

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>013288</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>03/07/2022</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>PARADIGM HEALTH</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>8904 BASH ST, SUITE B INDIANAPOLIS, IN 46256</b>
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	<p><b>INITIAL COMMENTS</b></p> <p>This visit was for a State licensure complaint survey of a hospice with deemed status through Accreditation Commission for Health Care (ACHC.) The State complaint investigation was initiated by the Indiana Department of Health.</p> <p>Complaint #: IN 00371864</p> <p>Survey Dates: 2/28/22, 3/1/22, 3/2/22, 3/3/22, 3/4/22, 3/7/22</p> <p>Complaint #IN 00371864; Substantiated with findings</p> <p>QR by Area 3 on 3-15-2022</p>	S 000	<p>POC accepted on 3-24-2022</p> <p><i>Deborah Franco</i></p>	
S 521	<p><b>418.54 INITIAL &amp; COMPREHENSIVE ASSESSMENT OF PATIENT</b></p> <p>The hospice must conduct and document in writing a patient-specific comprehensive assessment that identifies the patient's need for hospice care and services, and the patient's need for physical, psychosocial, emotional, and spiritual care. This assessment includes all areas of hospice care related to the palliation and management of the terminal illness and related conditions.</p> <p>This STANDARD is not met as evidenced by: Based on record review and interview, the agency failed to ensure all patients received a patient-specific comprehensive assessment that reflected the patient's current health status and included all information related to the palliation and management of the patient's terminal illness</p>	S 521		

Indiana State Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
---	-------	-----------

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>013288</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>03/07/2022</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>PARADIGM HEALTH</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>8904 BASH ST, SUITE B INDIANAPOLIS, IN 46256</b>
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 521	<p>Continued From page 1</p> <p>and related conditions for 1 (Patient #1) of 1 closed record reviewed and 3 (Patients #2, 3, and 4) of 4 active records reviewed.</p> <p>Findings include:</p> <p>1. A review of agency policy #4-042.1, titled "Comprehensive Assessment," last revised on 11/2020, indicated the comprehensive patient assessment included, but was not limited to, an assessment of pain, including the origin, location, duration, severity, and relief measures; an assessment of severity of secondary symptoms, such as nausea, vomiting, respiratory distress, and nutritional status; current treatment and patient response to that treatment; a physical assessment, including relevant data related to pertinent physical findings complications and risk factors that affect care; past and present medical history, pertinent diagnoses, and any comorbidities; past medical and surgical care.</p> <p>2. A review of the clinical record for Patient #1, for benefit period 10/12/ 21 - 1/9/22, evidenced a history and physical from the patient's recent hospitalization on 10/11/21. The history and physical indicated Patient #1 had a recent history of falls, UTI (urinary tract infection), weakness, and confusion, and had active problems which included confusion, diarrhea, nausea, vomiting, peptic ulcer, hypotension, liver cirrhosis, and bacteremia, identified as MRSA (Methycillin Resistant Staphylococcus Aureus - a contagious bacterial infection resistant to antibiotics) in the blood and urine.</p> <p>A review of Patient #1's CTI (Certification of Terminal Illness) for benefit period #1, which began 10/12/21, evidenced a primary terminal</p>	S 521		

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>013288</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>03/07/2022</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>PARADIGM HEALTH</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>8904 BASH ST, SUITE B INDIANAPOLIS, IN 46256</b>
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 521	<p>Continued From page 2</p> <p>diagnosis of senile degeneration of the brain, with comorbid diagnoses that included dementia without behavioral disturbance, cirrhosis of the liver (a type of liver damage), sepsis (infection in the blood) due to MRSA, idiopathic hypotension (a type of low blood pressure), urinary tract infection, portal hypertension (high pressure in the the portal vein that leads to the liver), diverticulitis (an inflammation of a small pouch/pouches that form in the digestive tract), and chronic peptic ulcer (a sore that forms on the lining of the stomach, esophagus, or small intestine. The CTI indicated Patient #1 was incontinent of bowel and bladder, was no longer eating, and only took sips of liquids. The patient had shortness of breath at rest which worsened with minimal exertion, and no longer recognized family or loved ones.</p> <p>A review of a physician order dated 10/13/21, evidenced Patient #1 had a 0.5 mm (millimeter) stage 1 sacral wound. The order failed to evidence further description, including but not limited to, measurements, the skin integrity, peri-wound integrity, and presence or absence of blanching.</p> <p>A review the patient's admission comprehensive assessment, dated 10/12/21, evidenced a primary diagnosis of senile degeneration of the brain, and secondary diagnoses of unspecified dementia without behavioral disturbance, unspecified cirrhosis of the liver, sepsis due to MRSA, idiopathic hypotension, UTI, portal hypertension, diverticulitis of the intestine, and chronic or unspecified peptic ulcer. Patient #1 was documented as being in an isolation room due to the presence of MRSA, and was in bed.</p> <p>The comprehensive assessment (C/A) failed to</p>	S 521		

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>013288</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>03/07/2022</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>PARADIGM HEALTH</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>8904 BASH ST, SUITE B INDIANAPOLIS, IN 46256</b>
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 521	<p>Continued From page 3</p> <p>accurately reflect the patient's current health status, and failed to include accurate information related to the palliation and management of the patient's terminal illness and related conditions. The C/A documented both a pain rating of 2/10 on the Edmonton Scale and a rating of no pain in the pain assessment section; failed to evidence a complete pain assessment to include the location, severity, character, duration, frequency, and effects of the pain. The C/A documented Patient #1 "never has shortness of breath." Both the CTI and the history and physical evidenced Patient #1 had shortness of breath even at rest. The C/A failed to evidence how Patient #1's "patient/caregiver" was interviewed when the patient was confused, and unable to recognize family/loved ones per the assessment. The C/A documented Patient #1 was bedfast with very limited mobility, and also documented Patient #1 needed help with ambulation and was a fall risk. Patient #1's nutrition was "probably inadequate" but failed to indicate per the CTI and history and physical that the patient no longer ate and evidenced failure to thrive. The C/A failed to specify whether the patient wanted to eat/was hungry but couldn't, or was no longer interested in eating. The C/A wound assessment section was blank, and failed to include a full integumentary assessment that included documentation of a stage 1 wound to the coccyx. Patient #1 was incontinent and the most recent bowel movement was documented as the day before and "WNL" (Within Normal Limits.) The C/A failed to evidence Patient #1 was discharged from the hospital 1 day prior and had watery diarrhea; failed to evidence whether Patient #1 had any understanding of imminent death. The C/A indicated the patient was incontinent of urine and did not have any recurrent UTIs, which was contrary to the hospice's CTI and history and</p>	S 521		

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>013288</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>03/07/2022</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>PARADIGM HEALTH</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>8904 BASH ST, SUITE B INDIANAPOLIS, IN 46256</b>
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 521	<p>Continued From page 4</p> <p>physical, which evidenced Patient #1's hospitalization 1 day before included a UTI positive for MRSA. The C/A failed to indicate positive for MRSA in the urine and the need for isolation. The C/A failed to evidence Patient #1's DME (Durable Medical Equipment) and Supply needs.</p> <p>3. A review of the recertification assessment for patient #2, dated 1/21/22, evidenced the patient had a diagnosis of COPD (Chronic Obstructive Pulmonary Disease) - a progressive/terminal disease affecting the lungs ability to exchange oxygen, and OSA (Obstructive Sleep Apnea) - a condition causing obstruction of the airway and resulting in absence of effective breathing, but failed to evidence the patient received a full respiratory assessment that included oxygenation needs related to oxygenation saturation (O2 Sat), and use of CPAP (Continuous Positive Airway Pressure - a type of assisted ventilation) when sleeping, and need for oxygen. The assessment indicated Patient #2 was incontinent but failed to evidence the date of the last bowel movement, and failed to evidence a complete abdominal assessment was performed that included auscultation and palpation. Review of the integumentary status and wound care sections indicated patient #2 had wounds #1 and #2, described as "closed;" and wounds #3, #4, and #5, described as "open." The patient was documented as having "become increasingly confused and forgetful and had several accidents resulting in wounds to both lower extremities." The assessment failed to evidence an accurate comprehensive assessment of the patient's wounds, including but not limited to, measurements, drainage, wound bed, surrounding tissue condition, type, and location; failed to include the current wound care and</p>	S 521		

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>013288</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>03/07/2022</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>PARADIGM HEALTH</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>8904 BASH ST, SUITE B INDIANAPOLIS, IN 46256</b>
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 521	<p>Continued From page 5</p> <p>treatment regimen; and failed to include whether wound care was provided at this visit. The assessment failed to include all health information related to the palliation and management of the patient's terminal illness and related conditions.</p> <p>4. Review of the admission comprehensive assessment for patient #3, dated 2/15/22, evidenced a terminal diagnosis of unspecified dementia without behavioral disturbance and secondary diagnoses of heart failure, paroxysmal atrial fibrillation, epilepsy - not intractable, with status, primary pulmonary hypertension, Crohn's disease, type 2 diabetes, and hyperlipidemia. The patient had a Karnofsky Performance score of 20% - low on the scale of 100 % being healthy and 10% being death imminent; hospital admission necessary, and a functional assessment score of "Ambulatory ability is lost," cannot walk without personal assistance. The medical equipment and supplies assessment indicated the patient had a hospital bed, overbed table, oxygen, and an oxygen concentrator. The assessment failed to evidence a complete and accurate neurological assessment to include Patient #3's seizure disorder, seizure plan, and assessment of how the patient had recently been in status epilepticus (seizure longer than 5 minutes,) failed to include a complete and accurate endocrine assessment, including but not limited to, the patient's diabetic status and diabetes care measures to include a diabetic foot assessment.</p> <p>5. A review of the comprehensive assessment for patient #4, dated 1/20/22 - 4/19/22, which indicated the patient had a terminal diagnosis of unspecified severe protein-calorie malnutrition with secondary diagnoses of senile degeneration</p>	S 521		

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>013288</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>03/07/2022</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>PARADIGM HEALTH</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>8904 BASH ST, SUITE B INDIANAPOLIS, IN 46256</b>
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 521	<p>Continued From page 6</p> <p>of brain, encounter for screening for diabetes mellitus, hypertension, and sequelae of cerebral infarction, but failed to include diagnosis(es) related to the patient's non-healing lower extremity wounds. The patient had a Foley catheter for urinary incontinence and required assistance for all activities of daily living and instrumental activities of daily living, including but not limited to dressing, mobility, bathing, grooming, and wound care. The assessment indicated the patient was unable to ambulate without assistance. Functional limitations included ambulation, bathing, continence, dressing, transfer, glaucoma, and glasses. Functional ability was scored as "Ambulatory ability is lost." There was a moderate risk for pressure sores. The patient was documented as both alert and forgetful, had a history of seizures, had shortness of breath with minimal exertion, and evidenced a flat affect, had difficulty coping, and was discouraged. Durable medical equipment needs included a bath/shower bench, grab bars, an overbed table, and a raised toilet seat, and special mattress. The patient had 3 wounds to the right lower extremity, and Patient #4 refused observation, assessment, or treatment by the nurse due to intolerable pain when touched. The assessment failed to include an accurate and complete functional assessment that included the need for a wheelchair and/or walker, waffle boots/heel protectors, dressing supplies, diabetic supplies, and catheter supplies; failed to include an accurate endocrine assessment that included the patient's diabetic status and plan, and blood sugars identified in the summary of &gt;1000 (which increased the risk of coma;) failed to include a diabetic foot assessment; failed to include a pain assessment that included a plan for intolerable pain related to the heel wound; failed to include a psychosocial assessment that identified a plan for</p>	S 521		

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>013288</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>03/07/2022</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>PARADIGM HEALTH</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>8904 BASH ST, SUITE B INDIANAPOLIS, IN 46256</b>
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 521	<p>Continued From page 7</p> <p>the patient's flat affect and difficulty coping; failed to include a neurological assessment that included the type, frequency, duration, and treatment of the patient's seizures, and a seizure plan; and failed to include a nutritional assessment that included the patient's primary diagnosis of severe protein calorie malnutrition. Review of a communication note dated 1/31/21 evidenced "Multiple attempts made during week of admission to reach patient's contact. No return calls received ... MSW to visit pt (patient) at facility ..." The assessment failed to include a psychosocial assessment that included identifying the patient's responsible party/representative, that the representative was a truck driver and was often hundreds of miles away, the patient was unable to use a cell phone, and the patient had extreme difficulty answering the landline provided in the facility room. The assessment failed to include the patient's and representative's knowledge level and ability to understand the disease process and the hospice care plan. The assessment indicated "no medication changes", but failed to include a pain management assessment that addressed the immediate needs of the patient related to the inability to tolerate dressing changes due to unbearable pain.</p> <p>On 3/7/22 at 10:30 AM, individual C (representative for patient #4) was interviewed concerning the patient's care and treatment. Individual C stated the patient complained receiving Tylenol rather than ordered pain medication when it was requested. Individual C stated the patient was unable to use a cell phone and had having difficulty answering the landline in the room due to coordination issues.</p> <p>On 3/4/22 at 3:30 PM, the administrator and chief compliance officer were interviewed concerning</p>	S 521		

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>013288</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>03/07/2022</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>PARADIGM HEALTH</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>8904 BASH ST, SUITE B INDIANAPOLIS, IN 46256</b>
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 521	Continued From page 8  the agency's policy for comprehensive assessments, and concerning the content of clinical records 1 - 4. The administrator and chief compliance officer verbalized agreement the assessments above failed to reflect the current health status of the patients, and failed to include all information related to the palliation and management of their terminal illnesses and related conditions that affected care and treatment during hospice. On 3/7/21, prior to the survey exit, the administrator presented a new performance improvement plan as part of the agency's ongoing QAPI (Quality Assessment Performance Improvement) program which addressed the agency's evaluation and plan for achieving compliance in comprehensive assessments.	S 521		
S 523	418.54(b) TIMEFRAME FOR COMPLETION OF ASSESSMENT  The hospice interdisciplinary group, in consultation with the individual's attending physician (if any), must complete the comprehensive assessment no later than 5 calendar days after the election of hospice care in accordance with §418.24.  This STANDARD is not met as evidenced by: Based on record review and interview, the agency failed to ensure all patients received a comprehensive assessment no later than 5 days after the election of the hospice benefit in 1 of 4 active records reviewed (patient #5.)  1. Review of agency policy #4-042.1, last revised 11/2020, titled "Comprehensive Assessment,"	S 523		

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>013288</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>03/07/2022</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>PARADIGM HEALTH</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>8904 BASH ST, SUITE B INDIANAPOLIS, IN 46256</b>
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 523	<p>Continued From page 9</p> <p>indicated a comprehensive patient assessment will be performed by the interdisciplinary group no later than 5 calendar days after the election of hospice care.</p> <p>2. Review of the clinical record for patient #4 evidenced a communication note by employee D (licensed social worker), dated 1/31/22, which indicated employee D, (a Licensed Social Worker) made multiple attempts "during week of admission" to reach the patient, and did not receive return calls. A care plan meeting was held and evidenced the "MSW (Medical Social Worker) to visit pt at facility regardless of making contact with pt family this week due to no response from family last week."</p> <p>Review of a document titled "Post Admission Care Coordination", dated 1/20/22, evidenced "Social Worker - Yes. Please begin within 5 days."</p> <p>On 3/7/22 at 10:30 AM, individual C (representative for patient #4) was interviewed concerning the patient's care and treatment. Individual C stated having no recollection of declining a visit from social work, and stated, "I wouldn't decline any services. I need all the help I can get." Individual C stated as a truck driver, they were usually several hundred miles from the patient, and couldn't always answer the phone. Individual C also stated the patient did not know how to use a cell phone and had difficulty answering the landline in the patient's room.</p> <p>On 3/7/22 at 3:30 PM, the administrator and chief compliance officer were interviewed concerning the comprehensive assessment and the Medical Social Worker. Both individuals stated the social worker had not been able to reach the patient, but</p>	S 523		

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>013288</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>03/07/2022</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>PARADIGM HEALTH</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>8904 BASH ST, SUITE B INDIANAPOLIS, IN 46256</b>
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 523	Continued From page 10  verbalized agreement that the "Post Admission Care Coordination" document indicated the patient wanted a visit within 5 days of the election date.	S 523		
S 545	418.56(c) CONTENT OF PLAN OF CARE  The hospice must develop an individualized written plan of care for each patient. The plan of care must reflect patient and family goals and interventions based on the problems identified in the initial, comprehensive, and updated comprehensive assessments. The plan of care must include all services necessary for the palliation and management of the terminal illness and related conditions, including the following:  This STANDARD is not met as evidenced by: Based on record review and interview, the agency failed to ensure all patients had an individualized written plan of care that reflected the patient and family goals and interventions based on the comprehensive and updated comprehensive assessments, and included all services necessary for the palliation and management of the terminal illness and related conditions for 1 of 1 closed patient record reviewed (Patient #1) and 1 of 4 active patient records reviewed (patient #2.)  Findings include:  1. A review of the plan of care for patient #1, for the benefit period of 10/12/21 - 1/9/22, failed to evidence goals which were based on the patient's current comprehensive assessment,	S 545		

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>013288</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>03/07/2022</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>PARADIGM HEALTH</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>8904 BASH ST, SUITE B INDIANAPOLIS, IN 46256</b>
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 545	<p>Continued From page 11</p> <p>were specific to the patient's terminal illness, and included other conditions affecting the patient's care and services, including but not limited to the patient's active MRSA (Methycillin Resistant Staphylococcus Aureus - a potent bacteria that is resistant to antibiotics) and active wound/s; failed to ensure all goals were measurable and addressed the conditions and services necessary for the management of the patient's illnesses and course with hospice; failed to include family goals that were measurable, and specific to care of the patient and/or the family's management and coping through the end of life; and failed to include interventions that were patient specific, reasonable, and realistic based on the patient's and family's ongoing assessment and needs.</p> <p>2. A review of the plan of care for patient #2, for the benefit period of 2/4/22 - 4/4/22, failed to evidence goals which were based on the patient's most recent comprehensive assessment, were specific to the patient's terminal illness, and included other conditions affecting the patient's care and services, including but not limited to the patient's active wound/s; failed to ensure all goals were measurable and addressed the conditions and services necessary for the management of the patient's illnesses and course with hospice; failed to include family goals that were measurable and specific to care of the patient and/or the family's management and coping through the end of life; and failed to include interventions that were patient specific, reasonable, and realistic based on the patient's and family's ongoing assessment and needs.</p> <p>3. On 3/4/22 at 3:30 PM, the administrator and chief compliance officer were interviewed concerning the goals documented in the plans of care for Patient's 1 and 2. When queried as to</p>	S 545		

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>013288</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>03/07/2022</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>PARADIGM HEALTH</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>8904 BASH ST, SUITE B INDIANAPOLIS, IN 46256</b>
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 545	Continued From page 12  whether the goals listed on the respective plans of care included measurable outcomes and reasonable interventions, the administrator and the chief compliance officer stated that the patient goals were chosen from the agency's electronic medical record and failed to be patient realistic, specific and measurable.  On 3/7/21 at 9:30 AM, prior to the survey exit interview, the administrator and chief compliance officer stated the agency had initiated training and performance plans to improve patient goals and ensure they reflected the specific needs of the patient and family, were measurable, and included interventions that were reasonable and based on the patient's current assessment.	S 545		
S 546	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.  This STANDARD is not met as evidenced by: Based on record review and interview, the agency failed to ensure all patients received a plan of care that included all services needed for the management and palliation of the patient's terminal illness and all other conditions affecting the patient's care and treatment while receiving hospice for 1 of 1 discharged record reviewed (patient #1) and 3 of 4 active patient records reviewed (Patients #2, 3, and 4).	S 546		

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>013288</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>03/07/2022</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>PARADIGM HEALTH</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>8904 BASH ST, SUITE B INDIANAPOLIS, IN 46256</b>
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 546	<p>Continued From page 13</p> <p>Findings include:</p> <p>1. A review of the plan of care for Patient #1, for the benefit period of 10/12/21 - 1/9/22, failed to include all durable medical equipment in use or needed, including but not limited to dressing supplies, briefs, hospital bed, isolation supplies/PPE (personal protective equipment); failed to include orders for wound care; failed to include case coordination with the skilled facility; and failed to include orders and coordination of care related to MRSA (Methycillin Resistant Staphylococcus Aureus - a potent bacteria that is resistant to antibiotics).</p> <p>2. A review of the plan of care for Patient #2, for the benefit period of 10/12/21 - 1/9/22, failed to include all durable medical equipment in use or needed, including but not limited to dressing supplies, briefs, hospital bed, wheel chair, PPE; failed to include accurate and specific orders for all wound care; failed to include case coordination with the skilled facility; and failed to identify the patient's primary caregivers or family members participating in the plan of care and the patient's hospice course.</p> <p>3. A review of the plan of care for Patient #3, for the benefit period of 2/15/22 - 5/15/22, failed to include all durable medical equipment in use or needed, including but not limited to dressing supplies, briefs, hospital bed, wheel chair/walker, and PPE; failed to include accurate and specific orders for all wound care; failed to include case coordination with the skilled facility; failed to include all care needed, including but not limited to the patient's diabetes and seizure management, and failed to identify the patient's primary caregivers or family members participating in the plan of care and the patient's</p>	S 546		

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>013288</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>03/07/2022</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>PARADIGM HEALTH</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>8904 BASH ST, SUITE B INDIANAPOLIS, IN 46256</b>
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 546	<p>Continued From page 14</p> <p>hospice course.</p> <p>4. A review of the plan of care for Patient #4, for the benefit period of 1/20/22 - 4/18/22, failed to include all durable medical equipment in use or needed, including but not limited to dressing supplies, briefs, hospital bed, wheel chair/walker, and PPE; failed to include accurate and specific orders for all wound care; failed to include case coordination with the skilled facility; failed to provide an accurate and detailed psychosocial assessment by a medical social worker within 5 days of the election of the hospice benefit; failed to include all care needed, including but not limited to the patient's diabetes and seizure management; and failed to identify the patient's primary caregivers or family members participating in the plan of care and the patient's hospice.</p> <p>5. On 3/4/22 at 3:30 PM, the administrator and the chief compliance officer were interviewed concerning the comprehensive assessments and content of the plans of care for Patients #1, 2, 3, and 4. When queried as to how each patient's plan of care was developed, both individuals stated the plan of care flows from information gathered during the comprehensive assessment. When queried as to whether the plans of care should include all pertinent diagnoses, both indicated yes. Both individuals verbalized agreement that not all patient diagnoses had been documented in the plans of care and not all integumentary impairments were measured and assessed per agency policy.</p>	S 546		