-anxiety					
	medications.						
		ed nursing visit note dated					
		he patient did not have anxiety					
	that significantly affected him/ her, the pain						
		ed to indicate the patient has					
		s not interfere with activity or					
		repeat pain assessment attent was at or below their					
	-	pain during the initial pain left trochanter wound					
		ed the depth description was					
		atient had a large amount of					
	-	vith strong odor, <25 %					
		5-100% Necrotic tissue slough					
	and 0-25% Necrotic	_					
	assessment failed to						
		acluded <2 cm undermining (2					
		z, 3 - 6 at o'clock, 6-9 at o'clock,					
		) and no tunneling. The sacral					
	wound assessment	<del>-</del>					
		ensive and with strong odor,					
	•	tion 0-25% of necrotic tissue					
	-	char. The assessment failed to					
	-	measurement but included < 2					
	cm undermining (2	cm at 12 - 3 o'clock, 3 - 6 at					
		ck, and 9-12 at o'clock) and 2.5					
	cm of tunneling at 9	9-12 o'clock. The left heel					
	continued to be a st	age 2 but the depth					
	description was des	scribed as necrotic without a					
		wound identification and					
		to be consistent and accurate					
		ound assessment websites.					
		indicated the patient's muscle					
		ning and orders were received					
		n to four times a day. The					
	narcotic count with	in the narrative note indicated					
	cm undermining (2 o'clock, 6-9 at o'clock cm of tunneling at 9 continued to be a st description was des measurement. The assessments failed the according to the work the narrative note it spasms were worse to increase Baclofer	cm at 12 - 3 o'clock, 3 - 6 at ock, and 9-12 at o'clock) and 2.5 o-12 o'clock. The left heel age 2 but the depth occibed as necrotic without a wound identification and to be consistent and accurate bund assessment websites. Indicated the patient's muscle ning and orders were received in to four times a day. The					

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Event ID: Z26G11 Facility ID: 007409

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 151599	(X2) MULTIPL A. BUILDING B. WING	e construction G <u>00</u>	CON	TE SURVEY MPLETED 01/2020
	PROVIDER OR SUPPLIER	LIATIVE CARE - INDIANA LLC	115	EET ADDRESS, CITY, STATE, 2 50 N MERIDIAN STREE RMEL, IN 46032		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFII TAG	CROSS-REFERENCED TO	TON SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
	Lorazepam 21 tabs conjunction with Xi taken in 72 hours in Roxanol 30 ml, and 72 hours). The nar provided was safety there was instruction comfort kit, instruction comfort kit, instruction comfort kit, instruction of the sk proper positioning, hydration and nutrition surfaces. These introconsistent with the failed to evidence at the patient's use of medications.  Review of the skilled 9/30/20, indicated that significantly after assessment continuation or pain or pain does movement and the residuated "N/A - Paracceptable level for assessment." The lassessment indicated 1 cm the depth descepation thad a large at with strong odor, concrotic tissue amore slough and eschar, cm at 12 - 3 o'clock and 9-12 at o'clock) wound assessment in the depth descepation and with small pure 25% epithelializated with slough and eschar, which is the same process.	(12 tabs taken in 72 hours in anax), Xanax 49 tabs 11 tabs a conjunction with Lorazepam), Norco 10 tabs (11 tabs taken in rative note indicated education of the interventions indicated in regarding the use of the tion regarding routine in, instruction regarding regarding appropriate eiton, and use of support the erventions failed to be interventions failed to be interventional failed to b				

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Event ID:

**Z26G11** F

Facility ID: 007409

If continuation sheet

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 151599		A. Bl	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 10/01/2020			
		ROVIDER OR SUPPLIER	LIATIVE CARE - INDIANA LLC	STREET ADDRESS, CITY, STATE, ZIP COD 11550 N MERIDIAN STREET, SUITE 375 CARMEL, IN 46032					
	(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY 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)	ΓE	(X5) COMPLETION DATE	
		- 3 o'clock. The left indicated a measure continued to be a stream description was desto wound identification consistent and accurassessment websites measurements of turbial failed to be consisted assessment. The nampatient's muscle spanorders were received times a day. The manarrative note indicated tabs 8 tabs taken with Lorazepam), Reprovided was safety there was instruction comfort kit, instructions and nutrit surfaces. These interconsistent with the failed to evidence a the patient's use of pertaining to the patient's respections and patient appeared to the surface of the patient's "stare" and patient appeared to the surface of the surface of the patient's "stare" and patient appeared to the surface of the surfa	theel wound assessment ement of 5.5 x 6.5 x 0.1 cm, age 2 but the depth cribed as necrotic. The n and assessments failed to be rate according to the wound as and the sacral wound enneling and undermining ent with the 9/28/20 errative note indicated the assessment wound as were worsening and does to increase Baclofen to four arcotic count within the ated Lorazepam 18 tabs, Xanax in 48 hours in conjunction accound 30 ml, and Norco 61 enote indicated education architecture in the interventions indicated in regarding the use of the tion regarding routine in, instruction regarding regarding appropriate entition, and use of support the error in the visit note comprehensive assessment of pain and anti-anxiety  (20 IDG note revealed that the failed to include any feedback tient's lack of progress toward rease use of anti-anxiety in medications and their lack of ceptable pain goal. The IDG formation in regards to the lafalled to mention when the						

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If continuation sheet

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i '		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED
		151599	B. WING		10/01/2020
NAME OF P	PROVIDER OR SUPPLIER			T ADDRESS, CITY, STATE, ZIP COD	775
PREMIER	R HOSPICE & PALI	LIATIVE CARE - INDIANA LLC		ON MERIDIAN STREET, SUITE ( MEL, IN 46032	3/5
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION tated the patient had been on	TAG	DELICIENCE!	DATE
		anxiety and the patient had			
		, which caused his legs to			
	spasm, and does have pain and discomfort, and				
		n routinely and Norco as			
	-	ver also stated that they were			
	-	y to provide wound care. The y felt the wounds were getting			
	worse.	y felt the woulds were getting			
		ngs were reviewed with the			
	_	f Compliance, Director of			
	Nursing, Patient Care Manager of the Bloomington Branch, and Administrator on 10/01/2020 at 1:20 p.m., the Director of Nursing				
		description and staging of			
		priate and interventions had			
		the patient #2, but the			
		s. In regards progress			
	_	Director of Nursing and Patient			
	requirement.	d they felt the record met the			
	requirement				
L 0591	418.64(b)(1)	050			
Bldg. 00	NURSING SERVI				
ыug. uu	. ,	ust provide nursing care under the supervision of a			
	_	Nursing services must			
		rsing needs of the patient			
	are met as identifi	ed in the patient's initial			
		orehensive assessment,			
	and updated asse	ssments.	T 0501	1 FO4 440 G4/5\/4\ NILIDOINIO	10/20/2020
	Based on record rev	riew and interview, the nurse	L 0591	<b>L 591</b> 418.64(b)(1) NURSING SERVICES	10/30/2020
		ents were accurately assessed		(1) The hospice must provide	
	-	was consistent, given the		nursing care and services by	or
	prescribed medications as received in a verbal			under the supervision of a	
		ng process, failed to indicate		registered nurse. Nursing ser	vices
		nd patient response after each		must ensure that the nursing	_
	uose given, for 2 of	2 records reviewed of recently		needs of the patient are met a	IS

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Event ID:

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Facility ID: 007409

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		151599	B. W	ING		10/01/	2020
		l .		CTDEET /	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	₹			N MERIDIAN STREET, SUITE :	375	
PREMIE	R HOSPICE & PAL	LIATIVE CARE - INDIANA LLC			EL, IN 46032	010	
I IXLIVIILI	THOO ICE AT AL	LIATIVE OAKE - INDIANA ELO		OARWIL			
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	-	TAG	DEFICIENCY)		DATE
	deceased patients.	(Patient #1, 3)			identified in the patient's initia	l	
	F. 1				assessment, comprehensive		
	Findings include:				assessment, and updated		
	1 D ' C	errenta de la composição			assessments.		
		ticle titled Preventing Delirium			How are you going to correct	t	
		Lessons From Recent Research			the deficiency? If already		
	_	indicated " The medications			corrected, include the	40	
	that most frequently contribute to delirium are benzodiazepines [Lorazepam], opioids				following steps and state da of correction.	te	
	[Morphine/Roxanol], and steroids Pain and				From 10/14/20-10/30/20, all		
	Delirium For the patient with pain who is treated				Nurses were In-serviced on the		
	at the end of life, pain relief often requires opiates,				following Premier Hospice &	IE	
	and pain is difficult to assess when the patient is				Palliative Care CHAP Hospice	_	
	already confused. Moaning, grimacing, and				Policy and Procedure Manual		
	1	occur in the nightmare of			2020 policies:	,	
		an be misunderstood as a			1.NURSING CARE, Policy I	No	
	_	state. Patients who are in pain			9-019;	ΝΟ.	
		riented, with problems in			2.IDENTIFICATION OF		
		on, cannot report accurately			MEDICATION FOR		
	whether a remedy v	-			ADMINISTRATION, Policy No	<b>)</b> .	
		d opioids administered in the			2-005;		
	_	tress can worsen confusion			3.POSSESSION OF CERTA	AIN	
	The older patient is				DRUGS AND OTHER		
	_	rium; the risk of delirium from			HEALTHCARE ITEMS- INDIA	ANA,	
	any cause is also gr	eater if the patient is older.			Policy No 2-005.B;		
	Delirium is more lil	kely to be missed if the patient is			4.ADMINISTRATION AND		
	lethargic and presen	nts no management problem			DOCUMENTATION OF		
	"				MEDICATIONS, Policy No. 2-	-006;	
					5.COMFORT KITS, Policy N	No.	
	2. Review of an ag	ency policy titled "Comfort			2-005.A.		
	Kits Policy No. 2-0	005.A.1" dated 5/11/20,			Involved staff acknowledged t	this	
		ation and use of Comfort Kits			in-service re-training in writing	-	
	1	he visiting hospice nurse will			Organization policies set forth		
		and family on the use and			the hospice nurse will ensure		
	storage of the comf	ort kit "			patients are accurately assess	sed	
					and charted assessments,		
		ord of patient #1 was reviewed			narrative, and intervention		
		ontained a plan of care for the			documentation is consistent.		
		8/06/20 to 10/04/20, with			Nurses may administer presc	ribed	
	medication orders,	included but not limited to,			medications as received in a		

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PRINTED: 11/20/2020 FORM APPROVED

CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES				OM	B NO. 0938-039
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		151599	B. WI	NG		10/01	/2020
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	R			N MERIDIAN STREET, SUITE 3	375	
PREMIE	R HOSPICE & PAL	LIATIVE CARE - INDIANA LLC		CARMEL, IN 46032			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	Lorazepam 1 mg ta	blet every 4 hours as needed			verbal order during the dying		
	for anxiety/ restless	ness/ agitation and Morphine			process and shall document the	ne	
	Concentrate 20 mg/	ml, give 0.25 ml every 4 hours			time, drug, amount, and patier	nt	
	as needed for severe pain/ air hunger.				response after each dose give	n.	
					The Hospice Nurse shall:		
	Review of a death v	visit note dated 8/21/20, the			A. Manage discomfort and pro	vide	
	narrative note state	d "Patient found to be			symptom relief.		
	extremely restless.	Order received to increase			1.B. Incorporate specializ	zed	
	dose and frequency	of morphine and lorazepam,			nursing skills related to palliati	ve	
	required multiple de	oses of of [sic] Lorazepam and			end-of-life care into all clinical		
	morphine with min	imal effect. Call to [name of			care.		
	Medical Director] a	gain and order given for haldol			1.C. Provide education o	n	
	1mg/hr " Revie	w of the clinical record failed to			disease process, self-care,		
	evidence verbal ord	lers that the nurse received			end-of-life care.		
	from the Medical D	Pirector. The note failed to			2.D. Provide emotional		
	evidence the specifi	ic order received as well the			support to the patient and fam	ily.	
	amount and time gi	ven during each episode.			3.E. Assess for risks of g	-	
					cultural, spiritual implications	·	
	During an interview	y on 09/30/20 at 9:20 a.m., the			exacerbated by the terminal		
	spouse indicated the	ey observed between the hour			diagnosis.		
	of Employee A's ar	rival and the patient's death, 0.5			4.F. Initiate appropriate		
	ml of Roxanol (no	comfort to the patient), then a			preventive and rehabilitative		
	whole syringe of Ro	oxanol (no comfort to the			nursing procedures.		
		nole syringe of Roxanol then			5.G. Prepare clinical and		
	Lorazepam, (no cor	nfort to the patient and family			progress notes that demonstra		
	member sent to dru	g store to pick up Haldol),			progress toward established		
	followed by anothe	r whole syringe of Roxanol and			goals.		
	Lorazepam. The ca	aregiver indicated she was not			6.H. Coordinate all service	es	
	provided any educa	tion on the medication and felt			and prioritization of needs with	n the	
		ns given multiple times in an			interdisciplinary group.		
		ir loved ones death.			7.I. Use a case managen	nent	
					approach and make referrals t		
	Employee A was in	terviewed on 10/01/20 at 9:00			other services as needed.		
		on the medication given,			8.J. Provide specialized		
	_	"multiple multiple" doses of			hospice training to other staff,		
		ad many calls to the doctor			family/caregivers to ensure		
	and called the Patie				adequate care.		
		S			9.K. Provide an ongoing		

4. The clinical record of patient #3, Election date

of 9/9/20, was reviewed and included a plan of

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evaluation of the patient and

family/caregiver response to care.

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		151599	B. W	ING		10/01	/2020
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIER	8			N MERIDIAN STREET, SUITE 3	375	
PREMIEI	R HOSPICE & PALI	LIATIVE CARE - INDIANA LLC			EL, IN 46032	. <del>.</del>	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	care dated 9/9/20, w	vith a medication list of, but not			10.L. Assess the ability of	f	
	limited to, Risperda	d 0.25 mg at bedtime,			the caregiver to meet the patie	ent's	
	Lorazepam 1 mg tal	blet every 4 hours as needed			immediate needs.		
	for anxiety and rest	lessness and Morphine			O. Assure communication		
	(Roxanol) concentra	ate 100 mg/5 ml (20 mg/ml) oral			between the hospice and othe	er	
	solution 0.25 ml evo	ery 4 hours as needed for pain			health care providers involved	l in	
	and shortness of breath.				care. Patient and family/careg	iver	
					education and training activitie	es	
	Review of a hospital paperwork dated 7/28/20				will be initiated and continued		
	revealed the patient	had a diagnosis of Dementia			throughout the course of care.		
	with behavioral dist	turbances and had been taking			Nursing services must ensure	that	
	Dispersedly 0.25 m	g daily then on 9/4/20, revealed			the nursing needs of the patie	nt	
	the patient was in the	ne hospital for a fractured hip			are met as identified in the		
	which was surgicall	ly repaired and was discharged			patient's initial assessment,		
	home with hydroco	done 5 mg - 325 mg.			comprehensive assessment, a	and	
					updated assessments. Orders		
	Review of a skilled	nursing visit note dated			be present for nurse medication		
	9/10/20, the pain as	sessment indicated the patient			administration. Orders for the		
	was not in pain and	the narrative note indicated			administration of medications		
	the patient stated hi	s/her hip was a little sore.,			must be given by a physician	(or	
	which was inconsis-	tent with the assessment.			other authorized independent	•	
	Interventions provid	ded section indicated the			practitioner) and include patie		
	_	was reviewed and was intact			name, patient identifier, the na		
	with current expirat	ion dates and was instructed			of the medication, dosage,		
	1	mfort kit. The narrative			dilution, route, frequency of		
	section indicated the	ere was no narcotic count			administration, and rate of		
	because the medica	tions had not been picked up			infusion. The individual receiving	ing	
		The interventions provided was			the order must record it, sign i	-	
	inconsistent with th				immediately and have the		
					prescribing person sign it in		
	Review of a skilled	nursing visit note dated			accordance with state and fed	leral	
		ntions provided section			regulations. Licensed nursing		
		ce comfort kit was reviewed			personnel will administer and		
	_	current expiration dates and			document only those medicati	ons	
		ne use of the comfort kit. The			which have been ordered by t		
		dicated there was no narcotic			physician, as a part of the plan		
		nedications were not at the			care and have been approved		
		armacy. The interventions			safe administration and monitor		
	_	sistent with the narrative			during a hospice visit. Hospice	-	
	section.				patients not residing in a nursi		

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

PRINTED: 11/20/2020 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETED	
		151599	B. WI	NG		10/01/	2020
				CTD FFT A	ADDRESS CITY STATE ZID COD		
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD	75	
DDEMIE	DUOCRIOE & DALL	LATIVE CARE INDIANALIO			N MERIDIAN STREET, SUITE 3	3/5	
PREMIE	R HOSPICE & PALI	LIATIVE CARE - INDIANA LLC		CARINE	EL, IN 46032		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROVIDED'S DI AN OF CODDECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE
					home will receive a comfort kit	as	
	Review of a skilled	nursing visit note dated			needed, based on their		
	9/14/20 from 10:02	p.m. to 10:34 p.m., the pain			comprehensive assessment. T	he	
		d the patient was not in pain.			comfort kit will contain emerge		
	The narrative note indicated a phone call was				medication(s) as ordered by th	-	
		aregiver reporting the patient			patient's physician or the Hosp		
		l bedsores. A prn (as needed)			Medical Director and will be	,,,,,	
		upon arrival, the patient was			maintained in the patient's hor	ne	
		and reported he/ she was			until orders are received for its		
		was inconsistent with the			use. After delivery: 1. The visit		
	- ·	pam and Roxanol was given.			hospice nurse will re-educate t	-	
		n was slightly red and warm.			patient and family on the use a		
		ks had reddened areas. No			storage of the comfort kit. The		
	_	ssments were documented.			hospice nurse will notify the		
		r was received. The note			patient's physician or Medical		
		t continued to be restless and			Director when there is a chang	ıo in	
		s contacted and orders were			the patient's condition that ma		
		morphine to 0.5 ml every 4			warrant use of one or more	у	
		m 2 mg every 4 hours. The			medications in the comfort kit	and	
		2 mg of Lorazepam and 1 ml of			will obtain specific orders for the		
	_	se also documented "prn dose			use.	ICII	
	_	re times." According to this			use.		
		d to follow the new verbal			How are you going to preven	•	
	orders provided by				the deficiency from recurring		
		Morphine and Lorazepam than			the future, even if already	, 111	
	what was prescribed				corrected?		
	what was prescribed				1.100% Focused chart audit	for	
	Review of a skilled	nursing visit note dated			90 days on Admissions, then	IUI	
		assessment indicated the			-	ortor	
		ose", answered of "no" to a			ongoing, 10% review each qua to ensure charting consistency		
	•						
	-	nxiety significantly affect the			between assessment, narrative		
	_	ed the patient's facial cues			and intervention documentatio	n,	
		alm expression and the			verbal medication orders are		
		elow their acceptable level for			included in the written plan of		
		al pain assessment. The			care, and charting of hospice		
		ated the patient was sleeping			nurse medication administration		
	_	nt was grimacing upon arrival,			includes time, drug, amount, a		
		tent with the assessments.			patient response after each do	se	
		ndicated that 2 mg of			given;		
	Lorazepam and 0.5	ml of morphine was given. The			2.100% Focused audit prior	to	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER	ì í	JILDING	00	COMPL	
		151599	B. W		10/01/202		
		10.000	1 "			.0,01/	
NAME OF P	PROVIDER OR SUPPLIEF	R			ADDRESS, CITY, STATE, ZIP COD		
					N MERIDIAN STREET, SUITE 3	375	
PREMIE	R HOSPICE & PAL	LIATIVE CARE - INDIANA LLC		CARME	EL, IN 46032		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	patient became unre	esponsive to touch and calling.			each Interdisciplinary Group		
	Orders were receive	ed to discontinue home			Meeting/IDG, then ongoing, 1	0%	
	medications and to schedule 2 mg of Lorazepam every 4 hours and Roxanol 0.5 ml every 4 hours.				each quarter to ensure chartir	ıg	
					consistency between		
	The assessment in t	the visit note was inconsistent			assessment, narrative, and		
	with the narrative a	and the skilled nurse failed to			intervention documentation, ve	erbal	
	follow physician or	ders and administered the			medication orders are include	d in	
	Lorazepam and Mo	orphine when the patient was			the written plan of care update	e;	
	not displaying any	signs of anxiety, restlessness,			and to ensure charting of hos	oice	
	nor pain.				nurse medication administration	on	
	Review of a skilled nursing visit note dated				includes time, drug, amount, a	and	
					patient response after each do	ose	
	9/16/20 at 10:29 a.r	m., the mental assessment			given;		
	indicated the patien	nt was "comatose", answered			3. Threshold for focused audit	s is	
	of "no" to a questio	n asking if anxiety			100% compliance with		
	significantly affect	the patient, indicated the			documentation of verbal order	and	
	patient was restless	, answered "no" when asked if			medication administration. If		
		re you uncomfortable because			threshold not met, Patient Car	e	
	of pain" and patient	t had no pain or pain does not			Managers will re-educate invo	lved	
	interfere with activi	ity or movement but did			staff, progressively, involving		
	indicate current sev	verity of verbal cues of			human resources for work pla	ns, if	
		ng, or moaning and the question			needed.		
	-	cues indicate "drawn around					
	_	The narrative note indicated			Who is going to be responsi	ble	
		ng to get up from the bed upon			for prevention above: i.e.,		
	_	tient was moaning and crying			director, supervisor, etc.?		
		ndicated that orders were			Patient Care Managers (PCM	s)	
	_	razepam and Morphine every			are responsible for audits and	staff	
		e patient was comfortable. The			correction. PCMs will be overs	seen	
		to document a consistent			by Director(s) of Clinical Servi	ces	
		ed to evidence a time, amount			(DCS) who report to the		
		inistered, and patient response			Administrator. The Administra	tor	
	after each dose of N	Morphine and Lorazepam			shall report Focus audit result	s to	
	given.				the QAPI Committee and ther	the	
					Governing Body for three		
		nursing visit note dated			consecutive quarters.		
		n., the pain assessment indicated					
	-	es were "relaxed and calm."			By what date are you going t	:0	
	The narrative note i	indicated the patient was in			have the deficiency correcte	d?	
	bed upon arrival th	ne patient had a calm facial	1		10/30/20		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	LETED
		151599	B. WI	NG		10/01/	
				_			
NAME OF P	PROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD		
					N MERIDIAN STREET, SUITE 3	375	
PREMIER	R HOSPICE & PAL	LIATIVE CARE - INDIANA LLC		CARME	EL, IN 46032		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	TC	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	IE	DATE
		ions were labored with			Nurses completed re-education	n by	
	accessory muscle use noted. The hospice nurse				10/30/20. By no later than	,	
	received an order to give "morphine and				10/30/20, the organization will		
		ery 15 minutes until			have implemented 100% Focu		
	_	epam 2 mg and Morphine 1 ml			audits on documentation of ve		
		a or mottling noted.			orders and medication	. =	
	_	d to 8. The narrative note			administration at Admission ar	nd	
	_	aken or orders obtained [verbal			Prior to each IDG.	•	
		ten]: Morphine 1 ml every 4					
		order written on 9/16/20 at					
		"Morphine 1 ml q [every] 4 hrs					
	_	ed Lorazepam Intensol 2 mg/					
	ml. The narrative note failed to be consistent on						
	what orders were re	eceived and written, failed to					
		nentation of terminal					
	· ·	to evidence the time, amount,					
		e after each dose of Morphine					
		en, and failed to indicate the					
		ons per minute prior to the					
	_	orazepam and Morphine every					
	15 minutes.	1 1					
	During an interview	y on 10/01/20 at 9:40 a.m., the					
	_	Celt that the morphine and					
		tient and how guilty they felt.					
	_	hey didn't receive any					
	_	e or side effects. The spouse					
		when the patient would have					
	1	s gave extra risperdal which					
	1	e spouse indicated the nurse					
		nen the patient was restless,					
	asked the patient if	•					
	_	e nurse instructed them to give					
		Roxanol to be given routinely.					
	_	f he/ she and the patient's					
	_	wn that Roxanol was morphine,					
		given the patient the					
	medication.	6 t					
	5. During an interv	riew on 9/30/20 at 4:55 p.m.,					

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Z26G11

Facility ID: 007409

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 151599		UILDING	instruction <u>00</u>	(X3) DATE : COMPL 10/01/	ETED
	PROVIDER OR SUPPLIER	LIATIVE CARE - INDIANA LLC		11550 N	NDDRESS, CITY, STATE, ZIP COD NMERIDIAN STREET, SUITE 3 L, IN 46032	75	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
ING	when asked if nurse administer more me restless/ actively dy Administrator stated orders" and the ager "comfort kits."	es have the ability to edications when the patient is ring than what is ordered, the d "No, we do not do standing ncy did not provide or order  ags were reviewed with the of Compliance, Director of		mo			BATE
	10/01/2020 at 1:20	ch, and Administrator on p.m., the Director of Nursing s were pretty restless, n was the standard					
L 0690 Bldg. 00	1861(r)(1) of the A accordance with the law, may order dru (2) If the drug order through electronic (i) It must be given nurse practitioner pharmacist, or phy (ii) The individual record and sign it	an as defined by section Act, or a nurse practitioner in the plan of care and State tugs for the patient. The ris verbal or given by or transmission- the only to a licensed nurse, (where appropriate), ysician; and receiving the order must immediately and have the the sign it in accordance with					
	Based on record rev failed to ensure nur- writing, signature w ordering physician	view and interview, the agency sing put verbal orders into vith date, and sent to the for signature for 2 out of 2 ewed of patients who recently	L 0	690	L 690 18.106(b) ORDERING ODRUGS (1) Only a physician as defined section 1861(r) (1) of the Act, or a nurse practitioner in accordance with plan of care and State law, may order drugs for the patient. (2) If the drug order is verifications of the patient of the	d by the	10/30/2020

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 10/01/2020 151599 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 11550 N MERIDIAN STREET, SUITE 375 PREMIER HOSPICE & PALLIATIVE CARE - INDIANA LLC CARMEL, IN 46032 (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 or given by or through electronic 1. The clinical record of patient #1 was reviewed transmissionon 09/30/20, and contained a plan of care for the It must be given only to (i) benefit period of 08/06/20 to 10/04/20, with a licensed nurse, nurse medication orders, included but not limited to, practitioner (where appropriate), Lorazepam 1 mg tablet every 4 hours as needed pharmacist, or physician; and for anxiety/ restlessness/ agitation and Morphine The individual receiving Concentrate 20 mg/ ml, give 0.25 ml every 4 hours the order must record and sign it as needed for severe pain/ air hunger. immediately and have the prescribing person sign it in Review of a death visit note dated 8/21/20, the accordance with State and narrative note stated "Patient found to be Federal regulations. extremely restless. Order received to increase dose and frequency of morphine and lorazepam, How are you going to correct required multiple doses of of [sic] Lorazepam and the deficiency? If already morphine with minimal effect. Call to [name of corrected, include the Medical Director] again and order given for Haldol following steps and state date 1 mg/hr .... " Review of the clinical record failed to of correction. evidence verbal orders that the nurse received From 10/14/20-10/30/20, all from the Medical Director. Nurses were In-serviced on the following Premier Hospice & During an interview on 09/30/20 at 9:20 a.m., the Palliative Care CHAP Hospice spouse indicated they observed between the hour Policy and Procedure Manual, of Employee A's arrival and the patient's death, 0.5 2020 policies: ml of Roxanol (no comfort to the patient), then a 1.IDENTIFICATION OF whole syringe of Roxanol (no comfort to the MEDICATION FOR patient), another whole syringe of Roxanol then ADMINISTRATION, Policy No. Lorazepam, (no comfort to the patient and family 2-005: member sent to drug store to pick up Haldol), 2.POSSESSION OF CERTAIN followed by another whole syringe of Roxanol and DRUGS AND OTHER Lorazepam. HEALTHCARE ITEMS- INDIANA, Policy No 2-005.B; Employee A was interviewed on 10/01/20 at 9:00 Involved staff acknowledged this a.m. When queried on the medication given and if in-service re-training in writing: the verbal order was written, Employee A stated Organization policies set forth that "multiple multiple" doses of meds were given, had the Hospice Nurse shall ensure many calls to the doctor and called the Patient orders will be present for nurse Care Manager and she didn't write the order since medication administration. Orders the patient was no longer "in the house." for the administration of medications must be given by a

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			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		A. BUILDING <u>00</u> B. WING			COMPLETED	
		151599	B. W	ING		10/01/	2020	
NAME OF P	ROVIDER OR SUPPLIER	3			ADDRESS, CITY, STATE, ZIP COD			
					N MERIDIAN STREET, SUITE 3	375		
PREMIER	R HOSPICE & PALI	LIATIVE CARE - INDIANA LLC		CARME	EL, IN 46032			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	,	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
		ord of patient #3, Election date			physician (or other authorized			
		ewed and included a plan of			independent practitioner) and			
		with a medication list of, but not			include patient name, patient			
	-	am 1 mg tablet every 4 hours as			identifier, the name of the			
	-	and restlessness and			medication, dosage, dilution,			
		l) concentrate 100 mg/5 ml (20			route, frequency of administra			
	- '	n 0.25 ml every 4 hours as			and rate of infusion. The indivi			
	needed for pain and	l shortness of breath.			receiving the order must recor			
	D: £1-:11 - 4				sign it immediately and have t	ne		
		nursing visit note dated orazepam and Roxanol was			prescribing person sign it in	loral		
		or restlessness. The note			accordance with state and fed	erai		
	_	at continued to be restless and			regulations.			
	•	as contacted and orders were			How are you going to preven	<b>.</b> +		
		e morphine to 0.5 ml every 4			the deficiency from recurring			
		am 2 mg every 4 hours. The			the future, even if already	,		
		2 mg of Lorazepam and 1 ml of			corrected?			
	_	rse also documented "prn dose			1.100% Focused chart audit	for		
	-	re times." Review of the clinical			90 days on Admissions, then	101		
		dence the written orders to			ongoing, 10% review each qua	arter		
	repeat the dosages g	given x 2.			to ensure verbal medication or			
					are included in the written plar	n of		
	Review of a skilled	nursing visit note dated			care;			
	9/16/20 at 10:29 a.r	m., indicated that orders were			2.100% Focused audit prior	to		
		razepam and Morphine every			each Interdisciplinary Group			
		e patient was comfortable.			Meeting/IDG, then ongoing, 10	ე%		
		cal record failed to evidence the			each quarter to ensure verbal			
	_	ve Lorazepam and Morphine			medication orders are included			
	every 15 minutes.				the written plan of care update			
					3.Threshold for focused aud	its is		
		nursing visit note dated			100% compliance with			
	•	., indicated the hospice nurse			documentation of verbal order			
		o give "Morphine and			compliance. If threshold not m	et,		
		5 minutes until comfortable.			Patient Care Managers will			
		nd Morphine 1 ml given x2. The			re-educate involved staff,	_		
		ated "Action taken or orders			progressively, involving human	a		
	-	ders must be written]:			resources for work plans, if			
		ry 4 hours. A physician order at 8:49 p.m. indicated			needed.			
		every] 4 hrs [hours],			Who is going to be reasonable	hlo		
	Morbine i ini d [	every   Time [moure],	1		Who is going to be responsil	JIE .	I	

Who is going to be responsible

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION (X3) DATE SI			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		151599	B. WI	NG		10/01/	2020
				_			
NAME OF P	ROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD		
					N MERIDIAN STREET, SUITE 3	575	
PREMIER	R HOSPICE & PALI	LIATIVE CARE - INDIANA LLC		CARME	EL, IN 46032		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DECLIDED IN AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	·	R LSC IDENTIFYING INFORMATION		TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			DATE
		epam Intensol 2 mg/ ml. The			for prevention above: i.e.,		
		to be consistent with what was			director, supervisor, etc.?		
		the visit note. (to give			Patient Care Managers (PCMs	s)	
		zepam every 15 minutes until			are responsible for audits and	,	
	comfortable).				correction. PCMs will be overs		
	comfortable).				by Director(s) of Clinical Service		
	3 During an interv	iew on 9/30/20 at 4:55 n m			(DCS) who report to the	JC3	
	3. During an interview on 9/30/20 at 4:55 p.m., when asked if nurses have the ability to administer more medications when the patient is				Administrator. The Administrat	tor	
					shall report Focus audit results		
		•			the QAPI Committee and then		
	restless/ actively dying than what is ordered, the Administrator stated "No, we do not do standing				Governing Body for three	u IC	
	orders."	140, we do not do standing			consecutive quarters.		
	orders.				consecutive quarters.		
	4 The above findir	ngs were reviewed with the			By what date are you going t	•	
		of Compliance, Director of			have the deficiency corrected		
	Nursing, Patient Ca	-			10/30/20.	4:	
	_	th, and Administrator on			Nurses completed re-educatio	n hv	
	_	p.m., in which no further			10/30/20. By no later than	ПБу	
	·	mentation was provided.			10/30/20, the organization will		
	information of doct	inicitation was provided.			have implemented 100% Focu		
					audits on documentation of ve		
					orders at Admission and Prior		
					each IDG.	ιο	
					each ibg.		
L 0696	418.106(e)(2)(i)(B	)				ļ	
L 0030		STORAGE DRUGS					
Bldg. 00							
Diag. 00	_	controlled drugs are first					
	ordered the hospid						
		ospice policies and				ļ	
		anaging the safe use and				ļ	
	•	lled drugs with the patient				ļ	
		and the family in a language				ļ	
		hey understand to ensure				ļ	
	·	are educated regarding the				ļ	
	sate use and disp	osal of controlled drugs;			1.000 140 100( )(0)(0)(0)		11/10/2020
			L 06	596	<b>L 696</b> 418.106(e)(2)(i)(B) LAB		11/12/2020
	Based on record rev	view and interview, the agency			DISPOSE STORAGE DRUGS	;	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		151599	B. W	ING		10/01/	2020
				CTREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	L				75	
DDEME	DUOCDIOE & DALL	LATIVE CARE INDIANALLO			N MERIDIAN STREET, SUITE 3	0/5	
PREMIER	R HOSPICE & PALI	LIATIVE CARE - INDIANA LLC		CARIME	EL, IN 46032		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE
	failed to ensure the	Interdisciplinary Group			[At the time when controlled di	rugs	
		n policies and procedures for			are first ordered the hospice	Ü	
		posal of controlled drugs with			must:]		
		er in a language and manner			(B) Discuss the hospice policie	es	
		I to ensure that the parties			and procedures for managing		
	-	of 3 patient records reviewed.			safe use and disposal of contr		
	(Patient #1)	F			drugs with the patient or	onou	
					representative and the family i	n a	
	Findings include:				language and manner that the		
	i mumgs meruuer				understand to ensure that the	-	
	Review of an agenc	y's document found within the			parties are educated regarding		
	admission folder tit	=			safe use and disposal of contr	-	
		11/17, stated " 1 The			drugs;	olica	
		rerbally discuss the policy in a			uiugs,		
	_	er that they understand to			How are you going to correc		
		osal medications Patient/			the deficiency? If already		
	_	ill be documented in the clinical			corrected, include the		
	-	patient death or when a			following steps and state dat		
		erwise no longer has a need			of correction.	.e	
		dications, the hospice nurse or			This area was not identified as		
		ospice staff will assist the			concern at the survey Exit	o a	
		spose of them or will instruct			Conference with the Organiza	tion	
		o dispose of them according to			From 10/10-10/12/20, all nurse		
		e will also provide information			were In-serviced on the follow		
		ail-back programs. 3. Drugs			Premier Hospice & Palliative (	Ŭ	
	will disposed of on				CHAP Hospice Policy and	oai C	
	will disposed of oil	Site			Procedure Manual, 2020 polic	ioc.	
	Review of a revised	policy titled "Home Use of			1.Home Use of Controlled	163.	
		ces Policy No. 2008.1" dated			Substances; Policy No. 2-008	).	
		2. The Admitting Nurse/ Case			2.Drug Disposal, Policy No		
	·	de a copy of the written			2.014g Disposal, Folicy No.	•	
		ures on the management of			Organization policies set forth	that	
		the patient/ representative and					
		a hospice patient no longer has			the Interdisciplinary Group sha discuss written policies and	A11	
		led substance, the Case				,d	
					procedures for the safe use ar		
	caregiver regarding	ct the patient and family/			disposal of controlled drugs wi		
	caregiver regarding	proper disposar.			the patient/caregiver in a langu	-	
	Davion of s	nalisy titlad "Dona Dia1			and manner that they understa		
		policy titled "Drug Disposal			The Admitting Nurse will provi	ue a	
	Policy No. 2-008.A	.1" dated 5/11/20, stated " 1.			copy of the written policy and		

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CENTERS FOR MEDICARE & MEDICAID SERVICES					OMB NO. 0938-039		
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETED	
		151599	B. W	ING		10/01/2020	
				CTREET	A DDDEGG CUTY CTATE TID COD		
NAME OF	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD N MERIDIAN STREET, SUITE 37	, E	
DDEMIE		LIATIVE CARE - INDIANA LLC			N MERIDIAN STREET, SUITE 37 EL, IN 46032	5	
FREIVIIE	R HUSPICE & PAL	LIATIVE CARE - INDIANA LLC		CARIVII	EL, IN 40032		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETION	i
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE	
	The Admitting Nur	rse/ Case Manager will provide			procedure on the management	of	
	a copy of the writte	en policies and procedures on			controlled drugs to the		
	the management ar	nd disposal of drugs, including			patient/representative and famil	y.	
	controlled drugs to	the patient/ representative and			The person responsible for drug	3	
	family. The Admit	ting Nurse/ Case Manager will			disposal will be identified. Per		
	verbally discuss the	e policy in a language and			policy, the Admitting Nurse will		
	manner that they us	nderstand to ensure the safe			verbally discuss the policy in a		
	use and disposal of	medication, including			language and manner that they		
	controlled drugs.	The Admitting Nurse/ Case			understand to ensure the safe		
	manager will docum	ment in the clinical record that			use/disposal of controlled drugs	š.	
	the patient/ Represe	entative and family have			The responsible individual will		
	received a copy of	the policies and procedures. 2.			acknowledge this education by		
	The Admitting Nur	rse/ Case Manager will			signing the policy that is provide	∍d	
		cal note who is responsible for			as part of the Hospice Patient		
	the disposal of the	patient's drugs 5. The nurse			Admission Booklet. A copy of th	ne l	
	will document in the	ne medical record: disposal			signed policy will be uploaded to	0	
		the patient/ family's verbal			the chart. In clinical notes, Nurs	es	
	_	understanding of the			shall document the patient or		
	disposal/ process as	nd their responsibility to			caregivers understanding of this	3	
	properly dispose of	f the unneeded medication(s)			policy at admission and any tim	е	
	Disposal of Contro	lled Substances - Family 1.			the patient or caregiver needs		
	When a hospice pa	tient no longer has a need for a			re-education. When a hospice		
	controlled substance	ee, the Case Manager will			patient no longer has a need for	ra	
		and family/ caregiver			controlled substance, the nurse	:	
	regarding proper di	isposal of the drugs 2. The			will re-instruct the patient and		
	_	Case Manger will document in			family/caregiver regarding prope		
		that the patient and family/			disposal. The nurse will docume	ent	
		en the written policies and			in the medical record: disposal		
	_	naging controlled drugs and			instructions given, the		
		sal of medication and took			patient/family's verbal response	as	
	responsibility to do	so "			to their understanding of the		
					disposal process and their		
	-	#1's clinical record, revealed a			responsibility to properly dispos	•	
		f 08/06/2020, and a plan of care			of the unneeded medication(s).	If	
		od of 08/06/2020 to 10/04/20,			the patient/family refuses the		
		led nursing 3 times a week for 2			disposal/destruction of		
	weeks then 2 times	a week for 7 weeks.			medications, this will be reporte	:d	
					to the patient's physician and		
	Review of admission	on note dated 8/6/20 and the			clinical supervisor and		

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following skilled nursing visit notes dated 8/7, 8/8,

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documented in the patient record.

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STATEMEN	TATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>			COMPLETED	
		151599	B. W	ING		10/01/2	2020
		<u> </u>		CTREET	ADDRESS CITY STATE ZIR COD		
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD	275	
DDEMIE	D LICEDICE & DAI	LIATIVE CARE INDIANALIC			N MERIDIAN STREET, SUITE (	3/3	
PREMIE	R HUSPICE & PAL	LIATIVE CARE - INDIANA LLC		CARIVIE	EL, IN 46032		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATF.	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	8/9, 8/10, 8/13, 8/1	7, 8/21/2020, failed to evidence			How are you going to prever	nt	
	that the safe use an	d management of controlled			the deficiency from recurring	g in	
	substances was discussed and the patient/ family				the future, even if already		
	verbal response as	to their understanding.			corrected?		
					1.100% focused chart audit	for	
	During an interview	v on 09/30/20 at 9:20 a.m., the			90 days on home patient		
	spouse indicated sh	e thought the hospice was			Admissions, then ongoing, 10	%	
	going to take the m	edications or destroy after the			each quarter to ensure		
	patient died. The s	pouse indicated a family			documentation of signed polic	.y	
	member, who was	a sheriff, took the medications			and that patients and caregive	ers	
	and had them destr	oyed. The death visit note			understand the drug disposal		
	dated 8/21/2020 fai	iled to evidence this			policy per charted education.		
	information.				Nurses shall securely submit	a	
					copy of signed document to the	ie	
		nterviewed on 10/01/20 at 9:00			office for chart attachments.		
		that the patient's medications			2.100% Focused audit prior	to	
	1	during the death visit for she			each home patient		
		go back in and that the DON			Interdisciplinary Group		
		Γhe death visit note dated			Meeting/IDG, then ongoing, 1	0%	
	8/21/2020 failed to	evidence this information.			each quarter to ensure and th	at	
					patients and caregivers		
		were reviewed with the			understand the drug disposal		
	_	of Compliance, Director of			policy per charted re-educatio		
	Nursing, Patient Ca	_			and that refusals are reported		
		ch, and Administrator on			the Clinical Supervisor/Desigr	I .	
		p.m., the Director of Nursing			3.Threshold for focused aud	lits is	
		ware of the employee not			100% with evidence		
	destroying patient #	#1's medications.			patient's/representative's		
					understanding of drug dispose	I .	
					threshold not met, Patient Car		
					Managers will re-educate invo	lved	
					staff, progressively, involving		
					human resources for work pla	ns, if	
					needed.		
					Who is going to be responsi	ble	
					for prevention above: i.e.,		
					director, supervisor, etc.?		
					Patient Care Managers (PCM		
	1		1		are responsible for audits and	staff	

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

PRINTED: 11/20/2020 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 151599	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 10/01/2020
	ROVIDER OR SUPPLIER	LIATIVE CARE - INDIANA LLC	11550	ADDRESS, CITY, STATE, ZIP COD N MERIDIAN STREET, SUITE 3 EL, IN 46032	375
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				correction. PCMs will be overs by Director(s) of Clinical Servi (DCS) who report to the Administrator. The Administrator. The Administration shall report Focus audit result the QAPI Committee and their Governing Body for three consecutive quarters.  By what date are you going to have the deficiency corrected 11/12/20.  Nurses completed re-education 11/12/20. By no later than 11/12/20, the organization will have implemented 100% Focus audits on drug disposal policy signed and education documentation at Admission at Prior to each IDG.	tor s to n the  to d? on by
L 0697 Bldg. 00	[At the time when ordered the hospid (C) Document in that the written po	STORAGE DRUGS controlled drugs are first			
	Based on record reversal failed to ensure the policy and documer record the written pure managing controlled the patient/ caregive patient records revied document the name	riew and interview, the agency clinician followed agency ated in the patient's clinical colicies and procedures for d drugs was discussed with the for 2 of 3 (Patient #1, 2) as ewed, and failed to ensure to of the drug, amount, and upon death for 1 of 2 (Patient	L 0697	L 697 418.106(e)(2)(i)(C) LAB DISPOSE STORAGE DRUGS [At the time when controlled d are first ordered the hospice must:] (B) Discuss the hospice policical and procedures for managing safe use and disposal of controlled with the patient or representative and the family	es the rolled

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 151599		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING  (X3) DATE SURVEY  COMPLETED  10/01/2020			ETED		
NAME OF I	PROVIDER OR SUPPLIE	3	•		ADDRESS, CITY, STATE, ZIP COD N MERIDIAN STREET, SUITE (	75	
PREMIE	R HOSPICE & PAL	LIATIVE CARE - INDIANA LLC			EL, IN 46032	575	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECT			(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	+	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	#3) closed records	reviewed.			language and manner that the	-	
	F' 1' ' 1 1				understand to ensure that the		
Findings include:				parties are educated regarding	-		
	1 Daview of an ac	ency's document found within			safe use and disposal of conti	olled	
		er titled "Drug Disposal			drugs;		
		1 11/17, stated " 1 The			How are you going to correct	•	
		verbally discuss the policy in a			the deficiency? If already		
		er that they understand to			corrected, include the		
		oosal medications Patient/			following steps and state da	te	
	family education will be documented in the clinical record 2. Upon patient death or when a hospice patient otherwise no longer has a need for one or more medications, the hospice nurse or				of correction.		
					This area was not identified as	s a	
					concern at the survey Exit		
					Conference with the Organiza	tion.	
		ospice staff will assist the			From 10/10-10/12/20, all nurs	es	
		ispose of them or will instruct			were In-serviced on the follow	•	
		to dispose of them according to			Premier Hospice & Palliative (	Care	
		e will also provide information			CHAP Hospice Policy and		
		nail-back programs. 3. Drugs			Procedure Manual, 2020 polic	ies:	
	will be disposed of	on site "			1.Home Use of Controlled		
	2 D : C	' 1 1' ('4 1 HTT - TT - C			Substances; Policy No. 2-00		
		ised policy titled "Home Use of ces Policy No. 2008.1" dated			2.Drug Disposal, Policy No	٠.	
		2. The Admitting Nurse/ Case			<b>2-008.A.</b> Organization policies set forth	that	
		de a copy of the written			the Interdisciplinary Group sha		
		ures on the management of			discuss written policies and	ali	
		the patient/ representative and			procedures for the safe use a	nd	
		a hospice patient no longer has			disposal of controlled drugs w		
		led substance, the Case			the patient/caregiver in a lang		
	Manager will instru	act the patient and family/			and manner that they underst	•	
	caregiver regarding				The Admitting Nurse will provi		
					copy of the written policy and		
		ised policy titled "Drug			procedure on the managemer	nt of	
		o. 2-008.A.1" dated 5/11/20,			controlled drugs to the		
		Admitting Nurse/ Case			patient/representative and fan	•	
		de a copy of the written			The person responsible for dr	-	
		ures on the management and			disposal will be identified. Per		
		ncluding controlled drugs to			policy, the Admitting Nurse wi		
		ntative and family. The			verbally discuss the policy in a		
	Admitting Nurse/ (	Case Manager will verbally			language and manner that the	eV.	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 10/01/2020 151599 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 11550 N MERIDIAN STREET, SUITE 375 PREMIER HOSPICE & PALLIATIVE CARE - INDIANA LLC CARMEL, IN 46032 (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 discuss the policy in a language and manner that understand to ensure the safe they understand to ensure the safe use and use/disposal of controlled drugs. disposal of medication, including controlled The responsible individual will drugs. The Admitting Nurse/ Case manager will acknowledge this education by document in the clinical record that the patient/ signing the policy that is provided Representative and family have received a copy of as part of the Hospice Patient the policies and procedures. 2. The Admitting Admission Booklet. A copy of the Nurse/ Case Manager will document in a clinical signed policy will be uploaded to note who is responsible for the disposal of the the chart. In clinical notes, Nurses patient's drugs ... 5. The nurse will document in shall document the patient or the medical record: disposal instructions given, caregivers understanding of this the patient/ family's verbal response as to their policy at admission and any time understanding of the disposal/ process and their the patient or caregiver needs responsibility to properly dispose of the re-education. When a hospice unneeded medication(s) ... Disposal of Controlled patient no longer has a need for a Substances - Family 1. When a hospice patient controlled substance, the nurse no longer has a need for a controlled substance, will re-instruct the patient and the Case Manager will instruct the patient and family/caregiver as needed family/ caregiver regarding proper disposal of the regarding proper drug disposal. drugs ... 2. The Admitting Nurse/ Case Manger The nurse will document in the will document in the clinical record that the patient medical record: disposal and family/ caregiver were given the written instructions given, the policies and procedures for managing controlled patient/family's verbal response as drugs and discussed the disposal of medication to their understanding of the and took responsibility to do so. 3. The hospice disposal process and their nurse, social worker, or chaplain attending the responsibility to properly dispose death of a hospice patient will inform the family/ of the unneeded medication(s). If caregiver of their responsibility to dispose of all the family/caregiver requests the patient's prescribed medications and will assistance with the disposal, the document this instruction in a clinical note and hospice nurse will observe and include the name of the drug, amount, method of provide verbal assistance as the disposal, and who witnessed the disposal .... " family/caregiver properly disposes of the prescribed medication(s). 4. Review of patient #1's clinical record revealed a The disposal will be documented start of care date of 08/06/2020, and a plan of care in a clinical note. Documentation for the benefit period of 08/06/20 to 10/04/20, with will include the name of the drug, orders for skilled nursing 3 times a week for 2 amount, method of disposal, the weeks then 2 times a week for 7 weeks. person disposing of the drug, and the role of the hospice employee Review of admission note dated 8/6/20 and the in assisting with the disposal. If

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		151599	B. W	ING		10/01/	/2020
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	R			N MERIDIAN STREET, SUITE 3	375	
PREMIE	R HOSPICE & PALI	LIATIVE CARE - INDIANA LLC			EL, IN 46032	37 3	
1 IXEIVIIEI	(11001 102 01 7121			O/ ti tiviL			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		ursing visit notes dated 8/7, 8/8,			the patient/family refuses the		
		7, 8/21/2020, failed to evidence			disposal/destruction of		
		olicy was adhered to by failing			medications, this will be report	ted	
		ponsible person for the			to the patient's physician and		
		al instructions given, patient/			clinical supervisor and		
		nse as to their understanding,			documented in the patient rec		
	as well as observing the medications being				How are you going to preven		
	destroyed upon death on 8/21/2020.				the deficiency from recurring	gin	
	D : 00/20/20 00 20				the future, even if already		
During an interview on 09/30/20 at 9:20 a.m., the				corrected?			
spouse stated she thought the hospice was going				1.100% focused chart audit	for		
to take the medications or destroy after the patient died. The spouse indicated a family member, who				90 days on home patient	0/		
	_				Admissions, then ongoing, 10	%	
	· ·	the medications and had them			each quarter to ensure		
	-	th visit note dated 8/21/2020			documentation of signed polic	y,	
	failed to evidence the	nis information.			that patients and caregivers		
	E1 A '	4ii 10/01/20 -4 0:00			understand the drug disposal		
		terviewed on 10/01/20 at 9:00			policy per charted education,		
		t the patient's medications			that disposal charting includes		
	-	during the death visit for she			name of the drug(s), amount(s	•	
		go back in and that the DON			method of disposal, the person		
		The death visit note dated evidence this information.			disposing of the drug, and the		
	8/21/2020 failed to	evidence this information.			of the hospice employee. Nurs		
	5 Parious of notion	nt #2's clinical record revealed a			shall securely submit a copy of		
	-	109/10/2020, and a plan of care			signed disposal policy docume to the office to be viewed in ch		
		od of 9/10/2020 to 12/08/2020,			attachments.	ıaıı	
		led nursing 3 times a week for 1				to	
		ek for 1 week, 3 times a week for			2.100% Focused audit prior each home patient	i.o	
	1	ne a week for 1 week.			Interdisciplinary Group		
	11 weeks, then 1 th	ne a week for 1 week.			Meeting/IDG, then ongoing, 10	<b>n</b> %	
	Review of the start	of care visit note dated 9/10/20			each quarter to ensure and the		
					patients and caregivers	<b>~</b> .	
	and the following skilled nursing visit notes dated 9/11, 9/12, 9/13, 9/14, 9/16, 9/18, 9/19, 9/20, 9/21,				understand the drug disposal		
	9/11, 9/12, 9/13, 9/14, 9/16, 9/18, 9/19, 9/20, 9/21, 9/23, 9/25, 9/28, and 9/30/20, failed to evidence the				policy per charted re-education	n.	
		s adhered to by failing to			drug disposal charting include		
		nsible person for the disposal,			the name of the drug(s),	-	
	•	tions given, patient/ family			amount(s), method of disposa	ı	
	-	to their understanding.			the person disposing of the dr		
	. Stour response us t	and and summing.			and the role of the hospice	ч <del>у</del> ,	

STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	r í	JILDING	00	COMPL	
		151599	B. W	ING		10/01/	2020
		<u> </u>	<u> </u>	CTDEET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	8			N MERIDIAN STREET, SUITE :	275	
PREMIE	R HOSPICE & PALI	LIATIVE CARE - INDIANA LLC			EL, IN 46032	313	
I IXLIVIILI	THOSI ICE &T ALI	LIATIVE CAILE - INDIANA ELC		CAINIL			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE.	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		ord of patient #3, Election date			employee, and that refusals to		
		ed a death visit note on 9/17/20,			dispose of unneeded narcotic	s are	
		nis writer witnessed [name of			reported to the Clinical		
	-	stroy medications." The			Supervisor/Designee;		
		ocument the name of the drug,			3.Threshold for focused aud		
	amount, and method	d of disposal.			100% with charted drug dispo		
	7 During an inter-	iovy on 9/30/20 at 4:55 n m			If threshold not met, Patient C		
	7. During an interview on 9/30/20 at 4:55 p.m., when queried on who was responsible for the				Managers will re-educate invo	oivea	
	when queried on who was responsible for the destruction of medications after death, especially				staff, progressively, involving human resources for work pla	nc if	
	narcotics, the Administrator stated that it was				needed.	115, 11	
	their policy that the clinician was not allowed to				necucu.		
	destroy the narcotics but they can witness the				Who is going to be responsi	hle	
		amily, but the family has a			for prevention above: i.e.,	5.0	
	-	ney do refuse, the clinician on			director, supervisor, etc.?		
		locument the refusal and			Patient Care Managers (PCMs)		
	notify the physician				are responsible for audits and staff		
	, , ,				correction. PCMs will be over		
	8. The above findir	ngs were reviewed with the			by Director(s) of Clinical Servi	ces	
	Regional Director o	of Compliance, Director of			(DCS) who report to the		
	Nursing, Patient Ca	re Manager of the			Administrator. The Administra	tor	
	Bloomington Branc	h, and Administrator on			shall report Focus audit result	s to	
	10/01/2020 at 1:20	p.m., in which no further			the QAPI Committee and ther	the	
	information or docu	mentation was provided.			Governing Body for three		
					consecutive quarters.		
					By what date are you going		
					have the deficiency correcte	d?	
					11/12/20.		
					Nurses completed re-education	on by	
					11/12/20. By no later than		
					11/12/20, the organization wil		
					have implemented 100% Foc audits on drug disposal at	us	
					Admission and Prior to each I	DG	
					Admission and Filor to each I	DG.	
S 0000							
Bldg. 00							

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 151599		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 10/01/2020		
	ROVIDER OR SUPPLIER	LIATIVE CARE - INDIANA LLC		11550 N	ADDRESS, CITY, STATE, ZIP COD N MERIDIAN STREET, SUITE 3 EL, IN 46032	375	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
	Deemed Hospice pr Survey Dates: 09/3 Complaint #: IN002	0 to 10/01/2020 337284: Substantiated. and unrelated to the d.	S 00	000	S 000 This Plan of Correction constitutes PREMIER HOSPIC & PALLIATIVE CARE - INDIA! LLC's written allegation of compliance for the deficiencies cited. However, submission of Plan of Correction is not an admission that a deficiency ex or that one was cited correctly This Plan of Correction is submitted to meet requirement established by state and/or fee law.	NA s this ists	
S 0515 Bldg. 00	(4) Choose his or  Based on record rev failed to ensure pati right to choose his o of 4 interviews cond  Findings include:  1. Review of the ag "Hospice Election o a section titled "Rig physician" which in have a right to choo oversee my care  2. Review of the ad contained the patien titled "Decision Ma indicated the patien attending physician"	right to the following:] her attending physician; riew and interview, the agency ents were informed of their or her attending physician in 3 ducted. (Patients #1, 3, 9)  gency's document titled of Benefit Statement" revealed that to choose an attending dicated "I understand that I se my attending physician to	S 03	515	S 515 418.52(c)(4) RIGHTS O THE PATIENT [The patient has a right to the following:] (4) Choose his or he attending physician. How are you going to correct the deficiency? If already corrected, include the following steps and state dat of correction. From 10/8/20-10/9/20, all Community Liaison staff were In-serviced on the following Premier Hospice & Palliative C CHAP Hospice Policy and Procedure Manual, 2020 polic and rules:  1.ADMISSION CRITERIA AI PROCESS- INDIANA, Policy N 1-009; 2.HOSPICE ELECTION	er t ce care ies,	10/30/2020

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PRINTED: 11/20/2020 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 151599		l í	JILDING	onstruction 00	(X3) DATE COMPL 10/01/	ETED	
	PROVIDER OR SUPPLIEF	LIATIVE CARE - INDIANA LLC		11550 N	ADDRESS, CITY, STATE, ZIP COD N MERIDIAN STREET, SUITE 3 EL, IN 46032	375	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	3. Review of the agency's active client roster and discharge report that was provided on 09/30/2020, revealed 25 out of 30 active client roster and 20 out of 27 discharged patients had the hospice medical director as their primary physician.  4. The family member for patient #1 was interviewed on 09/30/20 at 9:20 a.m., and indicated while the patient was at the hospital, a hospice liaison visited and was told that they could not use their own MD and had to use the hospice Medical Director, as well as what they could and could not do, would "get rid" of the patient's medications and provide only comfort medications, no emergency room visits, no reaching to their primary care physician, and they could only reach out to the hospice physician.  5. The family member for patient #3 was interviewed on 10/01/20 at 9:40 a.m., and indicated during their admission, they were not provided with an option to keep their primary care physician but was instructed that the Medical Director would be their primary physician while on service.				STATEMENT, Policy No. 1-03 3.§418.52 Condition of Participation: Patient's Rights. Involved staff acknowledged the in-service re-training in writing Organization policies set forthe the patient has the right to be informed of his or her rights, at the hospice shall protect and promote the exercise of these rights. The patient has the right choose his or her attending physician and to have this per involved in their medical care hospice settings as long as the attending physician, in turn, undertakes to provide care for patient.  How are you going to prevent	his that  nd  t to  son in all e	
					the deficiency from recurring the future, even if already corrected? 1.100% focused chart audit 90 days on Admissions, then ongoing, 10% review each qua to ensure patients were inform	<b>g in</b> for arter	
	interviewed on 09/3 indicated during the provided with an op physician. When as were signed indicat patient rights and if full detail, the family who had them sign reviewed "main top gave them "stuff to	aber for patient #9 was 80/2020 at 4:43 p.m., and eir admission, they were not oftion to keep their primary care sked about the consents that ing their understanding of these rights were explained in ly member indicated the person the admission documents of the person that are person that ar			they have the right to choose to attending physician, as evidently patient or representative placing their initials next to the statement "YOU HAVE THE RIGHT TO: choose your attent physician" education on Page of the Patient Hospice Admission Booklet. Nurses shall securely submit a copy of the initialed protection to the office for chart attachmental Nurses shall report any Complaints related to Liaison	their aced ding e 14 bion	

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PRINTED: 11/20/2020 FORM APPROVED OMB NO. 0938-039

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	r í		NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPL	
		151599	B. W	ING		10/01/	/2020
	PROVIDER OR SUPPLIER		•	11550 N	ADDRESS, CITY, STATE, ZIP COD N MERIDIAN STREET, SUITE 3	375	
PREMIE	R HUSPICE & PALI	LIATIVE CARE - INDIANA LLC		CARIVIE	EL, IN 46032		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY)		DATE
	~	iew on 09/30/2020 at 4:55 p.m., f patients are allowed to			misinformation/misunderstand		
	•	nysician for hospice services,			to the agency Administrator w		
	-	tated patients could "elect			will interview the beneficiary a caregivers;	iu/oi	
	who-ever, 100% the	-			2.Patient Care		
					Managers/Designee(s) shall p	hone	
	8. The above findings were reviewed with the				survey all new Admissions to		
	Regional Director of Compliance, Director of				verify patient/representative		
	Nursing, Patient Care Manager of the				understanding of education or	i	
	Bloomington Branch, and Administrator on				Patient's Rights including patie		
		p.m in which they responded			right to choose their attending		
	_	regivers signed the consents			physician;		
	•	erefore, they knew they had a			3.Thresholds for focused au		
		d how certain they were that			and phone surveys are 100%		
		liaisons were thoroughly ghts and consents upon			evidence patients/representati		
		out of 4 people indicated they			were informed and understood their right to choose their	1	
		use the Medical Director,			attending physician. If thresho	ld	
	they had no other re				not met, Patient Care Manage		
					will re-educate involved staff,		
					progressively, involving human	า	
					resources for discipline, if nee		
					Who is going to be responsil	ble	
					for prevention above: i.e.,		
					director, supervisor, etc.?		
					Patient Care Managers (PCM		
					are responsible for audits, sur	-	
					and staff correction. PCMs wil		
					overseen by Director(s) of Clir		
					Services (DCS) who report to Administrator. The Administra		
					shall report Focus audit and	.01	
					Patient survey results to the Q	ΑΡΙ	
					Committee and then the Gove		
					Body for three consecutive	9	
					quarters.		
					•		
					By what date are you going t		
	i e		1	J	have the deficiency corrected	a (	1

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 151599		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 10/01/2020	
	ROVIDER OR SUPPLIER	LIATIVE CARE - INDIANA LLC	11550	ADDRESS, CITY, STATE, ZIP COD N MERIDIAN STREET, SUITE : EL, IN 46032	375
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				10/30/20. Liaisons completed re-educat by 10/9/20. Nurses completed education on their role in compliance by 10/30/20. By n later than 10/30/20, the organization will have implem 100% Focus audits and Surve	o ented
S 0525 Bldg. 00	into consideration (1) The nature and admission (includiobjective data and Based on record reversalled to ensure concomplete and includiocation of diminish medical histories/manti-anxiety, muscle medications, as well measurements were reviewed. (Patient Findings include:  1. Review of an age "Comprehensive Astend 5/11/20, indication (1) The property of the propert	the following factors: d condition causing ng the presence or lack of subjective complaints).  Triew and interview, the agency reprehensive assessments were ded assessments of bruising, and breath sounds, past medication use of anti-seizure, relaxant, and pain as ensuring wound accurate for 2 of 3 records #1, 2)	S 0525	S 525 18.54(c)(1) CONTENT COMPREHENSIVE ASSESSMENT The comprehensive assessments take into consideration to following factors:  (1) The nature and condition causing admission (including presence or lack of objective and subjective complaints).  How are you going to correct the deficiency? If already corrected, include the following steps and state datof correction.  From 10/14/20-10/30/20, all	ent he the data
	comprehensive asse	ssment, all baseline data and mation will be documented in			

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STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		151599	B. W	ING		10/01/	2020
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	S.			N MERIDIAN STREET, SUITE 3	375	
PREMIER	R HOSPICE & PALI	LIATIVE CARE - INDIANA LLC			EL, IN 46032	-	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID			(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
TAG	,	LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	IE	DATE
		y 4. Skin Integrity E.			Premier Hospice & Palliative (	Care	
		cerbating factors for physical			CHAP Hospice Policy and		
	_	rent treatment and patient			Procedure Manual, 2020 police	ies,	
	response to that trea	atment. I. A physical			and wound assessment and c		
	assessment, includin	ng skin N. Patients past			guidelines:		
	and present medical	and psychiatric history			1.COMPREHENSIVE		
	including any pertinent diagnosis and any				ASSESSMENT, Policy No. 1-0	014	
	co-morbid conditions "				2.PAIN ASSESSMENT, Poli	су	
					No. 1-018;		
	2. According to an article titled "Table 2,				3.WOUND CARE, Policy No	٠.	
[National Pressure Ulcer Staging System] at					2-035.A;		
	•	m.nik.gov, described a deep			4.SKIN AND WOUNDCARE		
	tissue injury as a "pressure-related injury to				QUICK REFERENCE/GUIDEI	_INE;	
		s under intact skin Initially,			National Pressure Ulcer Advis	-	
		he appearance of a deep			Panel (NPUAP) Staging Syste		
		naroon localized area of			Involved staff acknowledged to		
		in or blood-filled blister due to			in-service re-training in writing		
	-	ng soft tissue from pressure			Organization policies set forth	that	
		tage 2 pressure wound is			complete comprehensive		
	_	ial thickness loss or dermis			assessment includes		
		low open ulcer with a red, pink			assessments of bruising, local	ion	
		slough. May also present as			of diminished breath sounds,		
		ptured serum-filled blister. or dry shallow ulcer without			acceptable pain range, past	_	
		A Stage 3 pressure wound is			medication histories/medication		
		thickness tissue loss.			use of anti-seizure, anti-anxiet muscle relaxant, as well as	у,	
		ay be visible, but bone,			ensuring wound measuremen	te	
		re not exposed. Slough may			are accurate and wounds are	.J	
	· ·	not obscure the depth of			staged according to the NPUA	·Ρ	
	•	clude undermining and			Staging System. The hospice		
		e 4 pressure wound is			conduct and document in writi		
		hickness tissue loss; extensive			patient-specific comprehensive	•	
		posed bone, tendon or			assessment that identifies the		
		eschar may be present on some			patient's need for hospice care		
	parts of the wound l				and services, and the patient's		
	-	nneling. An Unstageable			need for physical, psychosocia		
		as a "full thickness tissue loss			emotional, and spiritual care.		
	in which actual dep	th of the ulcer is completely			assessment will include all are		
	obscured by slough	(yellow, tan, gray, green, or			of hospice care related to the		
	brown) and / or escl	har (tan, brown or black) in the			palliation and management of	the	
1			1				

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		151599	B. W	NG		10/01/	2020
				CTREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	8				75	
DDEME	DUOCDIOE & DALL	LIATIVE CADE INDIANALIA			N MERIDIAN STREET, SUITE 3	175	
PREMIE	R HOSPICE & PALI	LIATIVE CARE - INDIANA LLC		CARIME	EL, IN 46032		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	rc	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	i E	DATE
	wound bed. Until e	enough slough and/ or eschar			terminal illness and related		
		se the base of the wound, the			conditions. During the		
	-	e cannot be determined "			comprehensive patient		
					assessment, all baseline data	and	
	3. Review of clinic	al record #1, Election date of			other relevant information will		
		ed the patient had bruising. The			documented in the patient's		
	assessment failed to	-			clinical record, including at lea	st	
		eation of the bruises.			the following information, as		
	. ,				relevant:		
	4. The clinical reco	ord for patient #2, Election date			A. An assessment of pain,		
	9/10/20, included history and physical from an				including the origin, location,		
	entity dated 8/14/20, which stated the patient has				duration, severity, and relief		
	a history of C6 spinal cord injury after a motor				measures.		
	vehicle accident in 2002 that resulted in the				[Nurses will document pain an	d	
		paraplegic, has sacral/ ischial			symptom assessments and	<b>-</b>	
	-	The patient was admitted prior			reassessments as required. W	hen '	
		on for sepsis related to wound			pain is identified, a more		
	_	ient underwent debridement		comprehensive pain assessment			
	_	py. The patient returned to			will be completed. Pain	5110	
		unresponsiveness and fever.			assessments will facilitate regu	ılar	
	_	ated again for recurrent sepsis			reassessment and follow-up by		
	_	g 3 seizures during their			clinicians.]	y	
	hospital stay.	8			1.B. An assessment of		
					severity of secondary sympton	ns	
	The clinical record	also contained notes from a			such as:	,	
		lity that the patient was sent to			1.1. Dyspnea, nausea, vomit	tina.	
	_	for wound treatment with a			constipation, respiratory distre		
	•	of device that decreases air			and nutritional status	,	
		and to help it heal), IV			2.2. Restlessness, anxiety,		
	-	otics for sepsis, and seizures.			emotional distress		
		ated the patient's sacral wound			3.3. Sleep Disorders		
		om 7 to 10 cm (centimeter) due			4.4. Skin Integrity		
		sing further infection to the			5.5. Confusion		
		note also indicated the patient			1.C. An assessment of th	e	
		an anxiety disorder. On 9/1,			need for a bowel regimen, esp		
	_	he patient had a deep tissue			when the patient is prescribed		
		eel possibly measuring 2.6 x 5			opioids.		
		wound to the right trochanter			2.D. Nature and condition	1	
		0.1 cm, left heel measuring was			causing admission	•	
		tageable deep tissue injury			3.E. Alleviating and		
	acserioca as an uns	angenore deep assue mjury	1		J.L. Allevialing and		

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		151599	B. W	ING		10/01/	/2020
		l		STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	ROVIDER OR SUPPLIER	8			N MERIDIAN STREET, SUITE 3	R75	
DDEMIE	2 HUSDICE 8 DVI I	LIATIVE CARE - INDIANA LLC			N MERIDIAN STREET, SUITE S EL, IN 46032	)   3	
I IXLIVIILI	CITOOL OL OL ALI	LIVITAL CAIL - INDIANA ELO		OAINIE	-L, IIV 70002		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	-	m, Stage IV left trochanter			exacerbating factors for physic	cal	
		x 0.4 cm on 8/28/20. During the			symptoms		
		atient had critical labs and			Effectiveness drug therapy		
		tment and hospice was			2. Unwanted side and toxic ef	fects	
	presented.				3. Drug interactions (actual or		
					potential)		
	_	of care for the benefit period of			4. Duplicate drug therapy		
	09/10/20 to 12/8/20. The medication list on the				F. Current treatment and patie	ent	
	plan of care indicated the patient was prescribed				response to that treatment		
	and taking Alprazolam (Xanax) 0.5 mg (milligrams)				G. An assessment of the patie		
	-	eded for anxiety, Baclofen 20			response to palliative treatmer		
mg twice a day for muscle relaxant, levetiracetam					H. An assessment of the patie		
	500 mg and Vimpat 100 mg twice a day for				well-being, comfort and dignity		
	· ·	5 mg-325 mg tablet every 6			throughout the dying process.		
	hours as needed for	pain.			I. A physical assessment,		
					including blood pressure,		
		of care comprehensive			temperature, pulse, respiration	٦,	
		10/20, failed to include an			skin, and other relevant data		
		ge. The assessment failed to			related to pertinent physical		
	-	ation/ assessment of the			findings and the patient's term	inal	
	-	nti-anxiety medication, muscle			illness		
		re medication, pain medication,			J. Imminence of death		
	-	trochanter. Review of the			K. Patient's functional status		
		indicated the patient had a			including, but not limited to, th		
		e left greater trochanter that			degree of self-care and the an		
	` '	3.5 (W) x 0.5 (D) centimeters			and level of assistance neede	d	
	* **	und was stage 4 wound that			L. Patient's cognitive status		
		1.5 cm; and a stage 2 wound to			including the ability to underst		
		easured 7.6 x 7.6 x 0.1 cm. The			and participate in his or her ov		
		ated the right heel was			care Complication and risk fac	ctors	
	unblancheable and				that affect care planning		
		include a full assessment			M. Complication and risk facto		
		of the right heel, failed to			that affect care planning, inclu	ding	
	identify the left heel accurately according to				drug diversion		
	_	standards; failed to be			N. Patient's past and present		
	· ·	patient's stay at the facility			medical, psychiatric history,		
		sistent with ongoing			pertinent diagnosis, co-morbid	l	
	assessments as evid	enced by the following:			conditions		
					O. Name and address of the		
	Review of the upda	ted comprehensive			patient's attending physician		

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER  151599			A. BUILDING  B. WING	00	COMPLETED 10/01/2020
	PROVIDER OR SUPPLIER	LIATIVE CARE - INDIANA LLC	11550	ADDRESS, CITY, STATE, ZIP COD N MERIDIAN STREET, SUITE 3 EL, IN 46032	375
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	assessment dated 9/trochanter measured 8.3 measured 4 x 3.5 x 6 Review of the update assessment dated 9/trochanter measured 5 measured 5 x 6 x 0.  During an interview asked about the incorpatient wounds, the acknowledged the december of the patient's caregiver so Xanax for years for horrible dysreflexial spasm, and did have utilized the Baclofer needed.  5. The above finding Regional Director of Nursing, Patient Care Bloomington Brance 10/01/2020 at 1:20 preserved.	14/20, indicated the left 13.5 x 5 x 1 cm, the sacral 5 x 9 x 3 cm, and the left heel 0 cm.  23/20, indicated the left 15 x 5 x 0.5 cm, the sacral x 9 x 1.5 cm, and the left heel 1 cm.  2 on 9/30/20 at 5:00 p.m., when 2 on sistent measurements of the Patient Care Manager 2 iscrepancy.  3 on 10/1/20 at 9:14 a.m., the 4 tated the patient had been on 4 anxiety and the patient had 5 x 9 x 1.5 cm, and the left heel 1 cm.  3 on 9/30/20 at 5:00 p.m., when 3 on sistent measurements of the 1 cm.  4 on 10/1/20 at 9:14 a.m., the 4 tated the patient had 5 cm and discomfort, and 6 n routinely and Norco as 6 pain and discomfort, and 6 n routinely and Norco of		P. Name of hospital, other agencies, persons involved in past & present care of the pati Q. An evaluation of the home environment and assessment emergency preparedness R. Presence of any Advance Directives for care and/or discussions with patient and family/caregiver regarding the withholding/withdrawal of resuscitative services or treatr S. Equipment presently in hon and potentially needed by pati T. Review of current and relate past medications, including prescription and over-the-cour medications, supplements, he remedies, alternative treatmer allergy history and other medication information U. Patient and family/caregive support systems and the care family/caregiver is available, capable, and willing to provide including applicable strengths patient, physical, psychosocial and/or spiritual resources avai V. The patient's psychosocial status, including emotional barriers to treatment, cognitive limitations, memory and orientation, family relationship social history, source and adequacy of environmental and other resources, coping mechanisms, and the patient's and family/caregiver's reaction illness.  W. An assessment of the paties.	the dent of ment ne ent ed nter rbal nts, r the e, of l, ilable es s, and s n to

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PRINTED: 11/20/2020 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 151599			(X2) MULTIPLE CO A. BUILDING B. WING	onstruction  00	(X3) DATE SURVEY COMPLETED 10/01/2020
	ROVIDER OR SUPPLIER	LIATIVE CARE - INDIANA LLC	11550 N	ADDRESS, CITY, STATE, ZIP COD N MERIDIAN STREET, SUITE 3 EL, IN 46032	375
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	5.112
				and family/caregiver's spiritual orientation, including, as appropriate, any involvement in religious group such as a chur or synagogue or a support grosuch as Alcoholics Anonymou and spiritual concerns or need such as despair, suffering, gui etc.  X. Involvement of family/caregineighbors, and/or other individuals/organizations, incluinvolvement in any support groy. An assessment of the need volunteer services to offer sup or respite to the patient and family/caregiver  Z. A bereavement assessment the needs of the patient's familiand other individuals  AA. Laboratory results  BB. Medical, alcohol, and other drug history  CC. TB screening  DD. Specific, individualized paneeds/problems pertinent to the hospice care being provided EE. Past medical and surgical care, including dates of onset/exacerbation  FF. The patient's and family/caregiver's educational needs, abilities, motivation, and readiness to learn.  GG. The need for referrals and further evaluation by appropriate health professionals  1. The assessment should determine: Probable prognosis six (6) months or less; Patient	n a sch sup s sis lit, liver, liver, liding pups for port tof ly liver attent ne did did attent so of liver

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PRINTED: 11/20/2020 FORM APPROVED OMB NO. 0938-039

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 151599	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	COMP	E SURVEY PLETED 1/2020
	ROVIDER OR SUPPLIE	R LIATIVE CARE - INDIANA LLC	11550	ADDRESS, CITY, STATE, ZIP CO N MERIDIAN STREET, S EL, IN 46032		
(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 CORR (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE AF DEFICIENCY)	EECTION OULD BE PPROPRIATE	(X5) COMPLETION DATE
				problems and needs reterminal illness; Patient related to the terminal ill During each wound car nurse to review prior wo assessment, note signif discrepancies from prio wound assessment, corto manager and to the pand resolve discrepance medical record docume Wound care will be evareviewed at least weekl response to treatment. care will be performed in accordance with physician practice standards. physician will be update regarding a patient's word on an ongoing basis. The organization will notify the physician immediately in signs and symptoms of deterioration, including significant bleeding, or enlargement. If there is improvement in a wound weeks of a treatment, the physician will be consulted determine if a change in care is appropriate.  How are you going to the deficiency from retthe future, even if alreadorected?  1.100% focused charmed on the sum of	goals Ilness. e visit, bund ficant or to current mmunicate chysician, y in the entation. Iluated and y in All wound on ian orders The ed bund status he of there are wound infection,  no d after two he Ited to h wound  prevent curring in ady  t audit for or then enter to	

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PRINTED: 11/20/2020 FORM APPROVED OMB NO. 0938-039

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 151599	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY  COMPLETED  10/01/2020	
	PROVIDER OR SUPPLIE	R LIATIVE CARE - INDIANA LLC	11550	ADDRESS, CITY, STATE, ZIP COD N MERIDIAN STREET, SUITE 3 EL, IN 46032	375	
(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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
				assessment; 2.100% focused wound care audit for 90 days on all Wound care patients, then ongoing, 11 each quarter to ensure pressure ulcer assessment according to NPUAC Staging System; 3.Threshold for focused audit 100% compliance with comprehensive assessment a wound staging. If threshold no met, Patient Care Managers with resources for work plans, if needed.  Who is going to be responsite for prevention above: i.e., director, supervisor, etc.? Patient Care Managers (PCM are responsible for audits and correction. PCMs will be oversiby Director(s) of Clinical Servic (DCS) who report to the Administrator. The Administrations shall report Focus audit results the QAPI Committee and them Governing Body for three consecutive quarters.  By what date are you going to have the deficiency corrected 10/30/20. By no later than 10/30/20, the organization will have implemented 100% Focus audits on Comprehensive Assessment at Admission and	e d 00% ure co lits is and cot vill no ble  Is) staff seen ces tor s to n the cod? con by	

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 151599		(X2) MULTIPLE CONSTRUCTION       (X3) DATE SURVE         A. BUILDING       00       COMPLETED         B. WING       10/01/2020			
	ROVIDER OR SUPPLIER	LIATIVE CARE - INDIANA LLC	11550	ADDRESS, CITY, STATE, ZIP COD N MERIDIAN STREET, SUITE : IEL, IN 46032	375
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				ongoing for Wounds.	
S 0533 Bldg. 00	hospice interdiscip collaboration with physician, if any) a that have taken plaassessment. It must the patient's progroutcomes, as well patient's response update must be act as the condition of no less frequently.  Based on record reversalized to ensure the assessment included information on the patient to care for 2 of 3 recomprehensive Assessment included information on the patient of the patient identified during the thereafter the comprehensive Assessment included visit, the Case Manaevaluate the patient identified during the thereafter the comprehensive of an agreement of the patient identified during the thereafter the comprehensive of an agreement of the patient identified during the thereafter the comprehensive of an agreement of the patient identified during the thereafter the comprehensive of an agreement of the patient identified during the patient iden	comprehensive be accomplished by the	S 0533	S 533 418.54(d) UPDATE OF COMPREHENSIVE ASSESSMENT The update of the comprehen assessment must be accomplished by the hospice interdisciplinary group (in collaboration with the individu attending physician, if any) an must consider changes that he taken place since the initial assessment. It must include information on the patient's progress toward desired outcomes, as well as a reassessment of the patient's response to care. The assessment update must be accomplished as frequently as condition of the patient require but no less frequently than ev	sive  al's ald ave

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 151599		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 10/01/2020			
	VIDER OR SUPPLIER	LIATIVE CARE - INDIANA LLC		11550 N	DDRESS, CITY, STATE, ZIP COD I MERIDIAN STREET, SUITE 3 EL, IN 46032	75	
(X4) ID PREFIX TAG	(EACH DEFICIENCE REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION DATE
pa an The regard Does do was pa of deed and The skeep and	atient and family/or and as appropriate, whe patient's disease gimen D. Medical diministration G. occumentation of plucation will considure as taught to the patient's response to a staught to the patient's response to a staught to the patient's response to a staught to the patient's and family, and behaviors of spice visits. Reservice with a spice of an age and an agency of an age and an agency of a spice of a	caregiver will receive verbal, written instructions on: B. exprocess C. The medical tion management and Prescribed treatments 7. atient and family/ caregiver st of: A. Describing what tient B. Describing the othe teaching, including level d the ability to repeat or as taught. C. Describing any needs not currently met 11. mily/caregiver's knowledge, s will be assessed during ducation, when appropriate, " ency policy titled "Pain tion Policy No. 2-026.1" dated 3. Documentation of patient		TAG		e on & in the stee on the stee	DATE
[ [ ]	iii ivianagement	. 2. Tron-pharmacological			be upuated as frequently as th	<del>-</del>	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		151599	B. WI	NG		10/01/	2020
			<u> </u>	OTD DET	IDDREGG CHTV CT TE TO COP		
NAME OF P	PROVIDER OR SUPPLIER	t .			ADDRESS, CITY, STATE, ZIP COD	75	
DDEMIE	DUOCDIOE & DALI	LIATIVE CARE INDIANALIC			N MERIDIAN STREET, SUITE 3	375	
PREMIE	R HOSPICE & PALI	LIATIVE CARE - INDIANA LLC		CARME	EL, IN 46032		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	interventions will b	e considered for the treatment			condition of the patient warran	ıts.	
	of pain 4. Patien	t and family / caregiver			Each visit, the nurse will		
	education will focus	s on the use and side effects of			assess/data collect for:		
		ljuvant medications, expected			1.A. Pain, including the		
	responses to therapy	y, and the importance of			origin, location, duration, seve	rity,	
	administering medi-	cations according to prescribed			and relief measures		
	dosage and frequen	cy."			2.B. Symptoms such as,		
					nausea, vomiting, respiratory		
		article titled "Table 2,			distress, patient's response to		
	[National Pressure l	Ulcer Staging System] at			care		
	https://www.ncbi.nl	lm.nik.gov, described a deep			<ol><li>3.C. Factors that alleviate</li></ol>	e or	
		ressure-related injury to			exacerbate physical symptom:	s	
	subcutaneous tissues under intact skin Initially,				4.D. Current treatment		
	these lesions have the appearance of a deep				related to the identified sympton	oms	
	bruise purple or r	naroon localized area of			and the patient's response		
	discolored intact sk	in or blood-filled blister due to			5.E. Vital signs appropria	te	
		ng soft tissue from pressure			to the patient's condition		
		tage 2 pressure wound is			6.F. Breath sounds		
	_	ial thickness loss or dermis			7.G. Skin integrity		
		low open ulcer with a red, pink			8.H. Bowel sounds,		
		slough. May also present as			elimination (urinary and bowel	)	
		ptured serum-filled blister.			9.I. Mental status		
		or dry shallow ulcer without			10.J. Appetite/diet, nutrition	onal	
		A Stage 3 pressure wound is			status		
		thickness tissue loss.			11.K. Functional status		
		ay be visible, but bone,			12.L. Safety/home		
		re not exposed. Slough may			environment		
	_	not obscure the depth of			13.M. Patient and		
	I	clude undermining and			family/caregiver support		
		e 4 pressure wound is			14.N. Progress toward		
		hickness tissue loss; extensive			hospice goals and patient nee	ds	
	destruction; with exposed bone, tendon or				and problems		
	muscle. Slough or eschar may be present on some				15.O. Compliance with		
	1 ~	bed. Often includes			treatments and medication		
	I -	nneling. An Unstageable			regimen		
		as a "full thickness tissue loss			16.[Narcotic Counts include	-	
		th of the ulcer is completely			Quantity of medication used s	ince	
		(yellow, tan, gray, green, or			last count and Reason is a		
	1	har (tan, brown or black) in the			required ongoing assessment		
	wound bed. Until e	nough slough and/ or eschar			17.P. The need for an		

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 151599		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 10/01/2020	
	ROVIDER OR SUPPLIER	LIATIVE CARE - INDIANA LLC	11550	ADDRESS, CITY, STATE, ZIP COD N MERIDIAN STREET, SUITE 3 EL, IN 46032	375
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	is removed to expos	se the base of the wound, the cannot be determined "		alternative setting or level of c	are ve
	6. According to an Documentation of F	article titled "Assessment and ressure Ulcers" at		assessments should focus on progress toward goals:  19.A. Patient's response	
	https://healthinsight.org/Internal/events/Nursing _Home/Assessment_and_Documentation_Pressu re_Ulcers%20_0110719_Color.pdf_described			care 20.B. Changes in patient condition, level of deterioration	
	epithelialization as a wound surface is co	a "process by which the vered by new epithelium, this		21.C. Changes in patient diagnoses/prognosis	
	_	und has filled with The tissue is pink, almost urs on top of healthy		22.D. Changes in the patient's care environment or support systems	
	granulation tissue." Slough is described as "the presence of devitalized yellowish tissue is			23.E. Well-being 24.F. Comfort	
	observed and is formed by an accumulation of dead cells. Must not be confused with the presence of pus." Necrotic tissue is described as			25.G. Dignity throughout dying process 26.Based on the	the
	appear hard, dry and	g dead tissue. The wound may d black. Dead connective ray. The presence of dead		assessments, the plan of care—including problems, nec	eds,
	tissue in a wound pr	revents healing."		goals, and outcomes—will be reviewed and updated by the interdisciplinary group member	ers
	8/6/20, was reviewe	and for patient #1, start of care and included a plan of care d of 8/6/20 to 10/4/20. The		responsible for the case. Change/verbal orders will be entered immediately and	
	plan of care include of "Patient, family,	d, but was not limited to, goals caregivers are knowledgeable		forwarded to the physician. Patients and family/caregivers	s will
	and involved in hospice plan of care for patient pt/cg (patient/ caregiver) will verbalize understanding of indications, uses, and side effects of each medication and administer medications as prescribed as evidenced by no adverse effects from medication error, narcotic counts will be correct each visit through next benefit period Anxiety/ agitation/ restlessness will be managed with use prn [as needed] lorazepam as ordered through next benefit period			receive information regarding and the management of pain a integral part of hospice care.	as an
				patient and family/caregiver w receive verbal or written	
				instructions, as appropriate, regarding:  1.A. The pain process	
				2.B. The risk for pain 3.C. The pain assessmen	nt
	Patient/ caregiver measures to promot	will be able to verbalize e comfort related to		process 4.D. The importance of	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 151599		(X2) MULTIPLE ( A. BUILDING B. WING	OO	(X3) DATE SURVEY COMPLETED 10/01/2020	
	ROVIDER OR SUPPLIER	LIATIVE CARE - INDIANA LLC	11550	TADDRESS, CITY, STATE, ZIP COD IN MERIDIAN STREET, SUITE MEL, IN 46032	375
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	next benefit period			effective pain management 5.E. Methods for pain management, when identified	l as
	note indicated the e	0 IDG (interdisciplinary group) ducation provided were safety ation. Narcotic count indicated:		part of treatment 6.F. Potential limitations pain management modalities	
	and Lorazepam 10 t	ets), Roxanol 30 ml (milliliters), tabs. Patient and/or caregiver copriate use, use of side rails		7.G. Side effects of pain treatment 8.Documentation of pati	
	understand the appropriate use, use of side rails and returns demonstration, and dexamethasone was called into the patients pharmacy. Review of			and family/caregiver instruction and understanding in the clinical and understand and understanding in the clinical and understanding in the clinical and understanding in the clinical and understanding in the c	on ical
	the skilled nursing visit note dated 8/7/20 indicated the only interventions/ goals achieved was pain management and safety. The updated comprehensive assessment/ skilled nursing visit			record will include: A. Specific information taught; B. Patient family/caregiver specific	and
	notes failed to evide progress towards the	ence the patient's/ caregiver e goals related to the specific		understanding; C. Response teaching; D. Additional learning needs. Nurses will document	ng
	caregiver understan	s educated and patient/ ding of each medication and aderstanding/ verbalization of		and symptom assessments a reassessments as required. Vector pain is identified, a more	
	measures to promot respiratory system.	e comfort related to		comprehensive pain assessm will be completed. Pain assessments facilitate	nent
	education provided.	0 IDG note indicated "N/A" to Narcotic count indicated:		reassessment and follow-up. During wound care visits, nur	
	Lorazepam 20 tabs. understand the appr	phine (Roxanol) 30 ml, and Patient and/ or caregiver opriate use of side rails and		review prior wound assessments note significant discrepancies prior to current wound	
	slightly labored at re	on. Respirations even but est at times and the patient tervention, no edema, and		assessment, communicate to manager and to the physiciar resolve discrepancy in the me	n, and
	Review of the skille	ical equipment) concerns.  ed nursing visit note dated e only interventions/ goals		record documentation. Woun care will be evaluated and reviewed at least weekly. All	d
	achieved was pain r updated comprehen	nanagement and safety. The sive assessment/ skilled assessment/ skilled are the		wound care will be performed accordance with physician or	
	patient's/ caregiver related to the specif	progress towards the goals ic medication that was t/ caregiver understanding of		and practice standards. The physician will be updated regarding a patient's wound son an ongoing basis. The	status

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		151599	B. W	ING		10/01/	/2020
		<u> </u>		CTREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIE	R			N MERIDIAN STREET, SUITE 3	275	
DDEMIE	P HOSDICE & DAI	LIATIVE CARE - INDIANA LLC			EL, IN 46032	313	
FREIVIIE	N HOSFICE & FAL	LIATIVE CARE - INDIANA LLC		CARIVIE	EL, IN 40032		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	each medication an				organization will notify the		
	_	palization of measures to			physician immediately if there	are	
	promote comfort related to respiratory system.				signs and symptoms of wound	t	
	The clinical record also failed to evidence the				deterioration, including infection	on,	
	· ·	cotic count/ if Lorazepam was			significant bleeding, or		
		is day or if there was a			enlargement. If there is no		
	miscount due to pro	evious days count indicated 10			improvement in a wound after	two	
	tabs.				weeks of a treatment, the		
					physician will be consulted to		
	Review of the 8/9/20 IDG note indicated "N/A" to				determine if a change in wour	ıd	
	education provided. Narcotic count indicated:				care is appropriate.		
	Norco 12 tabs, Morphine (Roxanol) 29.5 ml, and						
	Lorazepam 20 tabs. Patient and/ or caregiver				How are you going to prever	ıt	
	understand the appropriate use of side rails and				the deficiency from recurring	រូ in	
		on. Over the counter eye			the future, even if already		
		use instructed on hospice not			corrected?		
	_	ions. Review of the skilled			1.100% focused chart audit	for	
	_	ated 8/9/20 indicated the only			90 days on Update of		
	_	s achieved was pain			Comprehensive Assessment	orior	
	management and sa	-			to each Interdisciplinary Group	)	
	_	essment/ skilled nursing visit			Meeting/IDG, then ongoing, 1		
		ence the patient's/ caregiver			each quarter to ensure update	to to	
		ne goals related to the specific			the comprehensive assessme	nt;	
		s educated and patient/			2.100% focused wound care		
	1 -	nding of each medication and			audit for 90 days on all Wound		
		nderstanding/ verbalization of			care patients, then ongoing, 1		
	_	te comfort related to			each quarter to ensure pressu	ıre	
		The visit note also failed to			ulcer assessment according to	)	
		nent of when the patient used			NPUAC Staging System;		
	the Roxanol and re-	ason for use.			3.Threshold for focused aud		
					100% compliance with update		
		/20 IDG note indicated the			comprehensive assessment a		
	education provided was on safety and comfort				wound staging. If threshold no		
	medication. Narcotic count indicated: Norco 12				met, Patient Care Managers v	vill	
	tabs, Roxanol 28 ml, Lorazepam 21 tabs. Patient and/ or caregiver understand the appropriate use of side rails and returns demonstration. Shortness				re-educate involved staff,		
					progressively, involving huma	n	
					resources for work plans, if		
		e. Concerns and request for a			needed.		
		ent's bed. Review of the skilled					
nursing visit note indicated the only		1		Who is going to be responsi	ble		

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 151599		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 10/01/2020	
	ROVIDER OR SUPPLIER	LIATIVE CARE - INDIANA LLC	11550	ADDRESS, CITY, STATE, ZIP COD N MERIDIAN STREET, SUITE : EL, IN 46032	375
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	notes failed to evide progress towards the medication that was caregiver understand progress towards under the measures to promotous respiratory system. Evidence an assessment the Roxanol and the count since Lorazer 8/9/20.  Review of the 8/13/education provided medication. Narcotous tabs, Roxanol 28 mand/or caregiver under the side rails and return of side rails and return of breath at baseline bed extender and wavailable. Review of indicated the only in was pain management comprehensive assentes failed to evide progress towards the medication that was caregiver understand progress towards under the measures to promotous respiratory system. Evidence an assessment the Lorazepam.	fety. The updated sesment/ skilled nursing visit ence the patient's/ caregiver to goals related to the specific seducated and patient/ ding of each medication and aderstanding/ verbalization of the comfort related to to the patient used to the accuracy of the narcotic form was counted at 20 tabs on the count indicated: Norco 12 the patient used the accuracy of the narcotic form was counted at 20 tabs. Patient aderstand the appropriate use the actual that it was not for the skilled nursing visit note for the skilled nursing visit note for the patient's/ caregiver the goals related to the specific seducated and patient/ ding of each medication and aderstanding/ verbalization of the comfort related to the patient used.		for prevention above: i.e., director, supervisor, etc.? Patient Care Managers (PCM are responsible for audits and correction. PCMs will be over by Director(s) of Clinical Servi (DCS) who report to the Administrator. The Administration shall report Focus audit result the QAPI Committee and ther Governing Body for three consecutive quarters.  By what date are you going have the deficiency corrected 10/30/20. Nurses completed re-education 10/30/20. By no later than 10/30/20, the organization will have implemented 100% Focus audits on Update of Comprehensive Assessment to each IDG and Wounds ong	staff seen seen sices stor sto n the  to d? on by l us
	_	were safety and comfort ic count indicated: Norco 12			

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER  151599		A. BUILDING  B. WING	00	COMPLETED 10/01/2020	
	PROVIDER OR SUPPLIER	LIATIVE CARE - INDIANA LLC	11550 N	ADDRESS, CITY, STATE, ZIP COD N MERIDIAN STREET, SUITE 3 EL, IN 46032	375
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	tabs, Roxanol 28 ml and caregiver under side rails and return had tachycardia with 140-160, new order called into the pharmabove baseline. Revisit note indicated achieved was pain mupdated comprehensing visit notes of patient's/ caregiver prelated to the specified ducated and patien each medication and understanding/ verb promote comfort rel The visit note also of narcotic count since tabs on 8/13/20.  8. The clinical reco 9/10/20, was review comprehensive asse to include an accept the wound assessments stage 3 wound to the measured 10 (L) [le [depth] centimeters percent) granulation tissue; the sacral wo measured 18 x 25 x indicated a full thickness wound wi 0-25 % necrotic tiss narrative note indicated indicated indicated indicated in the sacratic percention in the	, Lorazepam 21 tabs. No falls stands the appropriate use of s demonstration. The patient h an irregular heart rate of for cardizem 120 mg daily was macy. No shortness of breath view of the skilled nursing the only interventions/ goals management and safety. The sive assessment/ skilled to evidence the progress towards the goals ic medication that was t/ caregiver understanding of			

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AND PLAN OF CORRECTION  AND PLAN OF CORRECTION  151599		· /	ILDING	onstruction 00	(X3) DATE COMPI 10/01	LETED	
	ROVIDER OR SUPPLIER	LIATIVE CARE - INDIANA LLC		11550 N	ADDRESS, CITY, STATE, ZIP COD N MERIDIAN STREET, SUITE EL, IN 46032	375	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	E	(X5) COMPLETION DATE
	9/10/20 to 12/8/20. the patient was press hours as needed for tablets 2 times daily Lorazepam 1 mg tal for anxiety, agitatio mg - 325 mg tablet pain, and Morphine mg/ml) oral solution needed for pain or a indicated the hospic readings from the paradings from the parading from the skille 9/11/20 included, but interventions provide using appropriate parading from the parad	of care for the benefit period of The medication list indicated cribed Xanax 0.5 mg every 6 anxiety, Baclofen 20 mg of or muscle relaxant, blet every 4 hours as needed n, and restlessness, Norco 5 1 every 6 hours as needed for concentrate 100 mg/5 ml (20 n give 0.25 ml every 4 hours as air hunger. The interventions be nurse to obtain blood sugar atient/ caregiver at each visit, 3 pressure ulcers (located at accral, and left heel), hospice in level and report changes in ian, and failed to evidence a cceptable level of pain. The d only two orders to instruct: the visit and to educate patient/ se and safety at each visit. No function was indicated in the  and nursing visit note dated at was not limited to, the ded: "Assessed pain level ain scale hospice comfort kit act with current expiration patient/ caregiver regarding . Instructed patient/ caregiver Reinforced nurse's ang safety " The narcotic are note indicated "Patient/ roper use of comfort kit" which the the narcotic count in the					
			1				I

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 151599		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 10/01/2020	
	PROVIDER OR SUPPLIEF	LIATIVE CARE - INDIANA LLC	11550	ADDRESS, CITY, STATE, ZIP COD N MERIDIAN STREET, SUITE ( EL, IN 46032	375
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY 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)	(X5) COMPLETION DATE
	narrative note. The indicated "Obtain L to current visit" wh goals met of "Patient procedure." The not "Patient/ caregiver proper safety measu but the visit note fareducation that was evidence an assessmant the home, Loraze and Norco 2 tabs. It visit note dated 9/12 repeat pain assessmant below their accepta initial pain assessmant evidence a blood surinterventions provide comfort kit reviewed expiration dates, instructed and the failed to in medications and who comfort kit. The not proper safety measu but the visit note failed to evidence a blood surinterventions and who comfort kit. The not proper safety measu but the visit note fareducation that was note failed to evidence.  Review of the skilled 9/13/20, the interventions comfort kit.	Interventions not provided ab as ordered Not applicable ich was inconsistent with the nt verbalizes tolerance to lab ote also indicated a goal met of verbalizes understanding of ares related to fall awareness" ided to evidence the specific provided. The note failed to ment of the right heel.  20 IDG note indicated the llows: the morphine was not epam 30 tabs, Xanax 33 tabs, Review of the skilled nursing 2/20 indicated the patient's ment "N/A - Patient was at or ble level for pain during the ent" and the visit note failed to agar assessment. The ded indicated "Hospice and and is intact with current structed patient/ caregiver mifort kit. The interventions on safety measures instructions regarding safety."			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 151599		(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 10/01/2020	
	PROVIDER OR SUPPLIEF	LIATIVE CARE - INDIANA LLC	11550	ADDRESS, CITY, STATE, ZIP COD N MERIDIAN STREET, SUITE : EL, IN 46032	375
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY 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)	(X5) COMPLETION DATE
	caregiver regarding interventions indicated " 10. Provision wound care per ord have stasis ulcers be interventions reveal caregiver on wound caregiver in perform proper disposal of ul Instructed patient/ of care in safety measures instructions regardificated the specificate taught from the confinition indicated a goal me verbalizes understated a goal me verbalizes understated assures related to note failed to evide was provided. The evidence an assessment.  Review of the 9/14/narcotic count as for in the home, Loraze Norco 1 tab. Review note dated 9/14/20 pain assessment "Norco 1 tab. Review note dated 9/14/20 pain assessment". Indicated "Hospice intact with current of intact with current of care in the care i	use of comfort kit. The sted. The interventions also ide venous [stasis ulcer] ers" when the patient does not but pressure ulcers. Other led "Instructed patient/ led care Instructed patient/ led care Instructed patient/ led care including sted wound supplies learegiver in preventative skin leatient/ caregiver regarding luding calories/ protein intake the wound healing Identified " when the plan of care led to include these instructions/ laterventions include: "Instruct Reinforced nurse's least and what was later that it is the caregiver led in the caregiver later of "Patient/ caregiver later of "Patient/ caregiver later of "Patient/ caregiver later of the right heel and the levidence a blood sugar later of the skilled nursing visit landicated the patient's repeat later of pain during the initial later of the right led included the later of pain during the initial later interventions provided comfort kit reviewed and is expiration dates, instructed legarding use of comfort kit"			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 151599		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 10/01/2020	
	ROVIDER OR SUPPLIER	LIATIVE CARE - INDIANA LLC	11550 N	ADDRESS, CITY, STATE, ZIP COD N MERIDIAN STREET, SUITE ( EL, IN 46032	375
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
IAU	when the narrative of and "Comfort meds pharmacy today." Or revealed " 10. Prowound care per order not have stasis ulcervisit note failed to it about the use of hydrote failed to evide heel.  Review of a physici indicated the hospic using verbal pain sechanges in pain lever effectiveness of promoved process of promoved process of promoved process of promoved process of	being PU [picked up] from Other interventions provided ovide venous [stasis ulcer] ers " when the patient does are but pressure ulcers. The include any documentation drocodone. The assessment an order dated 9/16/20, an order dated 9/16/20, an order dated sit and to report the elt to the physician, monitor Norco and prn morphine.  And nursing visit note dated an elast bowel movement was 9/14/20 visit note indicated amentary assessment indicated amentary assessment indicated are ulcers, but only identified and inaccurately indicated aster ulcers. The visit note at was a diabetic but failed to ent of blood sugars, the assessment "N/A - Patient are acceptable level for pain an assessment", the functional d the patient was a are patient is a paraplegic, the indicated the left trochanter suspected deep tissue injury and of purulent draining with a 100% necrotic slough tissue tic eschar tissue, the sacral	IAG		DATE
	with 0-25% of necro	otic slough and eschar tissue,			

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 151599	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 10/01/2020
PREMIE	PROVIDER OR SUPPLIER	LIATIVE CARE - INDIANA LLC	11550 N	ADDRESS, CITY, STATE, ZIP COD N MERIDIAN STREET, SUIT EL, IN 46032	E 375
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	N (X5) BE COMPLETION DATE
	and the left heel is a suspected deep tissue epithelialization tiss and 0-25% necrotic identification and as consistent and accurassessment websites to evidence an assessment websites as a possible seizure indicated the patient had pain in the visit note failed to in notified of the odor and possible seizure indicated "Hospice intact with current epatient/ caregiver rearrest The IDG note dated count was not compremembers in the hon uncomfortable getti  Review of the skille 9/18/20 indicated the lethargic, anxiety depatient, the patient's - Patient was at or be pain during the initin narrative note indicapatient lorazepam and patient being confus sentences and wincing patient was "active" discontinued routing ordered comfort me Morphine and Lorar within the narrative	a stage 2 but described as a me injury with 75-100% sue, soft black necrotic tissue slough tissue. The wound assessments failed to be rate according to the wound as. The assessment note failed asment of the right heel. The ated the patient was having stare without identifying this experiment. The narrative to was out of Norco and the he left arm on 9/15/20. The indicate if the physician was and drainage of the wounds are the interventions provided comfort kit reviewed and is expiration dates, instructed agarding use of comfort kit.  19/17/20 indicated the narcotic eleted due to multiple family the and the caregiver was might be medications out.  2d nursing visit note dated the patient was confused and the patient was confused and the patient was confused and the repeat pain assessment "N/A the low their acceptable level for all pain assessment" but the lated the clinician gave the mid hydrocodone due to the sed speaking in nonsensical sing. The note indicated the land notified the physician, the medications, and only dications/ scheduled to the conformation of the count failed the coun			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 151599		r í	JILDING	instruction 00	(X3) DATE : COMPL 10/01/	ETED	
	PROVIDER OR SUPPLIER	R LIATIVE CARE - INDIANA LLC		11550 N	ADDRESS, CITY, STATE, ZIP COD N MERIDIAN STREET, SUITE 3 EL, IN 46032	375	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION On the Yangay		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
	narcotic count as for home. Lorazepam tabs. Review of the dated 9/19/20, the I indicated that the pay when the patient haleft trochanter and sand oriented x3, and patient, the patient's hours, on a scale of pain) was a 6 but curpatient's repeat pair was at or below the during the initial paracotic count for the with the narcotic count for the with the narcotic count for the patient's anxiety levels being used from proposed from proposed from proposed from proposed from the same table.  Review of the 9/20/20, narcotic count as for home which is incontained to evide that significantly af assessment continuation pain or pain doe movement and the midicated "N/A - Paracceptable level for assessment" but the	of 20 IDG note indicated the follows: Morphine is not in the 22 tab, Xanax 11 tabs, Norco 45 e skilled nursing visit note integumentary section attent had zero pressure ulcers is wounds to bilateral heels, sacrum, the patient was alert exiety does not affect the is worst pain level in the last 24 in 1-10 (with 10 being the worse intention assessment "N/A - Patient in assessment". The IDG the morphine was inconsistent from 25 tabs on 9/18 to current to identify an assessment of the indicated the incomplete and in the incomplete i					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 151599		A. BUI	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 10/01/2020	
	PROVIDER OR SUPPLIER	LIATIVE CARE - INDIANA LLC	•	11550 N	DDRESS, CITY, STATE, ZIP COD I MERIDIAN STREET, SUITE 3 L, IN 46032	375	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	I	ID PREFIX CROSS-REFERENCED TO THE APPROPRIAT  TAG  PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		TE	(X5) COMPLETION
TAG	effective in managi failed to include an anxiety and pain le narcotics. The asse an assessment of th Review of the skille	ng their pain. The visit note assessment of the patient wel due to the use of the assment note failed to evidence e right heel.		IAU	D.I. CLACT		DATE
	that significantly af assessment continu no pain or pain doe	he patient did not have anxiety fected him/ her, the pain ed to indicate the patient has s not interfere with activity or repeat pain assessment					
	movement and the repeat pain assessment indicated "N/A - Patient was at or below their acceptable level for pain during the initial pain assessment." The left trochanter wound assessment indicated the depth description was						
	extensive and the patient had a large amount of purulent drainage with a strong odor, the sacral wound assessment indicated the depth description was extensive with a strong odor, and						
	the left heel continu depth description w narcotic count with	ned to be a stage 2 but the ras described as necrotic. The in the narrative indicated ken within 24 hours),					
	Lorazepam was bla 11. The visit note f	nk, Roxanol 29 ml, and Xanax ailed to include an assessment ty and pain due to the use of					
	evidence an assessr	assessment note failed to nent of the right heel. ed nursing visit note dated					
	9/23/20, indicated t that significantly af assessment continu no pain or pain doe	he patient did not have anxiety fected him/ her, the pain ed to indicate the patient has s not interfere with activity or repeat pain assessment					
	indicated "N/A - Pa acceptable level for assessment." The l	tient was at or below their pain during the initial pain eft heel continued to be a h description was described					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u> COMPLETED		
		151599	B. WING		10/01/2020
		<u> </u>	STREE	ET ADDRESS, CITY, STATE, ZIP COD	
NAME OF P	PROVIDER OR SUPPLIER	8		O N MERIDIAN STREET, SUITE	375
PREMIE	R HOSPICE & PALI	LIATIVE CARE - INDIANA LLC		MEL, IN 46032	
			<u>, l</u>		075)
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION (FACH CORRECTIVE ACTION SHOULD BE	(X5)
TAG	`	R LSC IDENTIFYING INFORMATION	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	COMPLETION DATE
TAG		neasurement of 5 x 6 x 0.1 cm.	IAG		DATE
		cation and assessments failed			
		accurate according to the			
		websites. The assessment			
		nce an assessment of the right			
		count within the narrative note			
		(9 tabs taken within 48 hours),			
		bs taken in 72 hours in			
		anax), Roxanol (Morphine) 30			
		tabs taken in 72 hours in			
	conjunction with Lo	orazepam). The caregiver			
	requested refills on	the Xanax and Lorazepam.			
	The visit note failed to evidence a comprehensive				
	assessment of the patient's use of pain and				
	anti-anxiety medica	itions.			
		ed nursing visit note dated			
		he patient did not have anxiety			
		fected him/ her, the pain			
		ed to indicate the patient has			
		s not interfere with activity or			
		repeat pain assessment tient was at or below their			
		pain during the initial pain			
	•	eft heel continued to be a			
		h description was described			
	-	a measurement. The wound			
		ssessments failed to be			
		rate according to the wound			
		s. The assessment note failed			
		ssment of the right heel. The			
		in the narrative note indicated			
	Lorazepam 33 tabs,	Xanax 60 tabs, Roxanol 30 ml,			
	_	The visit note failed to			
		nensive assessment of the			
	-	and anti-anxiety medications.			
	•	-			
	Review of the skille	ed nursing visit note dated			
	9/28/20, indicated the	he patient did not have anxiety			
	that significantly af	fected him/ her, the pain			

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	OF CORRECTION	IDENTIFICATION NUMBER  151599	A. BUILDING  B. WING	00	COMPLETED 10/01/2020
	PROVIDER OR SUPPLIER	LIATIVE CARE - INDIANA LLC	11550 N	ADDRESS, CITY, STATE, ZIP COD N MERIDIAN STREET, SUITE 3 EL, IN 46032	375
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	assessment continue no pain or pain does movement and the r indicated "N/A - Par acceptable level for assessment." The I stage 2 but the depth as necrotic without a identification and as consistent and accur assessment websites to evidence an assessment websites to evidence an assessment websites to evidence an assess narrative note indicaspasms were worser to increase Baclofer narcotic count withit Lorazepam 21 tabs conjunction with Xataken in 72 hours in Roxanol 30 ml, and 72 hours). The narrative was instruction comfort kit, instruct inspection of the skip proper positioning, by hydration and nutrit surfaces. These interesting the patient's use of predications.  Review of the skille 9/30/20, indicated the patient's use of predications.  Review of the skille 9/30/20, indicated the significantly aff assessment continue no pain or pain does movement and the residual continue of the patient's use of predications.	and to indicate the patient has a not interfere with activity or epeat pain assessment tient was at or below their pain during the initial pain eft heel continued to be a had description was described a measurement. The wound assessments failed to be rate according to the wound as the assessment note failed assent of the right heel. The rated the patient's muscle and orders were received in to four times a day. The in the narrative note indicated (12 tabs taken in 72 hours in rative note indicated (12 tabs taken in 72 hours in rative note indicated education and the patient of the interventions indicated in regarding the use of the ion regarding the use of the ion regarding appropriate ion, and use of support erventions failed to be narrative note. The visit note comprehensive assessment of the patient did not have anxiety and nursing visit note dated the patient did not have anxiety fected him/her, the pain and interfere with activity or repeat pain assessment tient was at or below their			

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 151599	(X2) MULT A. BUILI B. WING	DING	NSTRUCTION  00	(X3) DATE : COMPL 10/01/	ETED
	PROVIDER OR SUPPLIER	LIATIVE CARE - INDIANA LLC	1	1550 N	DDRESS, CITY, STATE, ZIP COD MERIDIAN STREET, SUITE 3 L, IN 46032	75	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PR	D EFIX 'AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
TAG	acceptable level for assessment." The le indicated a measure continued to be a st description was des wound identificatio consistent and accu assessment website measurements of tu failed to be consiste assessment. The as evidence an assessment arrative note indic spasms were worse to increase Baclofer narcotic count with Lorazepam 18 tabs, 48 hours in conjunc 30 ml, and Norco 6 indicated education interventions indicated education interventions indicate regarding routine in instruction regarding regarding appropria use of support surfa failed to be consisted. The visit note failed assessment of the panti-anxiety medicated.  8. During an interventional provide "comfort kings and interventional Director of Nursing, Patient Ca Bloomington Brance assessment of Bloomington Brance and Bloomington Brance assessment of Bl	repain during the initial pain eft heel wound assessment ement of 5.5 x 6.5 x 0.1 cm, age 2 but the depth cribed as necrotic. The n and assessments failed to be rate according to the wound s and the sacral wound nneling and undermining ent with the 9/28/20 sessment note failed to ment of the right heel. The ated the patient's muscle ning and orders were received in to four times a day. The in the narrative note indicated and axana 41 tabs 8 tabs taken in extion with Lorazepam), Roxanol 1 tabs. The narrative note provided was safety. The atted there was instruction of the comfort kit, instruction inspection of the skin, ag proper positioning, ate hydration and nutrition, and acces. These interventions ent with the narrative note. It to evidence a comprehensive attent's use of pain and actions.  The service were reviewed with the off Compliance, Director of the compliance that the co		AG	DETCIENCT		DATE

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	ETED
		151599	B. WI	NG		10/01	/2020
			<u> </u>	CED FEET	ADDRESS OF A STATE OF COD		
NAME OF P	ROVIDER OR SUPPLIER	1			ADDRESS, CITY, STATE, ZIP COD	75	
DDEME	DIJOODIOE & DALL	LIATIVE CADE INDIANALIO			N MERIDIAN STREET, SUITE 3	375	
PREMIER	R HUSPICE & PALI	LIATIVE CARE - INDIANA LLC		CARIME	EL, IN 46032		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	stated that the asses	sment was accurate in					
	indicating there wo	uld be no pain or anxiety if					
	_	rking and did not feel that there					
	needed to be any fu	rther assessments since the					
	patient was taking n	medications as prescribed. The					
	Director of Nursing	indicated he felt the					
	_	ging of wounds were					
	appropriate.	· <del>-</del>					
S 0544	418.56(b)						
	PLAN OF CARE						
Bldg. 00	The hospice must	ensure that each patient					
	and the primary ca	are giver(s) receive					
	education and trai	ning provided by the					
	hospice as approp	oriate to their					
	responsibilities for	the care and services					
	identified in the pla	an of care.					
			S 05	544	<b>S 544</b> 418.56(b) PLAN OF CA	RE	10/30/2020
		view and interview, the agency			The hospice must ensure that		
		t notes contained specific			each patient and the primary of		
		to patients and family			giver(s) receive education and		
		h their response for 2 of 3			training provided by the hospid		
	records reviewed. (	(Patient #1, 2)			appropriate to their responsibi		
					for the care and services ident	tified	
	Findings include:				in the plan of care.		
	1 5	1			How are you going to correct	t	
		ency policy titled "Patient			the deficiency? If already		
		Policy No. 2-025.1-3" dated			corrected, include the		
		Procedure 6 the			following steps and state dat	te	
	-	caregiver will receive verbal,			of correction.		
	* * *	written instructions on: B.			From 10/14/20-10/9/20, all Nu		
	-	e process C. The medical			were In-serviced on the follow	-	
	_	ntion management and			Premier Hospice & Palliative (	Jare	
		Prescribed treatments 7.			CHAP Hospice Policy and		
	•	patient and family/ caregiver			Procedure Manual, 2020 polic	ies:	
		ist of: A. Describing what			1.PATIENT EDUCATION		
		atient B. Describing the			PROCESS, Policy No. 2-025;		
		the teaching, including level			2.PAIN MANAGEMENT	0.	
		d the ability to repeat or			EDUCATION, Policy No. 2-02	ь;	
	demonstrate what w	vas taught. C. Describing any	1		3.BASIC HOME SAFETY,		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) I			(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>			COMPL	ETED
		151599	B. WI	NG		10/01/	2020
				CTD FFT A	ADDRESS CITY STATE ZID COD		
NAME OF F	ROVIDER OR SUPPLIER	1			ADDRESS, CITY, STATE, ZIP COD	75	
DDEMIE	DUOCDIOE & DALI	LIATIVE CADE INDIANALIO			N MERIDIAN STREET, SUITE 3	1/5	
PREMIE	R HOSPICE & PALI	LIATIVE CARE - INDIANA LLC		CARINE	EL, IN 46032		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	rc	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	I C	DATE
	additional learning	needs not currently met 11.			Policy No. 2-048.		
	_	mily/ caregiver's knowledge,			Involved staff acknowledged th	nis	
	skills, and behavior	s will be assessed during			in-service re-training in writing		
		education, when appropriate,			Organization policies set forth		
	will be provided "				organization shall ensure visit		
	2. Review of an agency policy titled "Pain Management Education Policy No. 2-026.1" dated 5/11/20, indicated " 3. Documentation of patient				notes contain specific details of	of	
					education to patients and fami		
					members along with their	.,	
					response. Patients and		
	and family/ caregive	_			family/caregivers will receive		
		e clinical record will include:			information regarding pain and	l the	
		ght B. Patient and family/			management of pain as an inte		
	caregiver understanding C. Response to teaching				part of hospice care. The patie	•	
	"	ang c. response to teaching			and family/caregiver will receive		
	****				verbal or written instructions, a		
	3 Review of clinic	al record #1, Election date of			appropriate, regarding:	13	
		ed a plan of care for the benefit			1.A. The pain process		
		to to 10/04/2020, with orders to			2.B. The risk for pain		
	_	"indications, uses, side effects			3.C. The pain assessmen	.+	
		prior to administration "			· ·	ıı	
		realed that the patient was			process 4.D. The importance of		
	-	nately 23 medications.			effective pain management		
	preserioed approxim	matery 25 medications.			5.E. Methods for pain		
	Daviany of a skilled	nursing visit note dated 08/07,			l ·		
		, 08/13/20, failed to evidence			management, when identified	as	
		education in regards to the			part of treatment		
	patient medications				6.F. Potential limitations of	וכ	
	patient medications				pain management modalities		
	D: £1-:11 - 4				7.G. Side effects of pain		
		nursing visit note dated			treatment		
		the patient was placed on			8.Documentation of patie		
		aily. The visit note failed to			and family/caregiver instruction		
		tion about the new medication			and understanding in the clinic	al	
	•	or education of the patient's			record will include: A. Specific		
	prescribed medicati	ons.			information taught; B. Patient a	and	
		0/00/00			family/caregiver specific		
		on 9/30/20 at 4:55 p.m., when			understanding; C. Response to		
	-	regivers should have a copy			teaching; D. Additional learning	-	
		rofile, the Administrator stated			needs. Nurses will document բ		
		on profile should be printed out			and symptom assessments an		
	and given to the pat	ient/ caregiver.			reassessments as required. W	hen '	

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		151599	B. W	ING		10/01/2020	
		<u> </u>	<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	8			N MERIDIAN STREET, SUITE 3	375	
PREMIER	R HOSPICE & PALI	LIATIVE CARE - INDIANA LLC			EL, IN 46032		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION	<u> </u>	TAG	DEFICIENCY)		DATE
					pain is identified, a more		
	-	on 10/01/20 at 9:20 a.m., when			comprehensive pain assessme	ent	
		provided them with a			will be completed. Pain		
		cating instruction or provided			assessments will facilitate reg		
	any verbal educatio				reassessment and follow-up b	У	
		regiver indicated they were			clinicians. Patients receive		
		all handwritten note which			information regarding basic ho	me	
		orphine, 0.5 ml (milliliters) to be			safety in the <i>Patient Hospice</i>		
	-	nd Ativan, 1 tab every hour			Admission Booklet, page 29,		
		(milligram), which was a new			including:		
		some confusion on the exact			Fire response including Oxy	/gen	
	-	ver indicated she was not			Safety		
		tion on the medication and felt			2. Electrical safety		
		ns given multiple times in an			3. Environmental and mobility		
	hour resulted in the	ir loved ones death.			safety		
					4. Bathroom safety		
	_	were reviewed with the			1.Documentation of patie		
	-	of Compliance, Director of			and family/caregiver instruction		
	Nursing, Patient Ca	_			the clinical record will include:		
	-	ch, and Administrator on			2.A. Specific Information		
		p.m., in which no further			taught		
	information or docu	mentation was provided.			3.B. Adaptations made to	)	
	4 75	1 1//0 E1 2 1 2			the environment		
		al record #2, Election date of			4.C. Patient and		
		plan of care for the benefit			family/caregiver understanding		
	-	to 12/8/2020, with only two			5.D. Return demonstration		
		afety measures each visit and			in use of equipment, if appropri		
	-	Camily on oxygen use and			6.E. Response to teachin	ıg	
		No other orders of instruction			7.F. Additional learning		
	was indicated in the	pian of care.			needs		
					1.	.4	
					How are you going to preven		
					the deficiency from recurring	<i>j</i> 111	
					the future, even if already corrected?		
					1.100% Focused chart audit	for	
						101	
					90 days on Admissions, then	arter	
					ongoing, 10% review each qua	ailei	
					to ensure specific patient education and response is		
			1		Legacation and response is		

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 151599	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 10/01/2020
	ROVIDER OR SUPPLIE	R LIATIVE CARE - INDIANA LLC	11550	ADDRESS, CITY, STATE, ZIP COD N MERIDIAN STREET, SUITE EL, IN 46032	375
(X4) ID PREFIX TAG	(EACH DEFICIEN	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 APPROPR DEFICIENCY)	(X5) COMPLETION DATE
				charted; 2.100% focused audit prior each Interdisciplinary Group Meeting/IDG, then ongoing, each quarter to ensure specipatient education and respondented; 3.Threshold for focused aut 100% compliance with documentation of patient and caregiver education. If threshold met, Patient Care Manag will re-educate involved staff, progressively, involving human resources for work plans, if needed.  Who is going to be response for prevention above: i.e., director, supervisor, etc.? Patient Care Managers (PCN are responsible for audits and correction. PCMs will be overby Director(s) of Clinical Serva (DCS) who report to the Administrator. The Administrator. The Administrator shall report Focus audit result the QAPI Committee and the Governing Body for three consecutive quarters.  By what date are you going have the deficiency corrections of the programment of the consecution of education at Admission and leducation at Admission and leducation at Admission and leducation of education at Admission and leducation at Admission and leduca	fic ise is dits is displayed displayed dits is displayed d

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` ´		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		151599	B. W	ING		10/01/	/2020
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIER	L		1	N MERIDIAN STREET, SUITE 3	375	
PREMIE	R HOSPICE & PALI	LIATIVE CARE - INDIANA LLC		CARMEL, IN 46032			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					to each IDG.		
0.0540							
S 0546	418.56(c)(1)						
D. 1 . 00	CONTENT OF PL						
Bldg. 00		must include all services					
		palliation and management					
		ess and related conditions,					
	including the follow						
	` '	o manage pain and					
	symptoms.		~ 0		2 - 40 - 50( )(4) 00N   TEN   T	0.5	40/20/2020
	D 1 1		S 03	546	<b>S 546</b> 18.56(c)(1) CONTENT (	OF	10/30/2020
		view and interview, the			PLAN OF CARE		
		roup (IDG) failed to ensure the			[The plan of care must include	all	
	*	d interventions for 1 of 1			services necessary for the		
	active record review	ved. (Patient #2)			palliation and management of	tne	
	E' 1' ' 1 1				terminal illness and related		
	Finding include:				conditions, including the		
	D:	ada arati aratida d IIDai ariti aira			following:]		
	_	y's policy titled "Prioritizing Jeeds Policy No. 1-033.1" dated			(1) Interventions to manage pa	ain	
		A written, individualized			and symptoms.		
		established within 48 hours of			How are you going to correct the deficiency? If already	ι	
	hospice benefit elec				corrected, include the		
	*	rioritization of patient			following steps and state dat	to	
	immediate problems	-			of correction.	ıe	
	miniculate problem	5/ Heeds			From 10/14/20-10/30/20, all		
	The clinical record	for patient #2, Election date			Nurses were In-serviced on th	<b>e</b>	
		istory and physical from an			following Premier Hospice &	-	
	· ·	), which stated the patient has			Palliative Care CHAP Hospice	<b>1</b>	
		al cord injury after a motor			Policy and Procedure Manual,		
		2002 that resulted in the			2020 policies:		
		paraplegic, has sacral/ ischial			1.INITIAL ASSESSMENT,		
		The patient was admitted prior			Policy No. 1-013;		
		on for sepsis related to wound			2.THE PLAN OF CARE-		
	-	ient underwent debridement			INDIANA, Policy No. 9-017;		
	•	py. The patient returned to			1.PRIORITIZING PATIENT		
		inresponsiveness and fever.			PROBLEMS/NEEDS, Policy N	lo.	
	-	ated again for recurrent sepsis			1-033.		
	_	g 3 seizures during their			Policy sets forth that the		
	hospital stay.				Interdisciplinary Group (IDG) s	shall	

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	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 151599	(X2) MULTIPLE C A. BUILDING B. WING	OO	(X3) DATE SURVEY COMPLETED 10/01/2020
PREMIE		LIATIVE CARE - INDIANA LLC	11550 CARM	ADDRESS, CITY, STATE, ZIP COD N MERIDIAN STREET, SUITE IEL, IN 46032	375
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY 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)	BITTE
	skilled nursing facilial after hospitalization wound vac (a type of pressure on the work (intravenous) antibin A 9/5/20 note indicincreased in size frostools, causing furth wound. The note aldiagnosis of an anxindicated the patienthe right heel possible wound to the right to 0.1 cm, left heel me unstageable deep tis cm, Stage IV left thron 8/28/20. During had critical labs and hospice was present Review of the start assessment dated 9 stated the patient has sepsis related to the hospitalization, the patient consumes 3 indicated the patient stage 3 left hip ulceright heel was unblanote went on to stat boots and the patier and bladder.  Review of the plan 09/10/20 to 12/8/20 plan of care indicate and taking alprazola and taking alprazola and taking alprazola and taking alprazola.	also contained notes from a lity that the patient was sent to a for wound treatment with a of device that decreases air and to help it heal), IV otics for sepsis, and seizures. ated the patient's sacral wound om 7 to 10 cm due to loose her infection to the sacral diso indicated the patient had a fiety disorder. On 9/1, the note to that a deep tissue injury to only measuring 2.6 x 5 cm, a parochanter measuring 2 x 0.8 x reasuring was described as an assue injury measuring 2.5 x 6 conchanter measured 3.5 x 3.5 x 0.4 at the patient's stay, the patient of care comprehensive and the distribution of care comprehensive and the distribution of the deep hospitalized x2 for a wounds and during the last patient had 3 seizures and the to 6 beers daily. The note to 6 beers daily. The note to 6 beers daily. The note to 6 beers daily are the patient wore waffle and boggy. The effect was incontinent of bowel of care for the benefit period of the medication list on the deat the patient was prescribed am 0.5 mg every 6 hours as Baclofen 20 mg twice a day for		ensure the plan of care include interventions for symptom contributions includes pain management, interventions for seizure and muscle relaxant therapy, interventions to prevent skin breakdown/infection, and interventions for education of patient of risks while taking narcotics. The hospice register nurse will complete an initial assessment utilizing scales/ration to establish a baseline status each symptom rated. Items assessed may include, but are limited to, the following:  1.A. Pain assessment 2.B. Vital signs 3.C. Fatigue, drowsiness 4.D. Nausea, appetite 5.E. Depression, anxiety 6.F. Shortness of breath 7.G. Well-being 8.The admitting registers and caregiver's primary concerns goals and immediate care new Nurses will determine the patient and interventions performed all visits in accordance with the plan of care. A written individualized patient and family/caregiver plan of care we established. The care provided the patient must be in accordance with the plan of care. The plan care will include orders for care will be based.	the the ared ating and of e not services errors, eds. If goduring the will be ed to ance on of re.
	include for anxiety,	Ductoten 20 mg twice a day tol	1	Time plan of care will be based	4 011

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 151599		A. BU	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 10/01/2020		
	PROVIDER OR SUPPLIE		<u> </u>	11550 N	ADDRESS, CITY, STATE, ZIP COD N MERIDIAN STREET, SUITE ( EL, IN 46032		
(X4) ID PREFIX	(EACH DEFICIE	STATEMENT OF DEFICIENCIE  NCY MUST BE PRECEDED BY FULL  DELSC IDENTIFYING INFORMATION		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	λΤΕ	(X5) COMPLETION
TAG	muscle relaxant, led 100 mg twice a date mg-325 mg tablet pain. The plan of instruct: safety me educate patient/ fate at each visit. No condicated in the plan but limited to, the understand the pain to interventions for anxiety, muscle respreyent any further and interventions to consuming alcohologory. During an intervier patient's caregiver Xanax for years for horrible dysreflexis spasm, and does he utilizes the Bacloff needed.  The above finding Regional Director Nursing, Patient Consuming on Brant 10/01/2020 at 1:20	exetiracetam 500 mg and Vimpat by for seizures, and Norco 5 every 6 hours as needed for care revealed only two orders to asures each visit and to mily on oxygen use and safety of the orders of instruction was an of care. The goals included, patient/caregiver will in scale. The plan of care failed in pain management, patient's laxant, seizures, interventions to in skin breakdown/infection, in education the patient of it while taking narcotics.  We on 10/1/20 at 9:14 a.m., the stated the patient had been on in anxiety and the patient had a, which caused his legs to ave pain and discomfort, and en routinely and Norco as its were reviewed with the of Compliance, Director of are Manager of the ch, and Administrator on in or documentation to provide.		TAG	the initial, comprehensive and ongoing comprehensive assessments performed by members of the interdisciplina group and will be reviewed on regular basis but no less than every fifteen (15) days. This p will focus on identified problem goals, and interventions. The patient and family/caregiver wencouraged to participate in the development of and continued updating of the plan of care and will be advised of any changes the plan of care. A written, individualized plan of care will established to assist with identification and prioritization patient immediate problems/needs. The plan of constitution should include:  A. Patient and family/caregiver needs (prioritized)  9.B. Goals  10.C. Dates problems identified/onset  D. Resolution dates  How are you going to prever the deficiency from recurring the future, even if already corrected?  1.100% Focused chart audit 90 days on Admissions, then ongoing, 10% review each que to ensure appropriate symptomic control interventions and respare charted;  2.100% Focused audit prior each Interdisciplinary Group	lan ms, will be me de	DATE

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	T OF DEFICIENCIES  OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 151599	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 10/01/2020		
	ROVIDER OR SUPPLIER	R LIATIVE CARE - INDIANA LLC	STREET ADDRESS, CITY, STATE, ZIP COD 11550 N MERIDIAN STREET, SUITE 375 CARMEL, IN 46032				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)  Monting/IDC them appraising 1	5.112		
				Meeting/IDG, then ongoing, 10 each quarter to ensure approprize symptom control interventions response are charted; 3. Threshold for focused aud 100% compliance with plan of care that includes intervention symptom control. If threshold met, Patient Care Managers vire-educate involved staff, progressively, involving huma resources for work plans, if needed.  Who is going to be responsifor prevention above: i.e., director, supervisor, etc.? Patient Care Managers (PCM are responsible for audits and correction. PCMs will be overs by Director(s) of Clinical Servi (DCS) who report to the Administrator. The Administrations shall report Focus audit result the QAPI Committee and ther Governing Body for three consecutive quarters.  By what date are you going to have the deficiency corrected 10/30/20. By no later than 10/30/20, the organization will have implemented 100% Focus audits on symptom control interventions at Admission and Prior to each IDG.	oriate s and dits is s for not vill n ble s) staff seen ces tor s to n the do d? on by		

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	IA (X2) MULTIPLE CONSTRUCTION (X3) DAT		(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	LETED
		151599	B. WI	NG		10/01	/2020
			<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	t			N MERIDIAN STREET, SUITE 3	375	
PREMIER	R HOSPICE & PALI	LIATIVE CARE - INDIANA LLC			EL, IN 46032	,,,	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		TE	COMPLETION	
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
S 0548	418.56(c)(3)						
	CONTENT OF PL	AN OF CARE					
Bldg. 00	[The plan of care i	must include all services					
	· ·	palliation and management					
		ess and related conditions,					
	including the follow						
	` '	itcomes anticipated from					
	implementing and	coordinating the plan of					
	care.						
			S 05	548	S 548 [The plan of care must		10/30/2020
		view and interview, the			include all services necessary		
		roup (IDG) failed to ensure the			the palliation and managemen		
	_	ed measurable goals for 1 of 1			the terminal illness and related	d	
	active record review	ved. (Patient #2)			conditions, including the		
					following:]		
	Finding include:				(3) Measurable outcomes anticipated from implementing	and	
	The clinical record	for patient #2, Election date			coordinating the plan of care.4		
		istory and physicals from an			418.56(c)(3) CONTENT OF P		
		), which stated the patient had			OF CARE		
	a history of C6 spin	al cord injury after a motor			How are you going to correct	t	
	vehicle accident in 2	2002 that resulted in the			the deficiency? If already		
	patient becoming a	paraplegic, had sacral/ischial			corrected, include the		
	and heel wounds. T	The patient was admitted prior			following steps and state dat	te	
	•	on for sepsis related to wound			of correction.		
	infections. The pati	ient underwent debridement			From 10/14/20-10/30/20, all		
	-	py. The patient returned to			Nurses were In-serviced on th	е	
	_	inresponsiveness and fever.			following Premier Hospice &		
	•	ated again for recurrent sepsis			Palliative Care CHAP Hospice	;	
	_	g 3 seizures during their			Policy and Procedure Manual,	,	
	hospital stay.				2020 policies:		
					1.INITIAL ASSESSMENT,		
		also contained notes from a			Policy No. 1-013;		
		lity that the patient was sent to			2.THE PLAN OF CARE-		
	-	for wound treatment with a			INDIANA, Policy No. 9-017;		
		of device that decreases air			3.PRIORITIZING PATIENT		
	_	and to help it heal), IV			PROBLEMS/NEEDS, Policy N	10.	
		otics for sepsis, and seizures.			1-033.		
		ated the patient's sacral wound			Policy sets forth that the		
	increased in size fro	om 7 to 10 cm (centimeters) due	1		Interdisciplinary Group (IDG) s	shall	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION X	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING <u>00</u>	COMPLETED	
151599 B. WING	10/01/2020	
CTREET ADDRESS CITY CTATE ZID COD		
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP COD  14550 N.MEDIDIAN CIPET, CHITE 277		
11550 N MERIDIAN STREET, SUITE 375	5	
PREMIER HOSPICE & PALLIATIVE CARE - INDIANA LLC CARMEL, IN 46032		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFRENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG  PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION	
TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY)	DATE	
to loose stools, causing further infection to the ensure the plan of care includes	3	
sacral wound. The note also indicated the patient patient specific, measurable goa		
had a diagnosis of an anxiety disorder. On 9/1/20, and outcomes. This includes		
the note indicated the patient had a deep tissue measurable goals for pain and		
injury to the right heel possibly measuring 2.6 x 5 anxiety management, seizure		
cm, a wound to the right trochanter measuring 2 x control, dysreflexia, prevention of	of	
0.8 x 0.1 cm, left heel measuring was described as skin breakdown/infection, and		
an unstageable deep tissue injury measuring 2.5 x education for patient and		
6 cm, Stage IV left trochanter measured 3.5 x 3.5 x caregivers on risks, including		
0.4 cm on 8/28/20. During the patient's stay, the narcotic interactions. The hospic	ce	
patient had critical labs and refused further registered nurse will complete ar		
treatment and hospice was presented. initial assessment utilizing		
scales/rating tools to assess for		
Review of the start of care comprehensive problems and to establish a		
assessment dated 9/10/20, the narrative note baseline status of each symptom	n	
stated the patient had been hospitalized x2 for rated. Items assessed may		
sepsis related to the wounds and during the last include, but are not limited to, the	ne	
hospitalization, the patient had 3 seizures and the following:		
patient consumed 3 to 6 beers daily. The note 1.A. Pain assessment		
indicated the patient had a Stage 4 sacral ulcer,  2.B. Vital signs		
stage 3 left hip ulcer, stage 2 left heel ulcer, and  3.C. Fatigue, drowsiness		
the right heel was unblancheable and boggy. The 4.D. Nausea, appetite		
note went on to state the patient wore waffle 5.E. Depression, anxiety		
boots and the patient was incontinent of bowel 6.F. Shortness of breath		
and bladder. The pain assessment failed to 7.G. Well-being		
evidence an acceptable pain range/ goal 8. The admitting registered		
established by the patient.  nurse will determine the patient's	s	
and caregiver's primary concern	١,	
Review of the plan of care for the benefit period of goals and immediate care needs	S.	
09/10/20 to 12/8/20. The medication list on the Nurses will document teaching		
plan of care indicated the patient was prescribed and interventions performed duri	ring	
and taking alprazolam 0.5 mg (milligrams) every 6 all visits in accordance with the		
hours as needed for anxiety, Baclofen 20 mg twice plan of care. A written		
a day for muscle relaxant, levetiracetam 500 mg individualized patient and		
and Vimpat 100 mg twice a day for seizures, and family/caregiver plan of care will	l be	
Norco 5 mg-325 mg tablet every 6 hours as needed established. The care provided to		
for pain. The plan of care revealed only two the patient must be in accordance.		
orders to instruct: safety measures each visit and with the plan of care. The plan or	of	
to educate patient/ family on oxygen use and care will include orders for care.		
safety at each visit. No other orders of instruction  The plan of care will be based or	n	

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	OF CORRECTION	IDENTIFICATION NUMBER  151599	A. BUILDING  B. WING	00	COMPLETED 10/01/2020
	PROVIDER OR SUPPLIER	LIATIVE CARE - INDIANA LLC	11550 1	ADDRESS, CITY, STATE, ZIP COD N MERIDIAN STREET, SUITE 3 EL, IN 46032	775
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	care failed to includ measurable goal and goals in regards to the muscle relaxant, seil breakdown/ infection caregiver understand narcotics.  During an interview patient's caregiver so Xanax for years for horrible dysreflexial spasm, and does have utilizes the Baclofer needed.  The above findings Regional Director of Nursing, Patient Care Bloomington Brance 10/01/2020 at 1:20 pages 1:20 pages 1:20 pages 2.	te plan of care. The plan of te an acceptable pain range as a failed to include measurable the patient's wounds, anxiety, tzures, to prevent further skin on and goals for patient/ ding of mixing alcohol with  on 10/1/20 at 9:14 a.m., the tated the patient had been on anxiety and the patient had which caused his legs to the pain and discomfort, and a routinely and Norco as  were reviewed with the of Compliance, Director of the Manager of the h, and Administrator on to m., in which no further mentation was provided.		the initial, comprehensive and ongoing comprehensive assessments performed by members of the interdisciplina group and will be reviewed on regular basis but no less than every fifteen (15) days. This pl will focus on identified problem goals, and interventions. The patient and family/caregiver w encouraged to participate in the development of and continued updating of the plan of care ar will be advised of any changes the plan of care. A written, individualized plan of care will established to assist with identification and prioritization patient immediate problems/needs. The plan of care should include:  A. Patient and family/caregive needs (prioritized)  9.B. Goals  10.C. Dates problems identified/onset  D. Resolution dates  How are you going to prevent the deficiency from recurring the future, even if already corrected?  1.100% Focused chart audit 90 days on Admissions, then ongoing, 10% review each quato ensure measurable goals at included in the plan of care;  1.100% Focused audit prior each Interdisciplinary Group Meeting/IDG, then ongoing, 10 Meeting/IDG, then on	an an ans, sill be

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 151599	(X2) MULTIPLE A. BUILDING B. WING	CONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 10/01/2020		
	PROVIDER OR SUPPLIER	LIATIVE CARE - INDIANA LLC	STREET ADDRESS, CITY, STATE, ZIP COD 11550 N MERIDIAN STREET, SUITE 375 CARMEL, IN 46032				
PREMIEF  (X4) ID  PREFIX  TAG	SUMMARY (EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)  each quarter to ensure appropriate and provided the plan of care update;  2. Threshold for focused aud 100% compliance with plan of care that includes intervention symptom control. If threshold met, Patient Care Managers of the resources for work plans, if progressively, involving human resources for work plans, if needed.  Who is going to be responsified for prevention above: i.e., director, supervisor, etc.? Patient Care Managers (PCM are responsible for audits and correction. PCMs will be overaby Director(s) of Clinical Service.	(X5) COMPLETION DATE  priate d in  dits is f ns for not will n  ble  s) I staff seen		
				(DCS) who report to the Administrator. The Administrators shall report Focus audit result the QAPI Committee and ther Governing Body for three consecutive quarters.  By what date are you going have the deficiency corrected 10/30/20.  Nurses completed re-education 10/30/20, the organization will have implemented 100% Focus audits on patient measurable goals at Admission and Prior each IDG.	to d? on by		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		ſ ´			(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u>			COMPLETED	
		151599	B. W	NG		10/01/2020		
	PROVIDER OR SUPPLIER	LIATIVE CARE - INDIANA LLC	•	11550 N	ADDRESS, CITY, STATE, ZIP COD N MERIDIAN STREET, SUITE 3 EL, IN 46032	375		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TC	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE	
TAG S 0553 Bldg. 00	418.56(d) REVIEW OF THE A revised plan of of information from the comprehensive as the patient's progregoals specified in a Based on record revelocity (Interdisciplinary Grevised plan of care progress toward out in the plan of care for (Patient #1, 2)  Findings include:  1. Review of an age "Interdisciplinary Grevised plan of care will be from the ongoing control of the patient will note changes, reprogress toward targeting include: A. Pharms symptoms management and increase or decrease Pain management and status of pressure ultereatments or proceed  2. The clinical recontrol of the patient of the patient will note changes, reprogress toward targeting include: A. Pharms symptoms management and the patient of the pati	PLAN OF CARE care must include ne patient's updated sessment and must note ess toward outcomes and the plan of care.  riew and interview, the IDG roup) failed to ensure the included the patient's comes and goals as specific or 2 of 3 records reviewed.  ency policy titled froup Meeting Policy No. /20, indicated " Each patient's updated utilizing the results comprehensive assessment interdisciplinary group to update form will be used for t and family/ caregiver It esponse to treatment and geted outcomes, with may acotherapeutic effectiveness of ment outcomes. B. An the in symptoms or acuity 2. 3. Condition of skin/ presence/ cers H. Plan for changes in	S 03		S 553 418.56(d) REVIEW OF PLAN OF CARE A revised plan of care must include information from the patient's updated comprehens assessment and must note the patient's progress toward outcomes and goals specified the plan of care. How are you going to correct the deficiency? If already corrected, include the following steps and state dat of correction. From 10/14/20-10/30/20, all Nursing staff were In-serviced the following <i>Premier Hospice Palliative Care CHAP Hospice Palliative Care CHAP Hospice Policy and Procedure Manual</i> , 2020 policies and rules:  1.PRIORITIZING PATIENT PROBLEMS/NEEDS, Policy No. 1-033;  2.MONITORING PATIENT'S RESPONSE/REPORTING TO PHYSICIAN, Policy No. 1-010 3.ONGOING COMPREHENSIVE ASSESSMENT, Policy No. 1-1 Involved staff acknowledged the in-service re-training in writing Organization policies set forth the IDG (Interdisciplinary Ground included in the IDG (Interdisciplinary Included in the IDG (Interdisciplinary Included in the IDG (Interdisciplinary Included in Incl	THE sive e in t te on & e Jo. Signification is that	10/30/2020	

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	T OF DEFICIENCIES DF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 151599	A. BU	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 10/01/2020	
PREMIER	ROVIDER OR SUPPLIER	LIATIVE CARE - INDIANA LLC		11550 N	ADDRESS, CITY, STATE, ZIP COD N MERIDIAN STREET, SUITE 3 EL, IN 46032	75	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
TAG	caregiver) will verb indications, uses, ar medication and adm prescribed as evided from medication errorect each visit th Patient/ Caregiver was pain scale, how to me changes to hospice. 5/10 or less by the eutilizing pain medication benefit period. Corror as ordered. Patient program AEB [as elegated benefit period. Corror as ordered. Patient program AEB [as elegated benefit period. Patient program AEB [as elegated benefit period benefit program AEB [as elegated benefit period benefit program AEB [as elegated benefit period benefit period benefit period benefit period. Patient's restabilized to comfor adventitious lung so [related to] increase increased SOA [she benefit period. Patient's restabilized to comfor adventitious lung so [related to] increase increased SOA [she benefit period. Patient's restabilized to comfor adventitious lung so [related to] increase increased SOA [she benefit period. Patient's restabilized to comfor adventitious lung so [related to] increase increased SOA [she benefit period. Patient's restabilized to comformation with the period perio	alize understanding of ad side effects of each minister medications as need by no adverse effects for, narcotic counts will be rough next benefit period. Will understand the numeric manage pain and report  Pt [Patient] will rate pain at end of each nursing visit by eations as ordered throughout mfort medications will be given will have an effective bowel widenced by] pt having a BM at least every 3 days period. Pt will be free early comiting] by the end of the through next benefit period. The period of each nursing enefit. Patient will rate ess by the end of each nursing enefit. Patient will maintain ection and within constraints of ear rating of 5/10 or less rest by sing visit through next benefit spiratory status will be at as possible AEB no bounds, discolored sputum r/t and productive cough or ortness of air] throughout ent/ caregiver will be able to to promote comfort related to not the terminal patient through. Pt will wear oxygen as at benefit period. Patient will next as possible of Patient will next as possible of Patient will next entry caregiver will be able to the promote comfort related to not the terminal patient through. Pt will wear oxygen as at benefit period. Patient will next AEB no falls or injury		TAG	shall ensure the revised plan of care includes the patient's progress toward outcomes and goals as specified in the plan of care update. Clinicians will monitor, document, and report patient's response to care and treatment provided on each hospice visit in IDG coordination. Progress of goals will be measured at regular intervals a updated on the plan of care. Clinicians will establish and maintain ongoing communication with the patient's physician and the hospice Medical Director to ensure responsive medical care the patient. A revised plan of comust include information from patient's updated comprehens assessment and must note the patient's progress toward outcomes and goals as specific in the plan of care. IDG Discussion shall note patient progress toward wound healing/wound goals, increase use of symptom control medications, identify lack of symptom assessment and relations, patient changes in status and implement updated goals interventions for actively dying patients.  How are you going to prevent the deficiency from recurring the future, even if already corrected?  1.100% Focused audit prior each Interdisciplinary Group	of the on. and or efor are the ive ed d ted s, and	DATE

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		151599	B. W	B. WING 10/01			2020
				CTREET	ADDRESS CITY STATE ZID COD		
NAME OF I	PROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP COD	75	
DDEME	D LIGODIOE A DAL	LIATIVE CARE INDIANALLO			N MERIDIAN STREET, SUITE 3	1/5	
PREMIER HOSPICE & PALLIATIVE CARE - INDIANA LLC		LIATIVE CARE - INDIANA LLC		CARINE	EL, IN 46032		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE .	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	i E	DATE
	throughout benefit	period. Patient/ caregiver			Meeting/IDG, then ongoing, 10	)%	
	understand the risks	s and benefits of side rail use			each quarter to ensure update	s	
	through next benefi	t period. Patient needs will be			and progress toward measura		
	met throughout the	next benefit period Patient			goals is included in plan of car		
	will receive persona	al care and hygiene, including			update;		
	other activities of d	aily living to their optimal level			2.Threshold for focused aud	its is	
	AEB remaining odd	or free, having a neat/ clean			100% compliance with plan of		
		next benefit period. Patient/			care that includes updates and		
	Caregiver understar	nd the risk and benefits of side			progress toward measurable		
	rail use through nex				goals. If threshold not met, Pa	tient	
		-			Care Managers will re-educate		
	Review of the agency's document titled 8/19/20				involved staff, progressively,		
	Hospice IDG Comprehensive Assessment and				involving human resources for	work	
	Plan of Care Update for patient #1, included IDG				plans, if needed.		
	notes from skilled r	nursing visits. The Plan of Care					
	Update failed to evi	idence the patient's/ caregiver			Who is going to be responsil	ole	
	progress towards al	l goals listed on the plan of			for prevention above: i.e.,		
	care, as well as the	specific medication that was			director, supervisor, etc.?		
	educated as evidence	ced by the following:			Patient Care Managers (PCMs	s)	
					are responsible for audits and	•	
	The 8/7/20 IDG not	te indicated the education			correction. PCMs will be overs		
	provided were safet	ty and comfort medication.			by Director(s) of Clinical Service	ces	
	Narcotic count indi	cated: Norco 12, Roxanol 30			(DCS) who report to the		
	ml, and Lorazepam	10. No falls. Patient and/ or			Administrator. The Administrat	or	
	caregiver understan	d the appropriate use, use of			shall report Focus audit results	s to	
	side rails and return	s demonstration, and			the QAPI Committee and then	the	
	dexamethasone was	s called into the patients			Governing Body for three		
	pharmacy. Review	of the skilled nursing visit note			consecutive quarters.		
	indicated the only is	nterventions/ goals achieved			·		
	was pain manageme	ent and safety.			By what date are you going t	0	
					have the deficiency corrected	d?	
	The 8/8/20 IDG not	te indicated "N/A" to education			10/30/20.		
	provided. Narcotic	count indicated: Norco 12,			Nurses completed re-educatio	n by	
	Morphine (Roxanol	l) 30 ml, and Lorazepam 20. No			10/30/20. By no later than		
	falls. Patient and/ or	r caregiver understand the			10/30/20, the organization will		
	appropriate use of s	ide rails and returns			have implemented 100% Focu	IS	
	demonstration. Res	spirations even but slightly			audits on progress toward pati	ent	
	labored at rest at tin	nes and the patient denied a			measurable goals Prior to eac	h	
	need for intervention	n, no edema, and DME			IDG.		
	(durable medical eq	quipment) concerns. Review of					

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AND PLAN OF CORRECTION  IDENTIFICATION NUMBER  151599		lì í	UILDING	00	COMPL 10/01/	ETED	
	ROVIDER OR SUPPLIER	LIATIVE CARE - INDIANA LLC		11550 N	DDRESS, CITY, STATE, ZIP COD I MERIDIAN STREET, SUITE 3 L, IN 46032	375	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY 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)	TE	(X5) COMPLETION DATE
	the skilled nursing v interventions/ goals management and sa	_					
	provided. Narcotic Morphine (Roxanol No falls. Patient and appropriate use of s demonstration. Ove and spouse instructe medications. Revie note indicated the o achieved was pain r	te indicated "N/A" to education count indicated: Norco 12, (2) 29.5 ml, and Lorazepam 20. (2) or caregiver understand the ide rails and returns the counter eye drops used (2) ed on hospice not delivering (2) when of the skilled nursing visit only interventions/ goals management and safety.					
	Narcotic count indic ml, Lorazepam 21. caregiver understan rails and returns der breath at baseline.	No falls. Patient and/ or d the appropriate use of side monstration. Shortness of Concerns and request for a ent's bed. Review of the skilled adicated the only achieved was pain					
	provided were safet Narcotic count indic ml, Lorazepam 20. caregiver understan rails and returns der breath at baseline. See bed extender and we available. Review of indicated the only in was pain management	ote indicated the education by and comfort medication. cated: Norco 12, Roxanol 28  No falls. Patient and/ or d the appropriate use of side monstration. Shortness of Spouse requests a bariatric as advised that it was not of the skilled nursing visit note interventions/ goals achieved ent and safety.					

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	OF CORRECTION	IDENTIFICATION NUMBER  151599	A. BUILDING  B. WING	00	COMPLETED 10/01/2020
	PROVIDER OR SUPPLIER	LIATIVE CARE - INDIANA LLC	11550 N	ADDRESS, CITY, STATE, ZIP COD N MERIDIAN STREET, SUITE 3 EL, IN 46032	375
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	Narcotic count indice ml, Lorazepam 21. understand the approper returns demonstratic tachycardia with an new order for cardizinto the pharmacy. baseline. Review of indicated the only in was pain managemed.  3. The clinical reconstruction of the benefit perion medication list indice prescribed Xanax 0. for anxiety, Baclofe muscle relaxant, Lo hours as needed for restlessness, Norconhours as needed for concentrate 100 mg give 0.25 ml every a fair hunger. The intensive nurse to obtain the patient of the composition.  Review of the composition of the wour patient had a stage 3 trochanter that measure centimeters (cm), wand 51-75% necrotic medical with a stage 3 trochanter that measure centimeters (cm), wand 51-75% necrotic medical with a stage 3 trochanter that measure centimeters (cm), wand 51-75% necrotic management in the patient had a stage 3 trochanter that measure centimeters (cm), wand 51-75% necrotic management in the patient had a stage 3 trochanter that measure centimeters (cm), wand 51-75% necrotic management in the patient had a stage 3 trochanter that measure centimeters (cm), wand 51-75% necrotic management in the patient had a stage 3 trochanter that measure centimeters (cm), wand 51-75% necrotic management in the patient had a stage 3 trochanter that measure centimeters (cm), wand 51-75% necrotic management in the patient had a stage 3 trochanter that measure centimeters (cm), wand 51-75% necrotic management in the patient had a stage 3 trochanter that measure centimeters (cm), wand 51-75% necrotic management in the patient had a stage 3 trochanter that measure centimeters (cm), wand 51-75% necrotic management in the patient had a stage 3 trochanter that measure centimeters (cm), wand 51-75% necrotic management in the patient had a stage 3 trochanter that measure centimeters (cm), was a stage 3 trochanter that measure centimeters (cm), was a stage 3 trochanter that measure centimeters (cm).	irregular heart rate of 140-160, zem 120 mg daily was called No shortness of breath above of the skilled nursing visit note enterventions/ goals achieved ent and safety.  In the stand of the skilled nursing visit note enterventions of goals achieved ent and safety.  In the stand of goals achieved ent and safety.  In the stand of the skilled nursing visit note enterventions of goals achieved ent and safety.  In the stand of the skilled nursing visit note enterventions of the skilled nursing visit note ente			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 151599		A. BUI	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 10/01/2020	
	PROVIDER OR SUPPLIE	R LIATIVE CARE - INDIANA LLC		11550 N	ADDRESS, CITY, STATE, ZIP COD N MERIDIAN STREET, SUITE EL, IN 46032	375	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	I	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR		(X5) COMPLETION
TAG	depth description is wound with 25 - 50 necrotic tissue slout the left heel that m description indicate with 100% epithelistissue slough and experience of the skill 9/13/20 and 9/14/2 indicated "Instructed provided wound supplies preventative skin coaregiver regarding calories/ protein in wound healing I " The plan of care these interventions measurable goals for Review of the 9/16 Comprehensive As update, the Medica patient had an unstable land wears was supported by the coassessments. The Care Manger, and manager, indicated providing informat wounds and the procurrent wound treatinclude if any other the patient in regar mattress, blood sugmorphine not being	ed nursing visit note dated 0, the interventions provided ed patient/ caregiver on wound patient/ caregiver in performing ing proper disposal of used Instructed patient/ caregiver in are Instructed patient/ g proper nutrition including take necessary to promote dentified sources of pressure failed to be updated to include and the prospective for these interventions.  1/20 Hospice IDG 1/		TAG	DEFICIENCY		DATE

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		151599	B. WI	NG		10/01/	2020
				CTDEET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	8				75	
DDEMIE	D LICEDICE & DALL	LATIVE CADE INDIANALIC			N MERIDIAN STREET, SUITE 3	75	
PREMIE	R HUSPICE & PALI	LIATIVE CARE - INDIANA LLC		CARIVIE	EL, IN 46032		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	E	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	Review of the skille	ed nursing visit note dated					
	9/16/20, indicated the	he last bowel movement was					
	on 9/9/20 when the	9/14/20 visit note indicated					
	9/14/20. The Integumentary assessment indicated						
	there were 3 pressur	re ulcers, but only identified					
	one at stage 3 and 4, and inaccurately indicated						
	zero to stage 2 pressure ulcers. The visit note						
	identified the patien	nt is a diabetic but failed to					
	include an assessme	ent of blood sugars, the					
	patient's repeat pain	assessment "N/A - Patient					
	was at or below the	ir acceptable level for pain					
	during the initial pa	in assessment", the functional					
	assessment indicate	d the patient was a					
	quadriplegic with th	ne patient is a paraplegic, the					
	wound assessment i	indicated the left trochanter is					
	a stage 3 but a suspe	ected deep tissue injury with a					
	large amount of pur	rulent draining with a strong					
	odor with 76-100%	necrotic slough tissue and					
	025% of necrotic es	schar tissue, the sacral wound					
	is a stage 4 but desc	cribed as a suspected deep					
	tissue injury with a	moderate amount of purulent					
		ng odor with 0-25% of necrotic					
	slough and eschar ti	issue, and the left heel is a					
	stage 2 but describe	ed as a suspected deep tissue					
		6 epithelialization tissue, soft					
		e and 0-25% necrotic slough					
	tissue. The wound	identification and					
	assessments failed t	to be consistent and accurate					
	according to the wo	ound assessment websites.					
	The narrative note i	ndicated the patient was					
	having episodes of	a fixed stare without					
	identifying this as a	possible seizure incident.					
		ated the patient was out of					
		nt had pain in the left arm on					
		note failed to indicate if the					
	physician was notifi	ied of the odor and drainage of					
	the wounds and pos						
		led indicated "Hospice					
	comfort kit reviewe	ed and is intact with current					

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 151599	(X2) MULTIPLE A. BUILDING B. WING	E CONSTRUCTION  G 00	COMP	ESURVEY LETED 1/2020
	PROVIDER OR SUPPLIER	R LIATIVE CARE - INDIANA LLC	1155	ET ADDRESS, CITY, STATE, ZIP COD 50 N MERIDIAN STREET, SU RMEL, IN 46032	TE 375	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	TION LD BE COPRIATE	(X5) COMPLETION DATE
TAG	expiration dates, in regarding use of co 9/17/20 indicated the completed due to make and the caregular getting the medicat.  Review of the skilled 9/18/20 indicated the lethargic, anxiety depatient, the patient's - Patient was at or lepain during the initial narrative note indice patient lorazepam and patient being confusion sentences and wince patient was "active discontinued routing ordered comfort medicated the patient was along within the narrative 25, Roxanol 30 ml, to include the patient was followed by the patient was along the patient w	structed patient/ caregiver mfort kit. The IDG note dated ne narcotic count was not nultiple family members in the giver was uncomfortable ions out.  ed nursing visit note dated ne patient was confused and oes not significantly affect the serepeat pain assessment "N/A pelow their acceptable level for ial pain assessment" but the ated the clinician gave the and hydrocodone due to the sed speaking in nonsensical ing. The note indicated the "and notified the physician, e medications, and only edications/ scheduled zepam. The narcotic count in note indicated Hydrocodone Lorazepam 29. The count failed	TAG	CROSS-REFERENCED TO THE APPR DEFICIENCY)	OPRIATE	DATE
	no pain, the patient "N/A - Patient was level for pain durin The IDG narcotic c	's repeat pain assessment at or below their acceptable g the initial pain assessment".  ount for the morphine was are narcotic count on 9/18, the				

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	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 151599	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 10/01/2020
PREMIEF	ROVIDER OR SUPPLIER	LIATIVE CARE - INDIANA LLC	11550 N	ADDRESS, CITY, STATE, ZIP COD N MERIDIAN STREET, SUITE EL, IN 46032	375
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
TAG	inconsistent number 9/18 to current 45 to assessment of the paragraph to the paragraph to the paragraph to the paragraph to the skille 9/20/20, indicated the significantly after assessment continue no pain or pain does movement and the radicated "N/A - Paracceptable level for assessment" but the patient reported the managing their pain include an assessment pain level due to the Review of the skille 9/21/20, indicated that significantly after assessment continue no pain or pain does movement and the radicated "N/A - Paracceptable level for assessment continue no pain or pain does movement and the radicated "N/A - Paracceptable level for assessment." The leassessment." The leassessment indicated extensive and the paragraph to th	r of Norco from 25 tabs on ab, and failed to identify an atient's anxiety level due to 7 mg used from previous day.  20 IDG note indicated the llows: Morphine is not in the insistent from 9/18/20.  Xanax 11 tabs, Norco 42 tabs. and nursing visit note dated the patient did not have anxiety feeted him/ her, the pain and to indicate the patient has a not interfere with activity or repeat pain assessment tient was at or below their pain during the initial pain narrative note indicated the prn Norco was effective in an attention. The visit note failed to ent of the patient anxiety and the use of the narcotics.  And nursing visit note dated the patient did not have anxiety feeted him/ her, the pain and to indicate the patient has a not interfere with activity or repeat pain assessment tient was at or below their pain during the initial pain eff trochanter wound did the depth description was atient had a large amount of with a strong odor, the sacral	TAG	DEFICIENCY	
	depth description w	as described as necrotic. The in the narrative indicated			

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 151599	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 10/01/2020
PREMIE	PROVIDER OR SUPPLIER	LIATIVE CARE - INDIANA LLC	11550 N	ADDRESS, CITY, STATE, ZIP COD N MERIDIAN STREET, SUITE EL, IN 46032	375
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	Lorazepam was bland 11. The visit note for	sen within 24 hours), nk, Roxanol 29 ml, and Xanax ailed to include an assessment y and pain level due to the use			
	9/23/20, indicated that significantly after assessment continue no pain or pain does movement and the reindicated "N/A - Paracceptable level for assessment." The leassessment indicate extensive and the parameter indicate extensive and the parameter indicate undermining (0.5 cm o'clock, 6-9 at o'clock of tunneling at 9 assessment indicate extensive and had a undermining (1 cm 6-9 at o'clock, and 9 tunneling at 9-12 o'clock of a stage 2 but the	d nursing visit note dated ne patient did not have anxiety fected him/ her, the pain ed to indicate the patient has a not interfere with activity or repeat pain assessment tient was at or below their pain during the initial pain eft trochanter wound d the depth description was atient had a large amount of ith a strong odor, the wound ted 5 x 5 x 0.5 cm with <2 cm at 12 - 3 o'clock, 3 - 6 at eck, and 9-12 at o'clock) and 1 1-12 o'clock. The sacral wound d the depth description was strong odor, with < 2 cm at 12 - 3 o'clock, 3 - 6 at o'clock, 0-12 at o'clock) and 1 cm of clock. The left heel continued the depth description was c with a measurement of 5 x 6			
	x 0.1 cm. The wour assessments failed to according to the wood The narcotic count windicated Norco 26 Lorazepam 9 (12 tall conjunction with Xaml, and Xanax 7 (4 conjunction with Lorequested refills on	c with a measurement of 3 x 6 and identification and o be consistent and accurate und assessment websites. within the narrative note (9 tabs taken within 48 hours), be taken in 72 hours in anax), Roxanol (Morphine) 30 tabs taken in 72 hours in orazepam). The caregiver the Xanax and Lorazepam.			

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	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 151599	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY  COMPLETED  10/01/2020
	ROVIDER OR SUPPLIER	LIATIVE CARE - INDIANA LLC	11550	ADDRESS, CITY, STATE, ZIP COD N MERIDIAN STREET, SUITE 3 EL, IN 46032	375
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	assessment of the partial anti-anxiety medical	atient's use of pain and tions.			
	9/25/20, indicated to that significantly af assessment continue no pain or pain does movement and the residual indicated "N/A - Pa acceptable level for assessment." The leassessment indicate extensive and the papurulent drainage weighthelialization, 76 and 0-25% Necrotic assessment failed to measurement but in cm at 12 - 3 o'clock and 9-12 at o'clock) wound assessment indescription was extensive and the papurulent drainage weighthelialization, 76 and 0-25% Necrotic assessment failed to measurement but in cm at 12 - 3 o'clock and 9-12 at o'clock) wound assessment indescription was extensive appropriate and paper of the second in the wood indicated Lorazepar Roxanol 30 ml, and failed to evidence a	e evidence a wound cluded <2 cm undermining (2, 3 - 6 at o'clock, 6-9 at o'clock, and no tunneling. The sacral indicated the depth ensive with moderate odor, ion 0-25% of necrotic tissue har. The assessment failed to measurement but included < 2 cm at 12 - 3 o'clock, 3 - 6 at ck, and 9-12 at o'clock) and 2 0-12 o'clock. The left heel			
	medications.				

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 151599		ì í	JILDING	instruction <u>00</u>	(X3) DATE : COMPL 10/01/	ETED		
		ROVIDER OR SUPPLIER	LIATIVE CARE - INDIANA LLC	STREET ADDRESS, CITY, STATE, ZIP COD 11550 N MERIDIAN STREET, SUITE 375 CARMEL, IN 46032				
	(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	Œ	(X5) COMPLETION DATE
		9/28/20, indicated to that significantly af assessment continue no pain or pain does movement and the rindicated "N/A - Pa acceptable level for assessment." The lassessment indicate extensive and the papurulent drainage we epithelialization, 76 and 0-25% Necrotic assessment failed to measurement but in cm at 12 - 3 o'clock and 9-12 at o'clock) wound assessment in description was extedescription was extedescription was extedescription was extedescription was extedescription was description	o evidence a wound cluded <2 cm undermining (2 c, 3 - 6 at o'clock, 6-9 at o'clock, and no tunneling. The sacral indicated the depth ensive and with strong odor, ion 0-25% of necrotic tissue that. The assessment failed to measurement but included < 2 cm at 12 - 3 o'clock, 3 - 6 at ck, and 9-12 at o'clock) and 2.5 o'clock. The left heel					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER  151599		A. BUILDING  B. WING	00	COMPLETED 10/01/2020	
	PROVIDER OR SUPPLIER	LIATIVE CARE - INDIANA LLC	11550 N	ADDRESS, CITY, STATE, ZIP COD N MERIDIAN STREET, SUITE 3 EL, IN 46032	375
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	provided was safety there was instruction comfort kit, instruct inspection of the skip proper positioning, hydration and nutrit surfaces. These into consistent with the refailed to evidence a the patient's use of predications.  Review of the skille 9/30/20, indicated that significantly affects assessment continue no pain or pain does movement and the reindicated "N/A - Pare acceptable level for assessment." The leassessment indicated 1 cm the depth descepatient had a large a with strong odor, <2 necrotic tissue amous slough and eschar, we cm at 12 - 3 o'clock, and 9-12 at o'clock) wound assessment in x 10 x 3 cm, the depand with small purues <25% epithelialization with slough and escundermining identificated a measure continued to be a statement of the skiller	ied and 5 cm of tunneling at 12 heel wound assessment ment of 5.5 x 6.5 x 0.1 cm,			

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	IPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILD	ING	00	COMPL	ETED
		151599	B. WING			10/01/	2020
			ST	TREET A	DDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	₹			I MERIDIAN STREET, SUITE 3	75	
PREMIEI	R HOSPICE & PAL	LIATIVE CARE - INDIANA LLC			L, IN 46032		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	II	D	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		EFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	TA	AG	DEFICIENCY)		DATE
		on and assessments failed to be					
		rate according to the wound					
		s and the sacral wound					
		inneling and undermining					
	failed to be consiste						
		rrative note indicated the asms were worsening and					
	1 ^	asms were worsening and and and a determined to increase Baclofen to four					
		arcotic count within the					
	1	ated Lorazepam 18 tabs, Xanax					
		in 48 hours in conjunction					
		Roxanol 30 ml, and Norco 61					
		e note indicated education					
	provided was safety. The interventions indicated						
	there was instruction regarding the use of the						
		tion regarding routine					
		in, instruction regarding					
	_	regarding appropriate					
		tion, and use of support					
	· ·	erventions failed to be					
	consistent with the	narrative note. The visit note					
	failed to evidence a	comprehensive assessment of					
	the patient's use of	pain and anti-anxiety					
	medications.						
	Review of the 9/30	/20 IDG note revealed that the					
	Medical Director's	failed to include any feedback					
	pertaining to the pa	tient's lack of progress toward					
	wound healing, inci	rease use of anti-anxiety					
	_	in medications and their lack of					
		ceptable pain goal. The IDG					
		formation in regards to the					
	1 ^	I failed to mention when the					
	patient appeared to	be actively dying.					
		v on 10/1/20 at 9:14 a.m., the					
		stated the patient had been on					
		anxiety and the patient had					
	I	, which caused his legs to					
	spasm, and does ha	ve pain and discomfort, and					

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TAG REGULATORY OR LSC IDENTIFYING INFORMATION  utilizes the Baclofen routinely and Norco as needed. The caregiver also stated that they were never taught on how to provide wound care. The caregiver stated they felt the wounds were getting worse.  4. The above findings were reviewed with the Regional Director of Compliance, Director of Nursing, Patient Care Manager of the Bloomington Branch, and Administrator on 10/01/2020 at 1:20 p.m., the Director of Nursing indicated he felt the description and staging of wounds were appropriate and interventions had been approached to the patient #2, but the declined their efforts. In regards progress	TE SURVEY MPLETED 01/2020	<u>00</u>	A. BUILDING  B. WING	IDENTIFICATION NUMBER  151599		
PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION  utilizes the Baclofen routinely and Norco as needed. The caregiver also stated that they were never taught on how to provide wound care. The caregiver stated they felt the wounds were getting worse.  4. The above findings were reviewed with the Regional Director of Compliance, Director of Nursing, Patient Care Manager of the Bloomington Branch, and Administrator on 10/01/2020 at 1:20 p.m., the Director of Nursing indicated he felt the description and staging of wounds were appropriate and interventions had been approached to the patient #2, but the declined their efforts. In regards progress		I MERIDIAN STREET, SUITE 375	11550 1			
needed. The caregiver also stated that they were never taught on how to provide wound care. The caregiver stated they felt the wounds were getting worse.  4. The above findings were reviewed with the Regional Director of Compliance, Director of Nursing, Patient Care Manager of the Bloomington Branch, and Administrator on 10/01/2020 at 1:20 p.m., the Director of Nursing indicated he felt the description and staging of wounds were appropriate and interventions had been approached to the patient #2, but the declined their efforts. In regards progress	COMPLETION	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	PREFIX	CY MUST BE PRECEDED BY FULL	(EACH DEFICIENC	PREFIX
towards goals, the Director of Nursing and Patient Care Manager stated they felt the record met the requirement.  S 0591  418.64(b)(1) NURSING SERVICES (1) The hospice must provide nursing care and services by or under the supervision of a registered nurse. Nursing services must ensure that the nursing needs of the patient are met as identified in the patient's initial assessment, comprehensive assessment, and updated assessments.  Based on record review and interview, the nurse failed to ensure patients were accurately assessed and documentation was consistent, given the prescribed medications as received in a verbal order during the dying process, failed to indicate the time, amount, and patient response after each dose given, for 2 of 2 records reviewed of recently deceased patients. (Patient #1, 3)  Findings include:  S 0591  S 591 418.64(b)(1) NURSING SERVICES (1) The hospice must provide nursing care and services by or under the supervision of a registered nurse. Nursing services must ensure that the nursing needs of the patient are met as identified in the patient's initial assessment, comprehensive assessment, and updated assessments.	10/30/2020	SERVICES (1) The hospice must provide nursing care and services by or under the supervision of a registered nurse. Nursing services must ensure that the nursing needs of the patient are met as identified in the patient's initial assessment, comprehensive assessment, and updated	S 0591	gs were reviewed with the f Compliance, Director of re Manager of the h, and Administrator on o.m., the Director of Nursing description and staging of oriate and interventions had the patient #2, but the s. In regards progress pirector of Nursing and Patient d they felt the record met the substitute of the patient #2 and the patient #3 and Patient #4 and the patient #4 and patient response after each 2 records reviewed of recently	needed. The caregiven never taught on how caregiver stated they worse.  4. The above finding Regional Director of Nursing, Patient Care Bloomington Branch 10/01/2020 at 1:20 prindicated he felt the wounds were appropheen approached to declined their efforts towards goals, the DC Care Manager stated requirement.  418.64(b)(1) NURSING SERVIC (1) The hospice may and services by or registered nurse. It ensure that the nursiare met as identified assessment, compand updated assessment, compand updated assessment documentation who prescribed medication order during the dying the time, amount, and dose given, for 2 of 2 deceased patients. (1)	

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STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		151599	B. W	NG		10/01/	2020
				CTD FET	ADDRESS CITY STATE ZID COD		
NAME OF F	ROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD	75	
DDEMIE	DUOCDIOE & DALI	LIATIVE CADE INDIANALIO			N MERIDIAN STREET, SUITE 3	175	
PREMIE	R HOSPICE & PALI	LIATIVE CARE - INDIANA LLC		CARINE	EL, IN 46032		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROVIDED'S DI AN OF CODDECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	rc	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	i E	DATE
	1. Review of an art	ticle titled Preventing Delirium			How are you going to correct	t	
		Lessons From Recent Research			the deficiency? If already		
	at ncbi.nim.nih.gov	indicated " The medications			corrected, include the		
	_	y contribute to delirium are			following steps and state dat	e	
	benzodiazepines [L				of correction.	-	
		l], and steroids Pain and			From 10/14/20-10/30/20, all		
	_	patient with pain who is treated			Nurses were In-serviced on the	e	
		ain relief often requires opiates,			following <i>Premier Hospice</i> &	-	
	_	to assess when the patient is			Palliative Care CHAP Hospice		
	•	Moaning, grimacing, and			Policy and Procedure Manual,		
	•	occur in the nightmare of			2020 policies:		
	-	an be misunderstood as a			1.NURSING CARE, Policy N	lo	
	-	tate. Patients who are in pain			9-019;		
		riented, with problems in			2.IDENTIFICATION OF		
	memory and attention, cannot report accurately				MEDICATION FOR		
	whether a remedy worked The				ADMINISTRATION, Policy No		
	-	d opioids administered in the			2-005;	•	
	_	tress can worsen confusion			3.POSSESSION OF CERTA	JN	
	The older patient is				DRUGS AND OTHER	\\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	
	_	rium; the risk of delirium from			HEALTHCARE ITEMS- INDIA	ΝΔ	
	-	eater if the patient is older.			Policy No 2-005.B;	,	
		kely to be missed if the patient is			4.ADMINISTRATION AND		
		nts no management problem			DOCUMENTATION OF		
	"	no no management process un			MEDICATIONS, Policy No. 2-0	006·	
					5.COMFORT KITS, Policy N		
	2. Review of an ag	ency policy titled "Comfort			2-005.A.	0.	
	-	005.A.1" dated 5/11/20,			Involved staff acknowledged th	nis	
	-	ation and use of Comfort Kits			in-service re-training in writing		
		he visiting hospice nurse will			Organization policies set forth		
		and family on the use and			the hospice nurse will ensure	uiui	
	storage of the comf				patients are accurately assess	ed	
					and charted assessments,	-Cu	
	3. The clinical reco	ord of patient #1 was reviewed			narrative, and intervention		
		ontained a plan of care for the			documentation is consistent.		
		8/06/20 to 10/04/20, with			Nurses may administer prescri	ibed	
	-	included but not limited to,			medications as received in a		
		blet every 4 hours as needed			verbal order during the dying		
		ness/ agitation and Morphine			process and shall document th	ne	
		ml, give 0.25 ml every 4 hours			time, drug, amount, and patier		
	as needed for severe				response after each dose give		
	as needed for severe	c pains an nanger.	1		I response anter each dose give	11.	

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STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	LETED
		151599	B. W	ING		10/01	/2020
		l .	<u> </u>	STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIEF	₹			N MERIDIAN STREET, SUITE 3	375	
PREMIER	R HOSPICE & PAL	LIATIVE CARE - INDIANA LLC			EL, IN 46032		
			I		· [		(V5)
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA  DEFICIENCY)	TE	DATE
IAU	REGULATURY OF	CESC IDENTIFTING INFORMATION	+	IAU	The Hospice Nurse shall:		DATE
	Review of a death s	visit note dated 8/21/20, the			A. Manage discomfort and pro	ovide	
		d "Patient found to be			symptom relief.	VIUC	
		Order received to increase			1.B. Incorporate specializ	zed	
	•	of morphine and lorazepam,			nursing skills related to palliati		
		oses of of [sic] Lorazepam and			end-of-life care into all clinical		
		imal effect. Call to [name of			care.		
	•	again and order given for haldol			1.C. Provide education o	n	
	_	w of the clinical record failed to			disease process, self-care,		
	evidence verbal orders that the nurse received				end-of-life care.		
		Director. The note failed to			2.D. Provide emotional		
		ic order received as well the			support to the patient and fam	ilv.	
	-	ven during each episode.			3.E. Assess for risks of g	-	
	g.	S 1			cultural, spiritual implications	,,	
	During an interviev	v on 09/30/20 at 9:20 a.m., the			exacerbated by the terminal		
	-	ey observed between the hour			diagnosis.		
	-	rival and the patient's death, 0.5			4.F. Initiate appropriate		
		comfort to the patient), then a			preventive and rehabilitative		
	whole syringe of R	oxanol (no comfort to the			nursing procedures.		
		hole syringe of Roxanol then			5.G. Prepare clinical and		
	Lorazepam, (no con	mfort to the patient and family			progress notes that demonstra		
		g store to pick up Haldol),			progress toward established		
		r whole syringe of Roxanol and			goals.		
	•	aregiver indicated she was not			6.H. Coordinate all servi	ces	
		tion on the medication and felt			and prioritization of needs with	n the	
		ns given multiple times in an			interdisciplinary group.		
	hour resulted in the	ir loved ones death.			7.I. Use a case manager	nent	
					approach and make referrals	to	
		nterviewed on 10/01/20 at 9:00			other services as needed.		
	_	l on the medication given,			8.J. Provide specialized		
		"multiple multiple" doses of			hospice training to other staff,		
	_	ad many calls to the doctor			family/caregivers to ensure		
	and called the Patie	ent Care Manager.			adequate care.		
	4 751	1 0 1 1 1 1 1 1 1 1			9.K. Provide an ongoing		
		ord of patient #3, Election date			evaluation of the patient and		
		ewed and included a plan of			family/caregiver response to c		
		with a medication list of, but not			10.L. Assess the ability of		
	-	al 0.25 mg at bedtime,			the caregiver to meet the patie	ent's	
		blet every 4 hours as needed			immediate needs.		
	I tor anxiety and rest	lessness and Morphine	1		O Assure communication		I

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PRINTED: 11/20/2020 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION  AND PLAN OF CORRECTION  IDENTIFICATION NUMBER  151599		JILDING	onstruction 00	(X3) DATE : COMPL 10/01/	ETED	
	PROVIDER OR SUPPLIER	LIATIVE CARE - INDIANA LLC	11550 N	ADDRESS, CITY, STATE, ZIP COD N MERIDIAN STREET, SUITE 3 EL, IN 46032	75	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY 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)	ΓE	(X5) COMPLETION DATE
	(Roxanol) concentresolution 0.25 ml everal and shortness of break revealed the patient with behavioral dist Dispersedly 0.25 m the patient was in the which was surgically home with hydroco Review of a skilled 9/10/20, the pain as was not in pain and the patient stated his which was inconsisted Interventions provided hospice comfort kit with current expiration the use of the consection indicated the because the medicate by the pharmacy. The inconsistent with the Review of a skilled 9/11/20, the intervention indicated the hospical and was instructed on the narrative section in count because the medical the hospical was instructed on the count because the medical count because the medical was instructed on the narrative section in count because the medical count be	ate 100 mg/5 ml (20 mg/ml) oral ery 4 hours as needed for pain eath.  al paperwork dated 7/28/20 had a diagnosis of Dementia turbances and had been taking g daily then on 9/4/20, revealed he hospital for a fractured hip by repaired and was discharged done 5 mg - 325 mg.  nursing visit note dated sessment indicated the patient the narrative note indicated s/her hip was a little sore., tent with the assessment. It ded section indicated the was reviewed and was intact ion dates and was instructed mfort kit. The narrative ere was no narcotic count tions had not been picked up the interventions provided was		between the hospice and othe health care providers involved care. Patient and family/caregic education and training activitie will be initiated and continued throughout the course of care. Nursing services must ensure the nursing needs of the patient are met as identified in the patient's initial assessment, comprehensive assessment, aupdated assessments. Orders be present for nurse medication administration. Orders for the administration of medications must be given by a physician (other authorized independent practitioner) and include patien name, patient identifier, the natof the medication, dosage, dilution, route, frequency of administration, and rate of infusion. The individual receivithe order must record it, sign it immediately and have the prescribing person sign it in accordance with state and federegulations. Licensed nursing personnel will administer and document only those medication which have been ordered by the physician, as a part of the plancare and have been approved safe administration and monited during a hospice visit. Hospice patients not residing in a nursi home will receive a comfort kit needed, based on their comprehensive assessment. To comfort kit will contain emergents and entered and the comprehensive assessment. To comfort kit will contain emergents	r in ver is that int ind will on or int interest one of for oring in as The	

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PRINTED: 11/20/2020 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER  151599		A. BUILDING  B. WING	00 00	COMPLETED 10/01/2020	
	PROVIDER OR SUPPLIER	IATIVE CARE - INDIANA LLC	11550 1	ADDRESS, CITY, STATE, ZIP COD N MERIDIAN STREET, SUITE 3 EL, IN 46032	375
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	5.112
	The narrative note in received from the carwas restless and had visit was made and alert, hallucinating, having pain, which assessment. Loraze The surgical incision The patient's buttool measurements/ asses. New antibiotic orderindicated the patient pace. Physician was received to increase hours and Lorazepar patient received the Morphine. The nurs repeared [sic] 2 mornote, the nurse failed orders provided by the administered more what was prescribed.  Review of a skilled 9/15/20, the mental patient was "comate question asking if an patient, and answere were "relaxed and carbait was at or be pain during the initian narrative note indication bed but the patient which was inconsist. The narrative note in Lorazepam and 0.5 patient became unreed Orders were received medications and to see the patient was defined as the patient was received medications and to see the patient was received to increase hours and patient was prescribed.	ndicated a phone call was aregiver reporting the patient a bedsores. A prn (as needed) upon arrival, the patient was and reported he/ she was was inconsistent with the pam and Roxanol was given. In was slightly red and warm, was slightly red and warm, was received. The note of continued to be restless and so contacted and orders were morphine to 0.5 ml every 4 m 2 mg every 4 hours. The 2 mg of Lorazepam and 1 ml of see also documented "prn dose the times." According to this dot follow the new verbal the physician and Morphine and Lorazepam than		medication(s) as ordered by the patient's physician or the Hosp Medical Director and will be maintained in the patient's hor until orders are received for its use. After delivery: 1. The visit hospice nurse will re-educate patient and family on the use a storage of the comfort kit. The hospice nurse will notify the patient's physician or Medical Director when there is a change the patient's condition that mawarrant use of one or more medications in the comfort kit will obtain specific orders for the use.  How are you going to prevent the deficiency from recurring the future, even if already corrected?  1.100% Focused chart audit 90 days on Admissions, then ongoing, 10% review each quato ensure charting consistency between assessment, narrativ and intervention documentation verbal medication orders are included in the written plan of care, and charting of hospice nurse medication administration includes time, drug, amount, a patient response after each do given;  2.100% Focused audit prior each Interdisciplinary Group Meeting/IDG, then ongoing, 10 each quarter to ensure charting consistency between	ne pice ne sing the sand neir t pin for arter ren, e, nn, on and ose tto 0%

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AND PLAN OF CORRECTION  AND PLAN OF CORRECTION  151599			r í	UILDING	ONSTRUCTION  00	(X3) DATE COMPI 10/01	LETED
	PROVIDER OR SUPPLIEF	LIATIVE CARE - INDIANA LLC		11550 1	ADDRESS, CITY, STATE, ZIP COD N MERIDIAN STREET, SUITE 3 EL, IN 46032	375	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		(X5) COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
		the visit note was inconsistent			assessment, narrative, and		
		nd the skilled nurse failed to			intervention documentation, ve		
		ders and administered the			medication orders are include		
	_	orphine when the patient was			the written plan of care update		
		signs of anxiety, restlessness,			and to ensure charting of hosp		
	nor pain.				nurse medication administration		
	Daview of a skilled	nursing visit note dated			includes time, drug, amount, a		
		n., the mental assessment			patient response after each do given;	JS <del>C</del>	
	indicated the patient was "comatose", answered				3. Threshold for focused audit	e ie	
	of "no" to a question asking if anxiety				100% compliance with	3 13	
		the patient, indicated the			documentation of verbal order	and	
		, answered "no" when asked if			medication administration. If		
	*	re you uncomfortable because			threshold not met, Patient Car	е	
	of pain" and patient had no pain or pain does not				Managers will re-educate invo		
	interfere with activity or movement but did				staff, progressively, involving		
	indicate current sev	erity of verbal cues of			human resources for work pla	ns, if	
	whining,whimperin	g, or moaning and the question			needed.		
	of severity of facial	cues indicate "drawn around					
	mouth and eyes." 7	The narrative note indicated			Who is going to be responsi	ble	
	the patient was trying	ng to get up from the bed upon			for prevention above: i.e.,		
	_	tient was moaning and crying			director, supervisor, etc.?		
	_	ndicated that orders were			Patient Care Managers (PCM	•	
		razepam and Morphine every			are responsible for audits and		
		e patient was comfortable. The			correction. PCMs will be overs		
		to document a consistent			by Director(s) of Clinical Servi	ces	
		ed to evidence a time, amount			(DCS) who report to the		
		nistered, and patient response			Administrator. The Administra		
	l .	Morphine and Lorazepam			shall report Focus audit result		
	given.				the QAPI Committee and then	tne	
	Review of a skilled	nursing visit note dated			Governing Body for three		
		., the pain assessment indicated			consecutive quarters.		
		ies were "relaxed and calm."			By what date are you going t	0	
		indicated the patient was in			have the deficiency correcte		
		e patient had a calm facial			10/30/20.		
	_	ions were labored with			Nurses completed re-education	n bv	
		se noted. The hospice nurse			10/30/20. By no later than	~ ;	
	· ·	give "morphine and			10/30/20, the organization will		
		ery 15 minutes until			have implemented 100% Focu		

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PRINTED: 11/20/2020 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER  151599		A. BUILDING B. WING	00 00	COMPLETED 10/01/2020	
	ROVIDER OR SUPPLIER	LIATIVE CARE - INDIANA LLC	115501	ADDRESS, CITY, STATE, ZIP COD N MERIDIAN STREET, SUITE 3 EL, IN 46032	375
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
IAU	comfortable. Loraz given x2. No edema Respirations slowed indicated "Action ta orders must be writt hours. A physician 8:49 p.m. indicated [hours], discontinue ml. The narrative n what orders were re evidence any docum restlessness, failed t and patient response and Lorazepam givenumber of respiration administration of Lot 15 minutes.  During an interview spouse stated they for a tivan killed the pat The spouse stated the education on the use stated in the past, we anxiety, they always always helped. The came in one day where a spouse stated if the Lorazepam and the Lorazepam and the spouse stated if adult child had know they wouldn't have a medication.	epam 2 mg and Morphine 1 ml a or mottling noted. It to 8. The narrative note ken or orders obtained [verbal en]: Morphine 1 ml every 4 order written on 9/16/20 at "Morphine 1 ml q [every] 4 hrs d Lorazepam Intensol 2 mg/ ote failed to be consistent on ceived and written, failed to nentation of terminal o evidence the time, amount, e after each dose of Morphine en, and failed to indicate the ons per minute prior to the orazepam and Morphine every  of on 10/01/20 at 9:40 a.m., the elt that the morphine and ient and how guilty they felt. They didn't receive any e or side effects. The spouse then the patient would have s gave extra risperdal which spouse indicated the nurse en the patient was restless, they wanted to be e nurse instructed them to give Roxanol to be given routinely. The/ she and the patient's we that Roxanol was morphine,	IAU	audits on documentation of verorders and medication administration at Admission at Prior to each IDG.	rbal
	when asked if nurse administer more me restless/ actively dy				

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i i		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING  (X3) DATE SURVEY  COMPLETED  10/01/2020		
		151599	B. WING		10/01/2020
	PROVIDER OR SUPPLIER	LIATIVE CARE - INDIANA LLC	1155	ET ADDRESS, CITY, STATE, ZIP COD 50 N MERIDIAN STREET, SUITE : MEL, IN 46032	375
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL	PREFIX	CROSS-REFERENCED TO THE APPROPRIA	
TAG		LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	"comfort kits."	ncy did not provide or order			
	Regional Director o Nursing, Patient Ca Bloomington Branc 10/01/2020 at 1:20 p	h, and Administrator on p.m., the Director of Nursing s were pretty restless,			
S 0690	418.106(b) ORDERING OF D	IDLICS			
Bldg. 00	(1) Only a physicia 1861(r)(1) of the A accordance with the law, may order drug. (2) If the drug order through electronic (i) It must be given nurse practitioner pharmacist, or phy. (ii) The individual in record and sign it	an as defined by section act, or a nurse practitioner in the plan of care and State ags for the patient. The ris verbal or given by or transmission- an only to a licensed nurse, (where appropriate), ysician; and receiving the order must immediately and have the an sign it in accordance with			
	failed to ensure nurs writing, signature w ordering physician t closed records revie passed. (Patients #1 Findings include:  1. The clinical reco	view and interview, the agency sing put verbal orders into vith date, and sent to the for signature for 2 out of 2 ewed of patients who recently 1, 3)	S 0690	S 690 18.106(b) ORDERING DRUGS (1) Only a physician as define section 1861(r) (1) of the Act, or a nurs practitioner in accordance with plan of care and State law, may order drugs for the patient. (2) If the drug order is vor given by or through electrotransmission-	d by e n the ay erbal nic
		/06/20 to 10/04/20, with		(i) It must be given only a licensed nurse. nurse	, 10

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ЛLDING	00	COMPL	ETED
		151599	B. W	ING		10/01/	2020
				_			
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD		
					N MERIDIAN STREET, SUITE 3	375	
PREMIE	R HOSPICE & PAL	LIATIVE CARE - INDIANA LLC		CARME	EL, IN 46032		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	IE	DATE
	medication orders,	included but not limited to,			practitioner (where appropriate	<del></del>	
	· ·	blet every 4 hours as needed			pharmacist, or physician; and	- /,	
		eness/ agitation and Morphine			(ii) The individual receiv	ina	
		ml, give 0.25 ml every 4 hours			the order must record and sign	•	
	as needed for sever	_			immediately and have the		
		The second			prescribing person sign it in		
	Review of a death y	visit note dated 8/21/20, the			accordance with State and		
		d "Patient found to be			Federal regulations.		
		Order received to increase			. Caorai rogalationo.		
	1	of morphine and lorazepam,			How are you going to correc	t .	
		oses of of [sic] Lorazepam and			the deficiency? If already	-	
	morphine with minimal effect. Call to [name of				corrected, include the		
	Medical Director] again and order given for Haldol				following steps and state dat	· 0	
		ew of the clinical record failed to			of correction.	æ	
		lers that the nurse received			From 10/14/20-10/30/20, all		
	from the Medical D				Nurses were In-serviced on th	•	
	nom the Medical L	offector.				E	
	During on interview	v on 09/30/20 at 9:20 a.m., the			following Premier Hospice & Palliative Care CHAP Hospice		
	_	ey observed between the hour					
		rival and the patient's death, 0.5			Policy and Procedure Manual, 2020 policies:		
		comfort to the patient), then a			1.IDENTIFICATION OF		
	1	oxanol (no comfort to the			MEDICATION FOR		
		nole syringe of Roxanol then					
		nfort to the patient and family			ADMINISTRATION, Policy No	-	
		g store to pick up Haldol),			2-005;	LIKI	
					2.POSSESSION OF CERTA	AIIN	
		r whole syringe of Roxanol and			DRUGS AND OTHER	N I A	
	Lorazepam.				HEALTHCARE ITEMS- INDIA	INA,	
	F1 A	4			Policy No 2-005.B;		
		iterviewed on 10/01/20 at 9:00			Involved staff acknowledged the		
	_	on the medication given and if			in-service re-training in writing		
		s written, Employee A stated			Organization policies set forth		
		doses of meds were given, had			the Hospice Nurse shall ensur		
	1	octor and called the Patient			orders will be present for nurse		
	_	she didn't write the order since			medication administration. Ord	ders	
	the patient was no l	onger "in the house."			for the administration of		
	0 751 11 1	1 0 1 1 1 2			medications must be given by		
	2. The clinical record of patient #3, Election date				physician (or other authorized		
		ewed and included a plan of			independent practitioner) and		
		with a medication list of, but not			include patient name, patient		
	limited to, Lorazepa	am 1 mg tablet every 4 hours as			identifier, the name of the		

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	UILDING	00	COMPL	ETED
		151599	B. W	ING		10/01/	2020
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	8			N MERIDIAN STREET, SUITE 3	375	
PREMIE	R HOSPICE & PALI	LIATIVE CARE - INDIANA LLC			EL, IN 46032		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	-	TAG	DEFICIENCY		DATE
		and restlessness and			medication, dosage, dilution,		
		l) concentrate 100 mg/5 ml (20			route, frequency of administra		
		n 0.25 ml every 4 hours as			and rate of infusion. The indiv		
	needed for pain and	l shortness of breath.			receiving the order must recor		
					sign it immediately and have t	he	
		nursing visit note dated			prescribing person sign it in		
		9/14/20 indicated Lorazepam and Roxanol was			accordance with state and fed	leral	
	-	or restlessness. The note			regulations.		
	_	t continued to be restless and					
		is contacted and orders were			How are you going to prever		
		e morphine to 0.5 ml every 4			the deficiency from recurring	g in	
		am 2 mg every 4 hours. The			the future, even if already		
	•	2 mg of Lorazepam and 1 ml of			corrected?		
	Morphine. The nurse also documented "prn dose				1.100% Focused chart audit	for	
	repeared [sic] 2 more times." Review of the clinical				90 days on Admissions, then		
		dence the written orders to			ongoing, 10% review each qu		
	repeat the dosages g	given x 2.			to ensure verbal medication o		
					are included in the written plai	n of	
		nursing visit note dated			care;		
		m., indicated that orders were			2.100% Focused audit prior	to	
	_	razepam and Morphine every			each Interdisciplinary Group		
		e patient was comfortable.			Meeting/IDG, then ongoing, 1		
		cal record failed to evidence the			each quarter to ensure verbal		
	_	ve Lorazepam and Morphine			medication orders are include		
	every 15 minutes.				the written plan of care update		
	D				3.Threshold for focused aud	lits is	
		nursing visit note dated			100% compliance with		
	_	., indicated the hospice nurse			documentation of verbal order		
		give "Morphine and			compliance. If threshold not m	iet,	
		5 minutes until comfortable.			Patient Care Managers will		
		nd Morphine 1 ml given x2. The			re-educate involved staff,		
		ated "Action taken or orders			progressively, involving huma	n	
	_	ders must be written]:			resources for work plans, if		
	_	ry 4 hours. A physician order			needed.		
		at 8:49 p.m. indicated			) NA/II		
		every] 4 hrs [hours],			Who is going to be responsi	DIE	
		epam Intensol 2 mg/ ml. The			for prevention above: i.e.,		
		to be consistent with what was			director, supervisor, etc.?	,	
		the visit note. (to give			Patient Care Managers (PCM		
	Morphine and Lora	zepam every 15 minutes until	1		are responsible for audits and	staff	

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 151599	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY  COMPLETED  10/01/2020
	PROVIDER OR SUPPLIER	LIATIVE CARE - INDIANA LLC	11550	ADDRESS, CITY, STATE, ZIP COD N MERIDIAN STREET, SUITE EL, IN 46032	375
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	(X5) COMPLETION DATE
	when asked if nurse administer more me restless/ actively dy Administrator stated orders."  4. The above findin Regional Director of Nursing, Patient Ca Bloomington Brance 10/01/2020 at 1:20	dications when the patient is ing than what is ordered, the d "No, we do not do standing ags were reviewed with the f Compliance, Director of		correction. PCMs will be over by Director(s) of Clinical Serv (DCS) who report to the Administrator. The Administrator. The Administration shall report Focus audit result the QAPI Committee and ther Governing Body for three consecutive quarters.  By what date are you going have the deficiency corrected 10/30/20.  Nurses completed re-education 10/30/20, the organization will have implemented 100% Focus audits on documentation of veorders at Admission and Prioreach IDG.	to to to d? on by  I us erbal
S 0696 Bldg. 00	[At the time when ordered the hospid (B) Discuss the written the safe use and discussed the hospid (B) Discuss t	STORAGE DRUGS controlled drugs are first	S 0696	S 696 418.106(e)(2)(i)(B) LAE DISPOSE STORAGE DRUGGE [At the time when controlled care first ordered the hospice must:] (B) Discuss the hospice policies	S Irugs

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		151599	B. W	NG		10/01/	2020
				CED FEET	ADDRESS STATE THE COD		
NAME OF F	ROVIDER OR SUPPLIER	<b>t</b>			ADDRESS, CITY, STATE, ZIP COD	7.5	
5554					N MERIDIAN STREET, SUITE 3	75	
PREMIE	R HOSPICE & PALI	LIATIVE CARE - INDIANA LLC		CARME	EL, IN 46032		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	BROWIDERIC BY AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'		COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	IE.	DATE
		d to ensure that the parties			and procedures for managing	the	
	•	of 3 patient records reviewed.			safe use and disposal of contr		
	(Patient #1)	- 1			drugs with the patient or		
	(=)				representative and the family in a		
	Findings include:				language and manner that the		
	i mumgs meruuer				understand to ensure that thes	-	
	Review of an agenc	ey's document found within the			parties are educated regarding		
	admission folder tit	-			safe use and disposal of control		
	Guidelines" revised 11/17, stated " 1 The				drugs;	Silou	
	case manager will verbally discuss the policy in a				urugo,		
	language and manner that they understand to				How are you going to correct		
	ensure the safe disposal medications Patient/				the deficiency? If already		
	family education will be documented in the clinical				corrected, include the		
	record 2. Upon patient death or when a				following steps and state dat	•	
	hospice patient otherwise no longer has a need				of correction.	C	
		dications, the hospice nurse or			This area was not identified as		
		ospice staff will assist the			concern at the survey Exit	a	
		ispose of them or will instruct			Conference with the Organizat	ion	
		to dispose of them according to			From 10/10-10/12/20, all nurse		
		e will also provide information			were In-serviced on the followi		
		ail-back programs. 3. Drugs			Premier Hospice & Palliative C	•	
	will disposed of on				CHAP Hospice Policy and	arc	
	will disposed of on				Procedure Manual, 2020 polic	iec.	
	Review of a revised	l policy titled "Home Use of			1.Home Use of Controlled		
		ces Policy No. 2008.1" dated			Substances; Policy No. 2-008	<b>}-</b>	
		2. The Admitting Nurse/ Case			2.Drug Disposal, Policy No.	-	
		de a copy of the written			2-008.A.	•	
		ures on the management of			Organization policies set forth	that	
		the patient/ representative and			the Interdisciplinary Group sha		
	_	a hospice patient no longer has			discuss written policies and		
	-	led substance, the Case			procedures for the safe use ar	nd	
		act the patient and family/			disposal of controlled drugs wi		
	caregiver regarding	-			the patient/caregiver in a langu		
	Tarogr, or regulating	Proper ampount			and manner that they understa	-	
	Review of a revised	l policy titled "Drug Disposal			The Admitting Nurse will provide		
		.1" dated 5/11/20, stated " 1.			copy of the written policy and	u	
	-	se/ Case Manager will provide			procedure on the managemen	t of	
		n policies and procedures on			controlled drugs to the	l Oi	
		d disposal of drugs, including			patient/representative and fam	ilv	
	_				l ·	-	
	controlled drugs to the patient/ representative and		1		The person responsible for dru	ıy	

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 151599	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 10/01/2020
PREMIE	PROVIDER OR SUPPLIER	LIATIVE CARE - INDIANA LLC	11550	ADDRESS, CITY, STATE, ZIP COD N MERIDIAN STREET, SUITE EL, IN 46032	375
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
	verbally discuss the manner that they un use and disposal of controlled drugs. T manager will docum the patient/ Represe received a copy of t The Admitting Nurse document in a clinic the disposal of the p will document in the instructions given, t response as to their disposal/ process an properly dispose of Disposal of Control When a hospice pat controlled substance instruct the patient a regarding proper dis Admitting Nurse/ C the clinical record the caregiver were give procedures for mandiscussed the disposaresponsibility to do  Review of patient # start of care date of for the benefit period with orders for skill weeks then 2 times  Review of admission following skilled in 8/9, 8/10, 8/13, 8/13, 8/13, 8/10, 8/10, 8/13, 8/13, 8/10, 8/10, 8/10, 8/13, 8/13, 8/10, 8/10, 8/10, 8/13, 8/13, 8/13, 8/10, 8/10, 8/10, 8/13, 8/13, 8/13, 8/10, 8/10, 8/10, 8/13, 8/13, 8/13, 8/10, 8/10, 8/10, 8/13,	ring Nurse/ Case Manager will policy in a language and derstand to ensure the safe medication, including he Admitting Nurse/ Case ment in the clinical record that intative and family have he policies and procedures. 2. se/ Case Manager will cal note who is responsible for patient's drugs 5. The nurse is medical record: disposal he patient/ family's verbal understanding of the did their responsibility to the unneeded medication(s) led Substances - Family 1. itent no longer has a need for a set, the Case Manager will and family/ caregiver sposal of the drugs 2. The lase Manger will document in that the patient and family/ in the written policies and aging controlled drugs and sal of medication and took so "  1's clinical record, revealed a 08/06/2020, and a plan of care dof 08/06/2020 to 10/04/20, ed nursing 3 times a week for 2 a week for 7 weeks.  In note dated 8/6/20 and the larsing visit notes dated 8/7, 8/8, 7, 8/21/2020, failed to evidence d management of controlled ussed and the patient/ family to their understanding.		disposal will be identified. Pe policy, the Admitting Nurse we verbally discuss the policy in language and manner that the understand to ensure the safe use/disposal of controlled dru. The responsible individual will acknowledge this education is signing the policy that is proved as part of the Hospice Patien. Admission Booklet. A copy of signed policy will be uploaded the chart. In clinical notes, Nushall document the patient or caregivers understanding of the policy at admission and any the patient or caregiver need re-education. When a hospic patient no longer has a need controlled substance, the nurwill re-instruct the patient and family/caregiver regarding prodisposal. The nurse will docuin the medical record: disposal instructions given, the patient/family's verbal responsibility to properly disposal process and their responsibility to properly disposal process and their responsibility to properly disposal from the unneeded medication of the unneeded medication of the patient/family refuses the disposal/destruction of medications, this will be report to the patient's physician and clinical supervisor and documented in the patient recurring the deficiency from recurring the future, even if already corrected?	rill a eey e ligs. Il by ided t f the d to urses this ime s e for a se d oper ment al ase as ose s). If rted

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 151599		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 10/01/2020			
NAME OF PROVIDER OR SUPPLIER  PREMIER HOSPICE & PALLIATIVE CARE - INDIANA LLC  (X4) ID  SUMMARY STATEMENT OF DEFICIENCIE  PREFIX  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION  During an interview on 09/30/20 at 9:20 a.m., the spouse indicated she thought the hospice was going to take the medications or destroy after the patient died. The spouse indicated a family member, who was a sheriff, took the medications and had them destroyed. The death visit note dated 8/21/2020 failed to evidence this information.  Employee A was interviewed on 10/01/20 at 9:00 a.m., and indicated that the patient's medications were not destroyed during the death visit for she			11550 N	DDRESS, CITY, STATE, ZIP COD I MERIDIAN STREET, SUITE 3 L, IN 46032	75			
	PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PR	ID EFIX FAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
		During an interview spouse indicated she going to take the me patient died. The spouse and had them destrodated 8/21/2020 fai information.  Employee A was in a.m., and indicated were not destroyed was not allowed to was made aware. To 8/21/2020 failed to the above findings Regional Director of Nursing, Patient Ca Bloomington Brance 10/01/2020 at 1:20	or on 09/30/20 at 9:20 a.m., the enthought the hospice was edications or destroy after the pouse indicated a family a sheriff, took the medications byed. The death visit note led to evidence this destroyed at 9:00 that the patient's medications during the death visit for she go back in and that the DON the death visit note dated evidence this information.  Were reviewed with the f Compliance, Director of re Manager of the h, and Administrator on p.m., the Director of Nursing vare of the employee not			1.100% focused chart audit if 90 days on home patient Admissions, then ongoing, 100 each quarter to ensure documentation of signed policy and that patients and caregive understand the drug disposal policy per charted education. Nurses shall securely submit a copy of signed document to the office for chart attachments.  2.100% Focused audit prior each home patient Interdisciplinary Group Meeting/IDG, then ongoing, 10 each quarter to ensure and the patients and caregivers understand the drug disposal policy per charted re-education and that refusals are reported the Clinical Supervisor/Designal Threshold for focused audit 100% with evidence patient's/representative's understanding of drug disposal threshold not met, Patient Care Managers will re-educate involstaff, progressively, involving human resources for work planneeded.  Who is going to be responsite for prevention above: i.e., director, supervisor, etc.? Patient Care Managers (PCMs are responsible for audits and correction. PCMs will be oversely Director(s) of Clinical Service (DCS) who report to the Administrator. The Administrator.	y y rs a e to 0% at n to ee; its is e lived es) staff eeen ces	

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	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	, ,		NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 00 COMPLETED  B. WING 10/01/2020				
		151599	B. WI	NG		10/01/	2020
	PROVIDER OR SUPPLIER	LIATIVE CARE - INDIANA LLC		11550 N	ADDRESS, CITY, STATE, ZIP COD N MERIDIAN STREET, SUITE 3 EL, IN 46032	375	
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					shall report Focus audit results the QAPI Committee and then Governing Body for three consecutive quarters.  By what date are you going to have the deficiency corrected 11/12/20.  Nurses completed re-education 11/12/20. By no later than 11/12/20, the organization will have implemented 100% Focus audits on drug disposal policy signed and education documentation at Admission a Prior to each IDG.	o d? n by	
S 0697	418.106(e)(2)(i)(C	) STORAGE DRUGS					
Bldg. 00	[	STORAGE DRUGS					
	Based on record reversal failed to ensure the policy and document record the written puring managing controlled the patient/caregived patient records revied document the name method of disposal #3) closed records refindings include:  1. Review of an age	riew and interview, the agency clinician followed agency ated in the patient's clinical colicies and procedures for d drugs was discussed with the for 2 of 3 (Patient #1, 2) awed, and failed to ensure to of the drug, amount, and upon death for 1 of 2 (Patient eviewed.	S 06	597	S 697 418.106(e)(2)(i)(C) LAB DISPOSE STORAGE DRUGS [At the time when controlled drare first ordered the hospice must:] (B) Discuss the hospice policie and procedures for managing safe use and disposal of controdrugs with the patient or representative and the family i language and manner that the understand to ensure that these parties are educated regarding safe use and disposal of controdrugs;	rugs es the olled n a y se g the	11/12/2020
	Guidelines" revised case manager will v	11/17, stated " 1 The erbally discuss the policy in a er that they understand to			How are you going to correct the deficiency? If already corrected, include the	t	

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STATEMENT OF DEFICIENCIES 2		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		COMPLETED		
		151599	B. WING		10/01/2020		
				CTREET	ADDRESS CITY STATE ZID COD		
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP COD	75	
DDEMIED HOODIGE & DALLIATIVE CADE. INDIANALI C			11550 N MERIDIAN STREET, SUITE 375 CARMEL, IN 46032				
PREIVIIE	PREMIER HOSPICE & PALLIATIVE CARE - INDIANA LLC				EL, IN 46032		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX			COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	DEFICIENCY)	. =	DATE
	ensure the safe disp	osal medications Patient/			following steps and state dat	е	
	family education w	ill be documented in the clinical			of correction.		
	record 2. Upon	patient death or when a			This area was not identified as	а	
	hospice patient other	erwise no longer has a need			concern at the survey Exit		
	for one or more me	dications, the hospice nurse or			Conference with the Organization.		
	other appropriate ho	ospice staff will assist the			From 10/10-10/12/20, all nurses		
	patient/ family to di	ispose of them or will instruct			were In-serviced on the follow	ng	
		to dispose of them according to			Premier Hospice & Palliative C	•	
	policy. The hospice	e will also provide information			CHAP Hospice Policy and		
	on take-back and m	ail-back programs. 3. Drugs			Procedure Manual, 2020 polic	ies:	
	will be disposed of	on site "			1.Home Use of Controlled		
					Substances; Policy No. 2-008;		
	2. Review of a revi	ised policy titled "Home Use of			2.Drug Disposal, Policy No.		
	Controlled Substances Policy No. 2008.1" dated				2-008.A.		
	5/11/20, stated " 2. The Admitting Nurse/ Case				Organization policies set forth	that	
	Manager will provide a copy of the written				the Interdisciplinary Group shall		
	policies and procedures on the management of				discuss written policies and		
	controlled drugs to the patient/ representative and				procedures for the safe use ar	nd	
		a hospice patient no longer has			disposal of controlled drugs wi		
		led substance, the Case			the patient/caregiver in a language		
	Manager will instru	ect the patient and family/			and manner that they understand.		
	caregiver regarding proper disposal."				The Admitting Nurse will provide a		
					copy of the written policy and		
	3. Review of a revised policy titled "Drug				procedure on the managemen	t of	
Disposal Policy No. 2-008.A.1" dated 5/11/20,		. 2-008.A.1" dated 5/11/20,			controlled drugs to the		
	stated " 1. The Admitting Nurse/ Case				patient/representative and fam	ily.	
	Manager will provide a copy of the written				The person responsible for dru		
	policies and procedures on the management and				disposal will be identified. Per		
	disposal of drugs, including controlled drugs to				policy, the Admitting Nurse wil	I	
	the patient/ representative and family. The				verbally discuss the policy in a	ı	
	Admitting Nurse/ Case Manager will verbally			language and manner that they			
	discuss the policy in a language and manner that		understand to ensure the safe				
	they understand to	ensure the safe use and			use/disposal of controlled drug	js.	
	disposal of medicat	ion, including controlled			The responsible individual will		
	_	ing Nurse/ Case manager will			acknowledge this education by		
		nical record that the patient/			signing the policy that is provide		
	Representative and	family have received a copy of			as part of the Hospice Patient		
	the policies and pro	cedures. 2. The Admitting			Admission Booklet. A copy of	the	
	Nurse/ Case Manager will document in a clinical				signed policy will be uploaded		
	_	sible for the disposal of the			the chart. In clinical notes, Nur		
	and the state of t				I ,		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA  AND PLAN OF CORRECTION IDENTIFICATION NUMBER  151599		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 10/01/2020		
NAME OF PROVIDER OR SUPPLIER PREMIER HOSPICE & PALLIATIVE CARE - INDIANA LLC		STREET ADDRESS, CITY, STATE, ZIP COD 11550 N MERIDIAN STREET, SUITE 375 CARMEL, IN 46032				
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
	the medical record: the patient/ family's understanding of the responsibility to prounneeded medication Substances - Family no longer has a need the Case Manager of family/ caregiver redrugs 2. The Adwill document in the and family/ caregiver policies and proceddrugs and discussed and took responsibilinurse, social worked death of a hospice procaregiver of their resthe patient's prescril document this instruinclude the name of disposal, and who was the process of	The nurse will document in disposal instructions given, verbal response as to their e disposal/ process and their operly dispose of the on(s) Disposal of Controlled of 1. When a hospice patient of for a controlled substance, will instruct the patient and garding proper disposal of the mitting Nurse/ Case Manger e clinical record that the patient er were given the written of the disposal of medication lity to do so. 3. The hospice of the controlled of the disposal of medication lity to dispose of all obed medications and will obed medications and of the drug, amount, method of witnessed the disposal "  In the drug, amount, method of witnessed the disposal "  In the drug and a plan of care of of 08/06/2020, and the observations as week for 2 as week for 7 weeks.  In note dated 8/6/20 and the observation of the all instructions given, patient/ones as to their understanding, the medications being the on 8/21/2020.		shall document the patient or caregivers understanding of the policy at admission and any tisthe patient or caregiver needs re-education. When a hospice patient no longer has a need of controlled substance, the nurse will re-instruct the patient and family/caregiver as needed regarding proper drug disposating the nurse will document in the medical record: disposal instructions given, the patient/family's verbal responsions to their understanding of the disposal process and their responsibility to properly disposing the unneeded medication(so the family/caregiver requests assistance with the disposal, the family/caregiver properly disposite the prescribed medication(so the patient/family refuses the disposal/destruction of medications, this will be report to the patient's physician and clinical supervisor and documented in the patient record the patient's physician and clinical supervisor and documented in the patient record the deficiency from recurring the future, even if already	me for a see  al. e se as see  be as see  line dhe beses s). If the doin rug, he and ree If ted  ord.  at	

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	a. Building <u>00</u>		00	COMPLETED	
151599		151599	B. WING			10/01/2020	
				CTDEET 4	ADDRESS CITY STATE ZIR COR		
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP COD N MERIDIAN STREET, SUITE 3	75	
					·	375	
PKEMIE	T HUSPICE & PALI	LIATIVE CARE - INDIANA LLC		CARIME	EL, IN 46032		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	During an interview	on 09/30/20 at 9:20 a.m., the			corrected?		
	spouse stated she th	ought the hospice was going			1.100% focused chart audit	for	
	to take the medicati	ons or destroy after the patient			90 days on home patient		
	died. The spouse in	ndicated a family member, who			Admissions, then ongoing, 10 <sup>th</sup>	%	
	was a sheriff, took t	the medications and had them			each quarter to ensure		
	destroyed. The dea	th visit note dated 8/21/2020			documentation of signed polic	y,	
	failed to evidence th	nis information.			that patients and caregivers		
					understand the drug disposal		
		terviewed on 10/01/20 at 9:00			policy per charted education,	and	
	a.m., and stated that	t the patient's medications			that disposal charting includes	the	
	were not destroyed	during the death visit for she			name of the drug(s), amount(s	s),	
	was not allowed to	go back in and that the DON			method of disposal, the perso	n	
	was made aware. T	he death visit note dated			disposing of the drug, and the	role	
	8/21/2020 failed to evidence this information.				of the hospice employee. Nurs	ses	
					shall securely submit a copy o	f	
	<ol><li>Review of patier</li></ol>	nt #2's clinical record revealed a			signed disposal policy docume	ent	
	start of care date of 09/10/2020, and a plan of care				to the office to be viewed in ch	nart	
	for the benefit period of 9/10/2020 to 12/08/2020,				attachments.		
		ed nursing 3 times a week for 1			2.100% Focused audit prior	to	
	week, 4 times a week for 1 week, 3 times a week for				each home patient		
	11 weeks, then 1 time a week for 1 week.				Interdisciplinary Group		
					Meeting/IDG, then ongoing, 10	0%	
	Review of the start of care visit note dated 9/10/20				each quarter to ensure and the	at	
and the following skilled nursing visit notes dated				patients and caregivers			
9/11, 9/12, 9/13, 9/14, 9/16, 9/18, 9/19, 9/20, 9/21,				understand the drug disposal			
		d 9/30/20, failed to evidence the			policy per charted re-education		
		adhered to by failing to			drug disposal charting include	S	
		nsible person for the disposal,			the name of the drug(s),		
	_	tions given, patient/ family			amount(s), method of disposa		
	verbal response as t	to their understanding.			the person disposing of the dr	ug,	
					and the role of the hospice		
		ord of patient #3, Election date			employee, and that refusals to		
		ed a death visit note on 9/17/20,			dispose of unneeded narcotics	s are	
		nis writer witnessed [name of			reported to the Clinical		
	, ,	stroy medications." The			Supervisor/Designee;		
	clinician failed to document the name of the drug,				3.Threshold for focused aud		
	amount, and method	d of disposal.			100% with charted drug dispo		
					If threshold not met, Patient C		
		iew on 9/30/20 at 4:55 p.m.,			Managers will re-educate invo	lved	
	when queried on who was responsible for the				staff, progressively, involving		

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AND PLAN OF CORRECTION IDENTIFIC		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 151599	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 10/01/2020		
NAME OF PROVIDER OR SUPPLIER  PREMIER HOSPICE & PALLIATIVE CARE - INDIANA LLC			STREET ADDRESS, CITY, STATE, ZIP COD  11550 N MERIDIAN STREET, SUITE 375  CARMEL, IN 46032				
(X4) ID PREFIX TAG	PREMIER HOSPICE & PALLIATIVE CARE - INDIANA LLC  (X4) ID SUMMARY STATEMENT OF DEFICIENCIE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)  human resources for work planeeded.  Who is going to be responsifor prevention above: i.e., director, supervisor, etc.?  Patient Care Managers (PCM are responsible for audits and correction. PCMs will be over by Director(s) of Clinical Serv (DCS) who report to the Administrator. The Administrashall report Focus audit result the QAPI Committee and ther Governing Body for three consecutive quarters.  By what date are you going have the deficiency corrected 11/12/20. Nurses completed re-education 11/12/20, the organization will have implemented 100% Focus audits on drug disposal at Admission and Prior to each I	ans, if  ible  is) I staff seen ices  ator as to a the  to ad?  on by I	(X5) COMPLETION DATE	

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