PRINTED: 04/14/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/S AND PLAN OF CORRECTION IDENTIFICATION			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		16	1580	B. WING_		04/	/08/2021
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		· · · · · · · · · · · · · · · · · · ·
ESSENCE	OF LIFE HOSPICE				3207 220TH TRAIL AMANA, IA 52203		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICE Y MUST BE PRECED LSC IDENTIFYING IN	ED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT ( (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPL DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
E 000	Initial Comments			ΕC	POC accepted	on 4/20/ ction	2/
	A Recertification Sur COVID-19 Focused I conducted by the De Appeals completed o	nfection Control partment of Insp	Survey was ections and		ooo POC accepted with date of correct 5/19/21. See attack document — B. Rasmu	esen	
L 000	The hospice was four compliance with the restablishment of Eme CMS and Centers for Prevention (CDC) recorded prepare for COVID-1: INITIAL COMMENTS	equirements of ergency Prepare Disease Contro commended pra 9.	he dness and I and	L(	000		
	The Department of li conducted a Recertifi with a COVID-19 Foo Survey 4/5/21 throug	cation Survey in used Infection	conjunction			,	
	The hospice was four compliance in relation Disease Control and recommended practic COVID-19.	n to CMS and C Prevention (CD	enters for C)				
L 531	The recertification su operating out of compatandard level hospic CONTENT OF COMPASSESSMENT CFR(s): 418.54(c)(7)	pliance with the e regulations. PREHENSIVE	* · · · · · · · · · · · · · · · · · · ·	L	531		
ARODATODY	[The comprehensive consideration the foll (7) Bereavement. An assessment of the ne and other individuals spiritual, and cultural	owing factors:] initial bereaven eds of the patie focusing on the factors that may	ent nt's family social, r impact their				
LABORATORY	DIRECTOR'S OF PROVIDER	SUPPLIER REPORTS	NTATIVE'S SIGNATURE		TITLE / /	. 11	(X6) DATE

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

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

Event ID: 00HT11

Facility ID: IAF0080

STATEMENT OF DEFICIENCIES (X1) PROVIDER/S AND PLAN OF CORRECTION IDENTIFICATI			PPLIER/CLIA N NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE S	
		16	1580	B. WING_			04/0	8/2021
	ROVIDER OR SUPPLIER OF LIFE HOSPICE				3207	EET ADDRESS, CITY, STATE, ZIP CODE 7 220TH TRAIL ANA, IA 52203		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICI Y MUST BE PRECEDI LSC IDENTIFYING IN	ED BY FULL	ID PREFI TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
L 531	Continued From page ability to cope with th Information gathered assessment must be care and considered care.	e patient's death from the initial b incorporated int in the bereavem	ereavement o the plan of ent plan of	L	531			
	This STANDARD is a Based on hospice per review and staff inter perform an initial bere within 5 days of the phospice benefit and a comprehensive asseand/or family bereave in a timely manner for (Patients #1, #5, #7 and the standard processes).	olicy review, clin view, the hospic eavement assest the cattern's election as part of the initial assent, to deter ement needs and a 4 of 13 sample	cal record e failed to sment, to the ial mine patient d risk factors					
	The hospice reported time of the survey.	d 34 current pati	ents at the					
	Failure to complete a assessment increase family/caregiver griewould not be addres prolonged or dysfund potentially increased hospice patients or s	ed the risk that p ving and bereave sed appropriatel ctional grieving a I the risk of self I	atient or ement needs y, leading to ind					
	Findings include:  According to the pol Patient Assessment patient needs and fi	, dated 7/2020, bindings from the	ased on the initial					
	assessment, the Par coordinates and des participate in the cor the patient within 5 of hospice.	signates disciplin mprehensive ass	es that must essment of					:

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 .	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		161580	B. WING		04/08	2021		
	ROVIDER OR SUPPLIER OF LIFE HOSPICE		] :	STREET ADDRESS, CITY, STATE, ZIP CODE 1207 220TH TRAIL AMANA, 1A 52203				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE		
L 531	Continued From pag	pe 2	L 531					
		admission to hospice on ved services in a nursing						
	The clinical record re	eview revealed:						
		sit completed by the social 2021, locked as completed on ssed the visit date).						
		admission to hospice on ved services in a private						
	The clinical record r	eview revealed:						
	identified the patien	rse visit, dated 12/1/2020, t bereavement risk minimal. d to include a complete sment.						
	,	n admission to hospice on d services in a private home						
	Clinical record revie	w revealed:						
	completed by the sl	ehensive assessment cilled nurse, dated 3/12/21, essment of the patient's						
	documented a bere The initial bereaven completed by the se	er note, dated 3/18/21, avement risk assessment. nent risk assessment ocial worker exceeded the 5 r regulation by 2 days.						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION				(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
	161	580	B. WING_			04/0	8/2021		
NAME OF PROVIDER OR SUPPLIER ESSENCE OF LIFE HOSPICE				32	REET ADDRESS, CITY, STATE, ZIP CODE 07 220TH TRAIL MANA, IA 52203				
PREFIX (EACH DEFICIENC)	ATEMENT OF DEFICIE Y MUST BE PRECEDE SC IDENTIFYING INF	D BY FULL	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE		
L 531 Continued From page 4. Patient #7 had an 3/14/21 and received Clinical record review a. The initial compre	admission to hos services in a nui	sing home.	L:	531					
a. The Initial compre completed by the skill failed to include asse bereavement risk.  b. The social worker documented the family visit.  The clinical record late of an initial bereavem social worker or any  The above findings for the above findings for the information properties and Clinical Manager further information properties and their far individualized written the hospice care and patients and their far individualized written the hospice interdisc with the attending phoreocean properties and the them so desire.  This STANDARD is Based on clinical review and staff interdiscommends as the standard review and staff interdiscommends.	led nurse, dated ssment of the parameter dated 3/17 ly refused the socked evidence of the risk assessment of the discipline.  The Patients #1, #4 the Hospice Ar. Hospice stafficion to the end of the services furnished in plan of care estiplinary group in the primary care patient's needs not met as evide cord review, hos	3/14/21, tient's  //21, cial work  f completion nent by the  5, #7, and dministrator provided no the survey.  ed to // an ablished by collaboration the patient or giver in f any of	L	543					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/S AND PLAN OF CORRECTION IDENTIFICATI						(X3) DATE SURVEY COMPLETED		
		16	1580	B. WING			04/0	8/2021
	OF LIFE HOSPICE				320	REET ADDRESS, CITY, STATE, ZIP CODE 07 220TH TRAIL MANA, IA 52203		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICE CY MUST BE PRECED R LSC IDENTIFYING IN	ED BY FULL	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
L 543	Continued From pagensure the provision the patient's plan of patients (Patient #1). The hospice reported patients.  Failure to follow the directed by the Interthe patient at risk for not meet the needs.  Findings include:  1. Patient #9 had a 10/15/2020 and recordering in a private a. The clinical recorder, dated 3/11/2. The order included dressing to the coorder as needed for skin.  The Skilled Nurse with the patient had an a has an superficial orderinage and show infection. Kerrafoan The hospice failed in notification or order observed or docum.	of care in accordance for 3 of 3 saturation and #9).  In a current censure patient's Plan of redisciplinary Group in inconsistent care of the patient.  The patient of the	mpled  us of 34  Care as p (IDG) put e that may  on date of rvices while  bal physician the physician. foam y 3 days and  documented accyx that ith no ptoms of d to the area. sician rea first easurements.	L	543			
	physician in a timel open area on the p  2. Patient #1 had a 2/12/21 and receive	atient's coccyx.  a hospice admissi	on date of					

		(X1) PROVIDER/SUFPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED		
		161580	B. WING			4/08/2021	
	ROVIDER OR SUPPLIER  OF LIFE HOSPICE		3207	EET ADDRESS, CITY, STATE, ZIP C 220TH TRAIL ANA, IA 52203			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
L 543	residing in a private Clinical record revie a. The Plan of Care 5/12/21, included in	home residence. w revealed: e (POC) dated, 2/12/21 to terdisciplinary group (IDG)	L 543				
	instructions to clear saline, apply Santyl	are to the left heel and a the wound with normal ointment, cover with Dakin's uze, and wrap with gauze					
	documented the nu the patient's heel ar	e visit note, dated \$/26/21, rse changed the dressing on a applied gauze saturated und, wrapped with kerlix ad with sock.					
	cleanse the wound	der, dated 3/30/21, ordered to with normal saline, cover with ver with dressing, and secure	h				
	1	acked documentation of a the use of Vaseline gauze for prior to 3/30/21.	,				
		d, 2/12/21 to 5/12/21, include essment of lung sounds.	d				
•	e. The skilled nurse and 3/26/21, lacked assessment of lung	£.					
	The nurse failed to						
		hospice admission date of ed hospice services while a home.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/S IDENTIFICAT			MINADED.		IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED	
		161	580	B. WING_		04/08/2021	
	OF LIFE HOSPICE				STREET ADDRESS, CITY, STATE, ZIP CO 3207 220TH TRAIL AMANA, IA 52203	DDE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIE LY MUST BE PRECEDE LSC IDENTIFYING INFO	D BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TO DEFICIENCY	ON SHOULD BE COMPLETI HE APPROPRIATE DATE	
L 543	Continued From pag	e 6		L.5	543		
	Clinical record review	v revealed:					
	a. The POC dated, a IDG orders for asses lung sounds, bowel pattern.	sment of oxyger	saturation,				
	b. The skilled nurse lacked documentation saturation, bowel pa	n of assessment	of oxygen				
	c. The skilled nurse lacked documentation pattern.						
	d. The skilled nurse lacked documentation saturation, lung soul	on of assessment	of oxygen				
	e. The skilled nurse lacked documentation and pain.	on of assessment					
	f. The skilled nurse lacked documentation pattern.						
	The nurse failed to f	follow the POC.					
L 547	The above findings were reviewed with Clinical Manager. If further information properties of the Content of PLA CFR(s): 418.56(c)(2)	the Hospice Admi Hospice staff provi prior to the end of N OF CARE	inistrator and ided no	L	547		
	[The plan of care m	ust include all ser	vices				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUI IDENTIFICATION				(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		161	580	B. WING			04/0	8/2021
	OF LIFE HOSPICE				STREET ADDRESS, CITY, STATE, ZIP CODE 3207 220TH TRAIL AMANA, IA 52203			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIE Y MUST BE PRECEDE LSC IDENTIFYING INFO	O BY FULL	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE
L 547	Continued From page necessary for the pal the terminal illness a including the followin (2) A detailed statem frequency of services specific patient and f	liation and managed related conditions  g:]  ent of the scope as necessary to me	nd	L	547			
	This STANDARD is not met as evider Based on clinical record review and h policy review, the hospice failed to enshospice Interdisciplinary Group developlans of care which specified the scop frequency for all services required by a provided to patients for 12 of 13 samp (Patients #1, #2, #3, #4, #5, #6, #7, #5, #12 and #13).  The hospice reported a current censurpatients.  Failure to identify a scope and frequency ordered services increased the potent hospice services to not adequately moneds of hospice patients and families.  Findings include:  Review of the hospice's policy, titled Care, dated 10/2017, identified the patient/caregiver as identified in the incomprehensive and updated assessment and patient. The POC is reviewed and up interdisciplinary group (IDG) every 15 more frequently if needed.		ospice ure the ped patient e and and led patients					
			cies for all ial for eet the					
			tient's plan services itial, nents of the dated by the					

		(X1) PROVIDER/SU IDENTIFICATIO					(X3)	(X3) DATE SURVEY COMPLETED		
		16	158 <b>0</b>	B. WING				04/08/2021		
	OF LIFE HOSPICE				STREET ADDRES 3207 220TH TRA AMANA, IA 52					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICI LY MUST BE PRECED LSC IDENTIFYING IN	ED BY FULL	ID PREFI TAG	X (EA	PROVIDER'S PLAN OF COR ICH CORRECTIVE ACTION SS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	COMPLE DATE	TION	
L 547	Continued From pag Review of the hospic - Content, dated 7/20 care includes a detail and frequency of ser specific patient and f  1. Patient #3 was ac 12/8/2020 and receive a nursing home. Clin the following:  a. The initial plan of included documental skilled nursing servic PRN (as needed).  b. An IDG update to note, dated 2/12/21 documentation of sk times a week and PI a month and PRN.  c. An IDG update to notes, dated 2/26/21 documentation of sk times a week and PI d. The plan of care and reason for the P  2. Patient #4 was ac 12/3/2020 and receive a nursing home. Clin the following:	re's policy, titled 220, identified the 220, identified the led statement of vices necessary family needs.  It is it is it is a vice of the plan of care and 3/26/21, included nursing send and 3/12/21, included to identify and social work and soci	e plan of the scope to meet the  e on e residing in ew revealed  3/2020, orders for reek and  meeting uded rices 1-2 ork 1-3 times  meeting cluded rices 1-2 ork PRN. a frequency  e on le residing in		547					
	a. The initial plan of included documental skilled nursing service PRN.	ition of physician	orders for							

STATEMENT O	F DEFICIENCIES	(X1) PROVIDER/SU	PPLIER/CLIA	(X2) MULT	IPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN OF	CORRECTION	IDENTIFICATIO	N NUMBER:	A, BUILDI	NG			
		16	1580	B. WING			04/0	8/2021
NAME OF PR	ROVIDER OR SUPPLIER					EET ADDRESS, CITY, STATE, ZIP CODE		
ESSENCE	OF LIFE HOSPICE					220TH TRAIL ANA, IA 52203		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFIC Y MUST BE PRECED LSC IDENTIFYING IN	ED BY FULL	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) ' COMPLETION DATE
L 547	Continued From page	e 9		L	547			
,	b. An IDG update to note, dated 2/12 and documentation of ski times a week and PF month and PRN, spir PRN, music therapy massage therapy 2-2 and volunteer calls 2 c. An IDG update to notes, dated 3/12 and documentation of so and PRN.  d. The plan of care and reason for the P 3. Patient #11 was a	2/26/21, include fled nursing servents, social work 2 itual 1-3 times a 2-4 times a month times a month times a month the plan of care d 3/26/21, including work 2-4 times a month failed to identify RN visits.	d d dees 1-2					
	received services when and had a death dat review revealed the	nile residing in a e of 2/12/21. Cl following:	private home inical record					
	a. The initial plan of documentation of ph nursing services 1-2	ysician orders f	or skilled					
	b. An IDG update to note, dated 2/12/21, skilled nursing servi week, 2 times a wee 2-4 times a month a	, included docun ces 1-2 times a ek and PRN and	nentation of week for one					
	c. The plan of care and reason for the l	-	a frequency					
	4. Patient #12 was 2/19/21, received so private home and h	ervices while res	siding in a					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUP AND PLAN OF CORRECTION IDENTIFICATION					(X3) DATE SURVEY COMPLETED		
		161	580	B. WING		04/08/	
	ROVIDER OR SUPPLIER  OF LIFE HOSPICE				STREET ADDRESS, CITY, STATE, ZIP CODE 3207 220TH TRAIL AMANA, IA 52203		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIE Y MUST BE PRECEDE LSC IDENTIFYING INFO	BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
L 547	Continued From page 3/27/21. Clinical recordillowing:  a. The initial plan of a included documentatis skilled nursing service PRN and social work PRN.  b. An IDG update to note, dated 3/12 and documentation of skill times a week and PR month and PRN and month and PRN.  c. The plan of care fa and reason for the PR and reason for the PR 5. Patient #13 was a 12/15/2020, received private home and had 2/17/21. Clinical recordillowing:  a. The initial plan of a included documentatis skilled nursing service PRN.  b. An IDG update to note, dated 12/31/20 included documentatis services 1-2 times a work 1-3 times a more	care, dated 2/26/2 on of physician of es 1-2 times a wes 1-3 times a month of the plan of care in 3/26/21, included led nursing services work 1-2 times a west a discharge date or discharge dat	21, rders for eek and th and heeting ees 1-2 3 times a 4 times a frequency e on esiding in a e of ed the 3/2020, rders for eek and meeting //21, sing	L 547			
	c. An IDG update to notes, dated 2/12 and documentation of skil	d 2/26/21, include	d				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SU AND PLAN OF CORRECTION IDENTIFICATION			1''	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		16	1580	B. WING			4/08/2021
	ROVIDER OR SUPPLIER OF LIFE HOSPICE			32	IREET ADDRESS, CITY, STATE, ZIP COD 207 220TH TRAIL MANA, IA 52203	E	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICI ICY MUST BE PRECED R LSC IDENTIFYING IN	ED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE EAPPROPRIATE	(X5) COMPLETION DATE
L 547	Continued From para week and PRN and d. The plan of care and reason for the 6. Patient #5 had a 9/39/2020 and rece a nursing home.  The clinical record  The POC, dated 10/1/4/2021 to 4/3/2020 nursing, social work health aide service.  The IDG meeting in 3/12/21 and 3/26/20 nurse 1 to 2 times a more music therapy 2 to The IDG failed to icordered.  7. Patient #9 had a 10/15/2020 and recin a private home in a private home.	review revealed the music therapy s.  ote, dated 2/12/21, included an order music therapy s.  ote, dated 2/12/21, included an order music therapy s.  ote, dated 2/12/21, included an order music therapy s.  ote, dated 2/12/21, included an order music therapy s.  ote, dated 2/12/21, included an order music therapy s.  ote, dated 2/12/21, included an order music therapy s.  ote, dated 2/12/21, included an order music therapy s.  ote, dated 2/12/21, included an order music therapy s.  ote, dated 2/12/21, included an order music therapy s.	a frequency  date of e residing in  e following:  21 and for skilled and home  2/26/21, der for skilled social worker (prn) and h and prn. of visits	L 547	DEFICIENCY)		
	The clinical record The POC, dated 1/1/4/2021 to 4/3/20/ nursing, social work home health aide: The IDG meeting if 3/12/21 and 3/26/2 nurse 1 to 2 times therapy 2 to 4 times worker 1 to 3 times	0/6/2020 to 1/3/20 21, included order rker, massage the services. note, dated 2/12/2 21, included an or a month and prn, es a month and prn	21 and s for skilled rapy and 1, 2/26?21, der for skilled massage and social				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUP IDENTIFICATION			(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED		
NAME OF D	DOMOCO OD OLOGO USO	161	580	B. WING		04/	08/2021
	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE 3207 220TH TRAIL AMANA, IA 52203		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIE ( MUST BE PRECEDE SC IDENTIFYING INFO	D BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(XS) COMPLETION DATE
L 547	Continued From page IDG failed to identify to 8. Patient #2 had an 9/16/2020 and received a nursing home.  a. The IDT update, do order for skilled nurse PRN, social worker: 0 times per month and foiled to identify a specific by the IDT update, do order for skilled nurse PRN, social worker: 0 times per month and foiled to identify a specific by the IDT update, do order for skilled nurse PRN, social worker: 0 times per month and foiled to specify a specific by a specific by the IDT update, do order for skilled nurse per month and foiled to specify a specific by the IDT update, do order for skilled nurse PRN, social worker: 0 times per month and foiled to identify a specific by the IDT update, do order for nursing: 0-1 week, then 1 time per worker visits PRN. The IDT update, do order for nursing: 0-1 week, then 1 time per worker visits PRN. The	the amount of visited admission to hose admission to hose added services while atted 2/12/2021 in the services of times 1 month, the services 1 month atted 3/12/2021 in the services 1 month, the services 1 month atted 3/12/2021 in the services 1 month attended 3/12/2021 in	pice on residing in resident and resident in resident	L 54'			
	specify a specific num  9. Patient #1 had a ho						

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SU IDENTIFICATIO		1	PLE CONSTRUCTION  G	(X3) DATE COMP	SURVEY LETED
		16	1580	B. WING_		04/	08/2021
	OF LIFE HOSPICE				STREET ADDRESS, CITY, STATE, ZIP CODE 3207 220TH TRAIL AMANA, IA 52203		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICI Y MUST BE PRECED LSC IDENTIFYING IN	ED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
L 547	Continued From page 2/12/21 and received residing in a private h dated 2/12/21 to 5/12 skilled nursing visits ineeded.  a. The IDG meeting 2/17, included IDG or times per week and a visits 1-3 times per m. The IDG failed to ider reason for the deliver and spiritual care ser b. The IDG meeting 2/26, included IDG or visits 1-2 times per m. 2-4 times per month and relaxation with usupdate also included visits 2-4 times per m. The IDG failed to ider reason for the deliver	hospice service nome residence. 1/21, included ID 1-2 times per we to update the Porders for nursing as needed and shouth and as needed and shouth and as needed for the pattern for massage on the for one more and as needed fise of essential of IDG orders for shouth and as needed fished as needed fished as needed fished for the pattern for one more and as needed fished for the pattern for one more and as needed fished for the pattern for one more and as needed fished for the pattern for the	The POC, G orders for ek and as  OC, dated visits 1-2 piritual care ided.  equency and ed nursing ient.  OC, dated ie therapy inth and then or comfort ills. The isocial work ided.	L 5			
	c. The IDG meeting 3/26, included IDG or 1-3 times per month.  The IDG failed to ider reason for the deliver services for the patie.  10. Patient #6 had a 3/12/21 and received residing in a nursing 3/12/21 to 6/10/21, in	to update the PC rders for volunte and as needed.  Intify a specific for ry of the as needent.  I hospice admiss hospice service home. The POC	oC, dated er services equency and led volunteer ion date of is while C, dated				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUF IDENTIFICATION		(X2) MULTIPLE A. BUILDING	E CONSTRUCTION	(X3) DATE:	
		161	580	B. WING		04/6	08/2021
	OF LIFE HOSPICE			3	STREET ADDRESS, CITY, STATE, ZIP CODE 1207 220TH TRAIL AMANA, IA 52203		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIE Y MUST BE PRECEDE LSC IDENTIFYING INF	D BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
L 547	Continued From page nursing visits 1-2 time. The IDG meeting to uncluded IDG orders of per week and as need 1-3 times per month at The IDG failed to idereason for the deliver and social work servion. Patient #7 had a 3/14/21 and received residing in a nursing 3/14/21 to 6/11/21, in nursing visits 1-2 time. The IDG meeting to understand a visits as needed.  The IDG failed to idereason for the deliver and social work servion. The IDG failed to idereason for the deliver and social work servion. Patient #10 had 2/8/21 and received in residing in a private in dated 2/8/21 to 5/8/2 skilled nursing visits oneeded.  a. The IDG meeting 2/12/21, included IDG meeting 2	es per week and update the POC, for nursing visits ded and social was as needed. Intify a specific frey of the as needeces for the patier hospice admission hospice services home. The POC cluded IDG orders per week and update the POC, orders for nursical as needed and so nutify a specific frey of the as needeces for the patier a hospice services nome residence. 1, included IDG of 1-2 times per we	dated 3/17, 1-2 times ork visits  quency and ed nursing at.  on date of s while , dated rs for skilled as needed.  dated ing visits 1-2 icial work  equency and ed nursing at.  sion date of while The POC, orders for ek and as	L 547			
	times per week and a visits 2-4 times per m The IDG failed to ide	as needed and so nonth and as nee	ocial work ded.				

	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SU IDENTIFICATIO		1 ' '		CONSTRUCTION	(X3) DATE S COMPLI	
		16	1580	B. WING			04/0	8/2021
	OF LIFE HOSPICE				32	REET ADDRESS, CITY, STATE, ZIP CODE 07 220TH TRAIL MANA, IA 52203		
(X4) (D PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICI Y MUST BE PRECED LSC IDENTIFYING IN	ED BY FULL	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
L 547	Continued From page reason for the deliver and social work servib. The IDG meeting 2/26/21, included IDC visits 2-4 times per more than the IDG failed to ide reason for the deliver therapy services for the above findings for the above for the sum PREVENTION CFR(s): 418.60(a)  The hospice must for practice to prevent the and communicable of standard precaution.  This STANDARD is Based on hospice probservation, the hospic provent contamin infection. The survey of 3 home visit observations.	y of the as need ces for the patie to update the PC orders for mustonth and as need the patient.  The patient #1, #2, #12 and #13 we strator and Clinical and further inforced no further inforced no further inforced in the transmission diseases, including the patient as evidenced as the transmission diseases, including the patient and/or the patient and/	nt.  DC, dated ic therapy ided.  equency and ided music  #3, #4, #5, in the reviewed idea idea idea idea idea idea idea id		579	DEFICIENT!		
	The hospice reporte patients.							
	Failure to ensure se follow accepted star control increased the	ndards of practic	e for infection					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUP IDENTIFICATION		1 ' '	IPLE CONSTRUCTION		TE SURVEY MPLETED
		161	580	B. WING_		o c	4/08/2021
	OF LIFE HOSPICE			•	STREET ADDRESS, CITY, STATE, ZIP CODE 3207 220TH TRAIL AMANA, IA 52203		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIE  Y MUST BE PRECEDE  LSC IDENTIFYING INF	D BY FULL	ID PREFII TAG	PROVIDER'S PLAN OF CORR ( (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
L 579	the home visit, the de and/or transmission of home.  Findings include:  According to hospice Control - Respiratory	evelopment of an of organisms from e policy, titled Infe Illness and Covid	thome to ction 1-19, dated	L	579		
	5/2020, identified to wash hands between and procedures on the same patient to cross-contamination of different body remove gloves promptly after use, befunding noncontaminated items and environmental surfaces, and before go another patient, and wash hands immavoid transfer of microorganisms to ot or environments.		o prevent sites and ore oing to ediately to				
	Patient #2 had an ac 9/16/2020 and receive a nursing home.  On 4/6/21 beginning visit observation with (RN). Staff C placed on barrier, placed as table and entered the pressure cuff, thermon second barrier. Son gloves and assess pulse oximetry, mad pen then assessed to the equipment back removed the urinary cover, assessed uring drainage bag back into complete hand by	at 10:30 AM, dure at 10:30 AM, at 10:30	ing a home red Nurse dside table overbed d the blood oximeter hands, put perature, r pad and he placed staff C. m the cloth rinary She failed				
	to complete hand hy stethoscope from he patient's lung sound	r neck and asses	sed				

	ATEMENT OF DEFICIENCIES (X1) PROVIDER(SI DENTIFICATION IDENTIFICATION			(X2) MULT A. BUILDII		INSTRUCTION	(X3) DATE S COMPLI	
	F PROVIDER OR SUPPLIER		580	B. WING_			04/0	8/2021
	OF LIFE HOSPICE				3207	STREET ADDRESS, CITY, STATE, ZIP CODE 3207 220TH TRAIL AMANA, IA 52203		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIE Y MUST BE PRECEDE LSC IDENTIFYING INF	D BY FULL	ID PREFI TAG	(	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
L 579	Continued From page and replaced stethos removed gloves and then used alcohol wij	cope around her performed hand pes to clean steth	nygiene, oscope and	L.	579			
	placed it in bag. RN blood pressure cuff a placed equipment ba returned the equipment	nd pulse oximete ick on dirty barrie	r and r and then					
	The nurse failed to re and reapply gloves b drainage bag and fai noncontaminated eq	efore touching the led to place	e urinary					
L 647	The above findings for with Hospice Administration Hospice staff provided to the end of the sun LEVEL OF ACTIVITY CFR(s): 418.78(e)	strator and Clinic ed no further infol vey.	al Manager.	L	647			
	Volunteers must pro- and/or direct patient that, at a minimum, of patient care hours of and contract staff. I records on the use of and administrative s services and time with	care services in equals 5 percent fall paid hospice The hospice must of volunteers for pervices, including	an amount of the total employees maintain atient care					
	This STANDARD is Based on hospice s failed to provide voluminimum, equals 5 care hours of all pai contract staff.	staff interview, the unteer services the percent of the tot id hospice employ	e hospice nat, at a al patient yees and					
	The hospice reporte patients.	ed a current cens	us 01 34					

STATEMENT OF DE AND PLAN OF COR		(X1) PROVIDER/SUF IDENTIFICATION		1 ' '	PLE CONSTRUCTION  IG		(X3) DATE COMP	SURVEY LETED
		161	580	B. WING_			04/	08/2021
	DER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE 3207 220TH TRAIL AMANA, IA 52203			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIE MUST BE PRECEDE SC IDENTIFYING INF	D BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORR. (EACH CORRECTIVE ACTION SHORE) CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE		(X5) COMPLETION DATE
L 647 Co	ntinued From page	18		L6	47			
pat not need of record need need need need need need need ne	ilure to maintain voltients puts the patient receiving the servieds of the patients and providing all regispice program.  Indings include:  Indings include:	ants and families ces necessary to and puts the hos pulatory requirem in 4/8/21 at 12:10 reported the period to a the volunte patient care hours do contracted stated the above ded no further in survey.  NAGEMENT  Written agreement dual, or organizate and services for ensure the provides services for ensure the provides services must be greements that the properties and effective made effective made effective made effective made effective made eff	at risk of meet the pice at risk ents for a  PM, the reentage of er hours of s of all paid off.  findings formation  t with ation to not must agement, all sion of be require that	L 6	55			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SU IDENTIFICATIO		1 ' '		CONSTRUCTION	(X3) DATE COMP	
		16	1580	B. WING			04/0	08/2021
	PROVIDER OR SUPPLIER				320	STREET ADDRESS, CITY, STATE, ZIP CODE 3207 220TH TRAIL AMANA, IA 52203		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFIC Y MUST BE PRECED LSC IDENTIFYING IN	ED BY FULL	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
L 655	Continued From page of care.  This STANDARD is a Based on review of agreements and hospice failed to ensibetween the hospice under arrangement in contract components.  The hospice reported agreements for servicompanies at the time.  Failure to include the components within the increased the potentiand oversight failed to would not receive seplan of care.  Findings include:  1. A medical equipmed dated 3/15/13, failed contractual language administrative manamaintains oversight services are delivered patient's plan of care.  2. A pharmacy continciude the following administrative manamaintains oversight services are delivered patient's plan of care.	not met as evide written contracturpice staff intervieure the written and 2 of 3 sample and 2 of 3 sample of the survey.  If a total of 26 written and a total again that hospice refused as specifically and the specific and serviced by the hospice refused in accordance accordance and the hospice refused in accordance and the hospice refused and serviced by the hospice refused and serviced and	al w, the preement led services required  Itten the rement with  anagement patient ed on the  contract, llowing tains once ces, all ce, and all with the  21, failed to alns pice ces, and all		655			
	patient's plan of care							

AND PLAN OF CORRECTION IDENTIFICATI		(X1) PROVIDER/SU IDENTIFICATIO		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		16	1580	B. WING		04/0	08/2021
	OF LIFE HOSPICE				STREET ADDRESS, CITY, STATE, ZIP CODE 3207 220TH TRAIL AMANA, IA 52203		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFIC Y MUST BE PRECED .SC IDENTIFYING IN	ED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
L 655	The surveyor reviewed the above fir the Administrator and hospice staff further information prior to the end of		ovided no	L 65	·	3	
L 679		gible, clear, comicated and dated of practice.  In ot met as evide ord review, hosp taff interview, the tries completed ical records were uired time frame ocipline credential (Patients #1, #3, 1).  If a current censulation and we are yresult in ineffection are.  Linical record do ormation and we are yresult in ineffection are.	plete, and in urrently nced by: cice policy hospice in the e signed, , and as for 9 of #4, #5, #6, us of 34  cumentation ere ctively  Data , dentified to business business	L 67			
<u> </u>	<u> </u>		+				<u></u>

#### PRINTED: 04/14/2021 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING\_ 161580 B. WING 04/08/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3207 220TH TRAIL **ESSENCE OF LIFE HOSPICE AMANA, IA 52203** (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) L 679 | Continued From page 21 L 679 During an interview on 4/6/21 at 10:04 AM, the Hospice Administrator reported all documentation is to be completed by two business days after the day of the visit. 1. Patient #4 was admitted to hospice on 12/3/2020 and received services while residing in a nursing home. Clinical record review revealed the following: a. The music therapy visit notes, dated 2/1, 2/8, 2/15, 2/24, 3/3, 3/12, 3/19 and 3/22/21, included an electronic signature with staff name but failed to identify the staff credentials. b. The handwritten paper massage therapy visit note, dated 2/18/21, included a handwritten signature with the staff name but failed to identify the staff credentials. c. The volunteer visit notes, dated 2/7 and 2/21/21, was marked as completed on 3/6/21 and 3/19/21 and 9 days late per hospice policy. 2. Patient #13 was admitted to hospice on 12/15/2020, received services while residing in a private home and had a discharge date of 2/17/21. Clinical record review revealed the following: a. The music therapy visit notes, dated 12/23,

staff credentials.

12/29/21 and 1/6/21, included an electronic signature with staff name but failed to identify the

b. The hospice aide visit notes, dated 1/11 and 1/14/21, was marked as completed on 1/19/21, 4

and 1 days late per hospice policy.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SU IDENTIFICATIO		1	TIPLE CONSTRUCTION		E SURVEY IPLETED
		16	1580	B. WING		0-	4/08/2021
	ROVIDER OR SUPPLIER  OF LIFE HOSPICE				STREET ADDRESS, CITY, STATE, ZIP COD 3207 220TH TRAIL AMANA, IA 52203	E	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICION Y MUST BE PRECEDO SC IDENTIFYING INF	D BY FULL	ID PREFI TAG		N SHOULD BE EAPPROPRIATE	(X5) COMPLETION DATE
L 679	Continued From page c. The hospice aide of was marked as compper hospice policy.  3. Patient #3 was ad 12/8/2020 and receive a nursing home.  Clinical record review visit note, dated 2/1/2 completed on 2/4/21, policy.  4. Patient #12 was a 2/19/21, received ser private home and had 3/27/21.  Clinical record review visit note, dated 2/24 completed on 3/1/21, policy.  5. Patient #5 had a 19/30/2020, and received in a nursing.  Clinical record review a. The massage the 2/10/2021 and 3/10/2 signed as completed b. The IDG notes fail meeting for coordinate.  6. Patient #8 had a 12/1/2020, and receives residing in a private.	visit note, dated leted on 2/4/21, mitted to hospice ed services while revealed the sken, was marked and a discharge date of the services while residual day late per hospice admission and the services and the services while residual day late per hospice admission and the services whome.  If you was electron and the services who was electron and the services and the services and the services and the services and the services.	con residing in led nursing as ospice ce on ling in a te of cial work as ospice lowing: ated onically ude a title.		679		

		(X1) PROVIDER/SU IDENTIFICATION			FIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		16	1580	B. WING			04/08/20	21
	OF LIFE HOSPICE				STREET ADDRESS, CITY, STATE, ZIP COO 3207 220TH TRAIL AMANA, IA 52203	DE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICE Y MUST BE PRECED SC IDENTIFYING IN	ED BY FULL	ID PREFI TAG		N SHOULD BE EAPPROPRIAT	COM	(X5) PLETION DATE
L 679	Continued From page Clinical record review a. The volunteer visit 2/18/21, failed to inclu.  7. Patient #1 had a h 2/12/21 and received residing in a private h Clinical record review narrative note, dated electronic signature of day late according to  8. Patient #6 had a h 3/12/21 and received residing in a nursing h Clinical record review notes, dated 3/17, 3/2 included a handwritte completion. The sign credentials or title of the siding in a private h Clinical record review a 2/8/21, included a h date of completion. The included a h date of completion. The included a h date of completion. The inclusion of the credentials or title of the completion.	revealed the formote, dated 2/4 ide a signature ospice admission hospice service ome residence.  revealed the sk 2/10/21, include from pletion of thospice policy.  ospice admission hospice service from experience.  revealed music 4, 3/30, and 4/6 in signature and ature lacked income music therapy hospice services from experience.  revealed:  rapy visit note, and written signature lacked income residence.  revealed:	/21 and and title.  In date of swhile  Illed nurse at a 2/15/21, 1  In date of swhile  Itherapy visit 6/21, date of slusion of the bist.  Identify the swhile at the and cked at the massage		579			
	b. The music therapy 2/24, 3/3, 3/10, 3/17, a handwritten signatu	3/23, and 3/30/	21, included					

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 04/14/2021 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AND PLAN OF CORRECTION COMPLETED A. BUILDING 161580 04/08/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3207 220TH TRAIL **ESSENCE OF LIFE HOSPICE** AMANA, IA 52203 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) L 679 Continued From page 24 L 679 The signature failed to include the credentials or title of the music therapist. The above findings for Patients #1, #3, #4, #5, #6, #8, #10, #12 and #13 were reviewed with Hospice Administrator and Clinical Manager. Hospice staff provided no further information prior to the end of the survey. L 683 DISCHARGE OR TRANSFER OF CARE L683 CFR(s): 418.104(e)(2) (2) If a patient revokes the election of hospice care, or is discharged from hospice in accordance with §418.26, the hospice must forward to the patient's attending physician, a copy of-(i) The hospice discharge summary; and (ii) The patient's clinical record, if requested. This STANDARD is not met as evidenced by: Based on clinical record review and staff interview, the hospice failed to ensure the hospice staff sent a copy of a discharge summary to the attending physician for 1 of 2 sampled (live) discharged patients (Patient #12). The hospice reported a total of 7 live discharge in the past 3 months. Failure to ensure the hospice staff included the attending physician in the process for imminent discharge placed the patient at risk for not receiving ongoing medical care and services to meet the needs of the patients. Findings: During an interview on 4/8/21 at 9:00 AM, the

STATEMENT OF DEFICIENCIES (X1) PROVIDER/S, AND PLAN OF CORRECTION IDENTIFICATION			(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		10	1580	B. WING		04/	08/2021
	OF LIFE HOSPICE				STREET ADDRESS, CITY, STATE, ZIP CODE 3207 220TH TRAIL AMANA, IA 52203		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFIC Y MUST BE PRECED SC IDENTIFYING IN	ED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
L 683	Continued From page Clinical Manager reposummary and medical hospice medical direct Patient #12 was admireceived services while and had a discharge of The discharge summary and the discharge summary and confirmed the she faxed to the attending director would have redischarge summary a meeting after the discontinuation of the CRIMINAL BACKGROCFR(s): 418.114(d)(1). The hospice must obtain criminal contracted employees contact or access to patient contact or access to patient systems.	orted the dischartion list are faxestor and attendirented to hospice the residing in a state of 3/27/21.  The discharge summant's attending pure 14/8/21 at 10:11 at the discharge eets lacked protein physician. The eceived a paper to the interdiscip that god.  The discharge eets lacked protein physician. The eceived a paper to the interdiscip that god.  The eceived the above yided no further survey.  DUND CHECKS  The employees who ess to patient resist require that a lab background continue t	d to the g physician.  on 2/19/21, orivate home  21, lacked y was hysician.  O AM, the summary of of being medical copy of the linary group  ackground have direct ecords. all contracted hecks on ct patient  enced by: equires	L 68			
	<u> </u>			1			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SI IDENTIFICATION				(X3) DATE SURVEY COMPLETED	
		10	61580	B. WING		0.	4/08/2021
NAME OF PROVIDER OR SUPPLIER ESSENCE OF LIFE HOSPICE					STREET ADDRESS, CITY, STATE, ZIP CODE 3207 220TH TRAIL AMANA, IA 52203		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC (EACH DEFICIENCY MUST BE PRECEI REGULATORY OR LSC IDENTIFYING IN		ED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
L795	Continued From page dependent adult abus check on all prospect employees with the p contact, within 30 day using either the lowa Repository (SING), o Department of Crimin conduct the criminal lusing the lowa Depar conduct the depende abuse background charter the depende abuse background charter the lowa Administrat requires the hospice clearance from the D Services (DHS) prior employee who DCI h record for any convict simple misdemeanor.  Based on review of estaff interview, the hocompletion of a crimin of 7 sampled employ began serving hospic survey, dated 7/16/18.  The hospice reported patients.  Failure to complete coas required by Feder potential risk of harm hospice staff and volupatient contact.  Findings include:  1. Staff E, Licensed F.	se, and child ab ive direct or cor otential for direct or cor otential for direct or spiror to the disconsistent of the disconsistent of the disconsistent of Human and adult abuse a necks.  Ive Code, Chapagency to obtain epartment of Human of Hum	attracted ct patient ate of hire, ion lowa (DCI) to ck, and a Services to and child ater 119, an authorized uman ospective a criminal e than a annel files and ensure check for 4 ters who a their last ater 134	L 79	5		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUI IDENTIFICATION		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
16			580	B. WING		0	04/08/2021	
NAME OF PROVIDER OR SUPPLIER  ESSENCE OF LIFE HOSPICE					STREET ADDRESS, CITY, STATE, ZIP CODE 3207 220TH TRAIL AMANA, IA 52203			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENC (EACH DEFICIENCY MUST BE PRECEDED B REGULATORY OR LSC IDENTIFYING INFORI		D BY FULL	ID PREFI TAG		SHOULD BE	(X5) COMPLETION DATE	
State back to	intinued From page to of 11/12/18.  Iff E's personnel file exground check, dathe hire date.  Staff F, Massage Tile 19/19.  Iff E's personnel file exground check, dathe hire date.  If g an interview or ministrator reported eded job position in eck was completed tended but she was entation until Decer Staff G, Volunteer, aff G's personnel file exground check, dathe hire date.  Staff H, Volunteer, expression of the ended tended but she was entation until Decer staff G's personnel file exground check, dather the date.  Staff H, Volunteer, expression of the hire date.  If H's personnel file exground check, dather the end of	e contained a crited 10/9/18, 34 herapist, had a herapist, had a herapist, had a crited 8/26/19, 115 had 8/21 at 11:25 d Staff F was offer August so the herapist to the job or unable to compriber. had a hire date had a hire date had a hire date had a hire date accontained a crited 6/6/19, 49 december as contained a crited 5/28/2020, description was performation was p	days prior  aire date of  minal days prior  AM, the ered an as ackground offer being lete the  of 7/25/19.  minal ays prior to  of  minal ays prior to	L	795			

POC accepted on 4/20/21 with date of correction 5/19/21. Sel 2567-B. Rasmussen

Essence of Life Hospice Amana, A #16-1580 Survey ending 4/8/2021

Document written 4/19/2021

Jacqueline Aanestad, Administrator signing document

Lacquele Unite

#### L 531 CONTENT OF COMPREHENSIVE ASSESSMENT 418.54(c)(7)

An initial bereavement assessment of the needs of the patient's family and other individuals focusing on the social, spiritual, and cultural factors that may impact their ability to cope with the patient's death. Information gathered from the initial bereavement assessment must be incorporated into the plan of care and considered in the bereavement plan of care.

Failure to complete an initial bereavement assessment increased the risk that patient or family caregiver grieving, and bereavement needs would not be addressed appropriate, leading to prolong or dysfunctional grieving and potentially increased the risk of self-harm for hospice patients or survivors.

This concern was reviewed on 4/8 and 4/9 with Social workers, 4/12, and 4/13 with nursing and social workers to review procedures for collecting the initial bereavement assessment and then reviewed what to do if SW was unable to meet patient/family or answer assessment questions in 5 days. Social Work will perform the assessment in 5 days, if unable then they will contact the nurse to complete the assessment before the end of 5 days for the comprehensive plan of care.

Additional Review will take place at QAPI meeting on 4/21/2021

Clinical charts will be reviewed at 25% of active charts monthly to ensure these items are met by social work and or nursing. Charts will be reviewed for 6 months to ensure compliance. This information will be reported to the QAPI report team monthly and to the managing member. After 6 months, ongoing monitoring will continue quarterly using a PIP tool with a minimum of 10% of charts audited by Patient Care coordinator or designee.

#### L 543 PLAN OF CARE CFR 5: 418.\$6(b)

All hospice care and services furnished to patient and families must follow an individualized written plan of care established by the hospice interdisciplinary group in collaboration with the attending physician (if any), the patient or representative, and the primary caregiver in accordance with the patient's needs if any of them so desire

Failure to follow the patients plan of care as directed by the interdisciplinary group put the patient at risk for inconsistent care that may not meet the needs of the patient.

Specifically, the delay in physician orders for wound care and nurses not following plan of care for assessment of patient.

Met with nursing staff on 4/8,4/9, 4/12, 4/14 to review interventions and how to obtain orders for wounds. Reviewed care plan interventions and added specifications for the Interventions to meet needs of patient assessment. Updated interventions were put in place on 4/19/2021

Reviewed policy on plan of care

Additional Review will take place at QAPI meeting on 4/21/2021

Clinical charts will be reviewed at 25% of active charts monthly to ensure orders are written and sent at time of implementation and interventions frequencies are met by nursing. Charts will be reviewed for 6 months to ensure compliance. This information will be reported to the QAPI report team monthly and to the managing member. After 6 months, ongoing monitoring will continue quarterly using a PIP tool with a minimum of 10% of charts audited by Patient Care coordinator or designee.

L547 Content of plan of care418,56@ (2)

Plan of care necessary for the palliation and management of the terminal illness and related conditions including the following: 2) A detailed statement of the scope and frequency of services necessary to meet the specific patient and family needs.

Failure to identify a scope and frequencies for all ordered services increased the potential for hospice services to not adequately meet the needs of hospice patients and families.

Met with each department Nursing, Social Work, Spiritual, Music, and Massage to review orders for scope and frequency of PRN orders. Meeting on 4/8,4/9/4/12,4/14. Each patient's orders were reviewed and re written to create a more specific plan of care to meet their needs.

Additional Review will take place at QAPI meeting on 4/21/2021

Clinical charts will be reviewed at 25% of active charts monthly to ensure these items are met by all disciplines. Charts will be reviewed for 6 months to ensure compliance. This information will be reported to the QAPI report team monthly and to the managing member. After 6 months, ongoing monitoring will continue quarterly using a PIP tool with a minimum of 10% of charts audited by Patient Care coordinator or designee.

#### 1579 PREVENTION CFR 418.60(a)

Hospice must follow the accepted standard of practice to prevent the transmission of infections and communicable diseases including the use of standard precautions.

Failure to ensure services during home visits follow accepted standard of practice for infection control increased the risk of contamination during the home visit, the development of an infection and or transmission of organisms from home to home.

Specifically, infection issues with bag technique and between tasks of contamination.

Met with all staff on 4/9/2021, and each department to review infection control policy. All staff viewed video on proper bag technique and completed infection control training course. Each staff will perform demonstration of bag technique and had staff supervisory visit. This training is done at hire and annually during our meeting yearly review and competency training.

Additional Review will take place at QAPI meeting on 4/21/2021

L 647 Level of Activity 418.78 (e) Volunteers must provide day to day administrative and or direct patient care services in an amount that at minimum equals 5 % of the total patient care hours of all paid hospice employees and contract staff. The hospice must maintain records on the use of volunteers for patient care and administrative services including the type of services and time worked.

Failure to maintain volunteer hours for hospice patients put the patients and families at risk of not receiving the services necessary to meet the needs of the patients and puts the hospice at risk of not providing all regulatory requirements for the hospice program.

Specifically, that our volunteers only provided 4/3% for 2019

During this time we had 2 significant volunteers move away and leave during winter months. We also had a new coordinator start. Administration met with Volunteer Coordinator on 4/13 and 4/16 to review when and how to utilize volunteers and recruitment. A plan to develop new volunteers and utilize the current ones more often.

Each month volunteer hours will be calculated to determine status and create additional opportunities for volunteers. Creating additional recruitment events will also be developed once the pandemic is over and allowing more interaction. Monitoring this monthly and report to QAPI and managing member.

Additional Review will take place at QAPI meeting on 4/21/2021

L 655 Professional Management Responsibility 418.100(e)

A hospice that has a written agreement with another agency, individual or organization to furnish any services under arrangement must retain administrative and financial management, and oversight of staff and services for all arranged services, to ensure the provision of quality care Arranged services must be supported by written agreements that require all services be

- 1. Authorized by the hospice
- 2. Furnished in a safe and effective manner by qualified personnel and
- 3. Delivered in accordance with the patients plan of care

Failure to include the required contract components within the contractual agreement increased the potential that hospice management and oversight failure to occur and the patient would not receive services specified on the plan of care.

Specifically DME and Pharmacy contracts did not include every required provision to furnish their services:

4/14 emailed with DME, reviewed items missing in the current contract (hospice retains administrative management, oversite of staff and services, all services are authorized by the hospice, and all services are delivered in accordance with the hospice plan of care); a revised contract was written also discussed

4/14 contacted pharmacy administrator about items missing in the current contract (hospice retains administrative management, oversight of staff and services and all services are authorized by the hospice); a revised contract was written and signed on 4/16/2021.

Annual Review of all contracts will be performed to ensure all items are in compliance. Overall responsibility of this item falls to the Administrator and designee. To be completed by 5/19/2021

#### L 679 Authentication 418.104 (b)

All entries must be legible, clear, complete, and appropriately authenticated and dated in accordance with hospice policy and currently accepted standards of practice.

Failure to ensure all clinical record documentation included accurate information and were completed timely may result in ineffectively coordinated patient care.

Specifically missing credentials on signatures and late documented visit notes.

4/8/2021 email to Music and Massage staff to instruct on making sure credentials were with all signature and designation of title. The electronic signature was corrected on 4/9/2021. 4/9/2021 all staff were re instructed in documentation policy of 2 business days. Staff signed off on policy review

Additional Review will take place at QAPI meeting on 4/21/2021

Clinical charts will be reviewed at 25% of active charts monthly to ensure credential are on documentation and timely items are met by staff. Charts will be reviewed for 6 months to ensure compliance. This information will be reported to the QAPI report team monthly and to the managing member. After 6 months, ongoing monitoring will continue quarterly using a PIP tool with a minimum of 10% of charts audited by Patient Care coordinator or designee.

#### L 683 DISCHARGE OR TRANSFER OF CARE 418.104 (e)(2)

2 If a patient revokes the election of hospice care or is discharged form hospice in accordance with 418.26 the hospice must forward to the patient attending physician a copy of the hospice discharge summary and the patient clinical record if requested

Failure to ensure the hospice staff included the attending physician in the process for imminent discharge placed the patient at risk for not receiving ongoing medical care and services to meet the needs of the patient.

Specifically, that the complete discharge summary was not sent to physicians and returned.

Met with nursing staff on 4/9 and 4/12,4/14 and office staff. Reviewed regulation and modified discharge summary to include a physician verification of receiving all information. By returning this form it verifies the receiving of the information.

Additional Review will take place at QAPI meeting on 4/21/2021

Clinical charts will be reviewed at 25% of discharged charts monthly to ensure these items are met by staff. Charts will be reviewed for 6 months to ensure compliance. This information will be reported to the QAPI report team monthly and to the managing member. After 6 months, ongoing monitoring will continue quarterly using a PIP tool with a minimum of 10% of charts audited by Patient Care coordinator or designee.

#### L 795 CRIMINAL BACKGROUND CHECKS 418.114 (d) (1)

The hospice must obtain a criminal background check on all hospice employees who have direct patient contact or access to patient records. Hospice contracts must require that all contracted entities obtain criminal background checks on contracted employees who have direct patient contact or access to patient records.

Failure to complete criminal background checks as required by Federal regulation, increased the potential risk of harm to agency patients from hospice staff and volunteers who had direct patient contact.

Specifically, background checks were done beyond 30 days before employee or volunteer starts dates. On 4/8 met with staff in charge of performing background check and orientation on boarding. Reviewed state regulations and how to implement this in the onboarding check list.

Quarterly starting May 2021, all new hire HR files will be reviewed to ensure these requirements are met by hospice and volunteer staff. This information will be reported to the QAPI report team quarterly and to the managing member.