Printed: 10/01/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		151561		B. WING		09/16/2021	
	OVIDER OR SUPPLIER			ESS, CITY, STA			
HEART TO	O HEART HOSPICE (	OF EASTERN INDIANA		RT, IN 4651	URT SUITE 2 6		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MU	STATEMENT OF DEFICIENCIES IST BE PRECEDED BY FULL REG DENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE COMPLETION	
E 000	Initial Comments			E 000			
L 000	An Emergency Prepconducted by the Interconducted Survey Dates: 9/7, 9 and 9/16/2021.  Facility Number: 010  Provider Number: 19  Unduplicated Censular Current Census: 36  At this Emergency File Heart Hospice of Earlin compliance with Exequirements for M Participating Provides §418.113.  INITIAL COMMENT  This was a State an survey for a hospice	51561 us: 169 Preparedness survey, Heastern Indiana LLC was for Emergency Preparedness edicare and Medicaid ers and Suppliers, 42 CF and Federal recertification eragency.  9/8, 9/9, 9/10, 9/13, 9/14, 00002	art to bund s	L 000			
	Current Census: 36						
	was found out of co Participation 42 CFF Comprehensive Ass Condition of Particip	pice of Eastern Indiana LI mpliance with Condition of R §418.54: Initial and sessment of the Patient, a pation 42 CFR §418.56:	of and				
LABORATOR'	Y DIRECTOR'S OR PROVIDI	ER/SUPPLIER REPRESENTATIVI	E'S SIGNATURE		TITLE	(X6) DATE	

(X2) MULTIPLE CONSTRUCTION

Any deficiency statement ending with an asterisk (\*) 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.

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		151561		B. WING		09/1	6/2021	
	OVIDER OR SUPPLIER  D HEART HOSPICE O	F EASTERN INDIANA	1178 FR	RESS, CITY, STA REMONT CO RT, IN 4651	URT SUITE 2			
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L 000	Interdisciplinary Group, Care Planning, and Coordination of Services.			L 000				
L 512	RIGHTS OF THE PATIENT CFR(s): 418.52(c)(1)			L 512				
		pain management and the hospice for conditi	ons					
	This Standard is not met as evidenced by: Based on observation, record review and interview, the agency failed to ensure all patients received effective pain management and/or symptom control for 4 of 15 records reviewed (#3, 5, 8, 9)							
	Findings include:							
	"Patient Rights and R Every patient has t	evised 10/31/2019 titled esponsibilities" indicate he right To receive ement and symptom co	ed "					
	"Medication Administrindicated " Agency orders when administ individual administering responsible for knowled The agency nurse will	evised 8/21/2015 titled ration and Management nurse will obtain physic ering medication Theng the medication is edge of usual dose . I provide the policies are agement administration	ian's e  nd					
	3. Review of an age 2/26/2021, titled "Inte and Responsibilities"	rdisciplinary Group Rol	es					

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L 512	[interdisciplinary grou and services including pharmacotherapeutic management outcom  4. An agency policy of Management indicate and symptom management and sympatient's right to recei management and sympain goal level will be the patient is satisfied and/or the current level assessed to be at a legatient's goal level will intervention be perfor will consider personal patients regarding pathe patient's history of the patient's history of the patient's physical, psystatus will conduct comprehensive assessibility assessed for home sure that the nursir identified medicatic [difficulty breathing] integrity emotional Characteristics of propain management the current level of patreatment, services at be provided Additioused in planning care needs"	p] will supervise the g: A. Drugs evaluate effectiveness of symptones"  evised 1/1/2020 titled "Fed " guidelines for paiement will respect ive effective pain inptom control patient assessed Determined with the established goe of pain control Paievel greater than the ll include an appropriate and by nursing staff I beliefs in educating in management Asset pain and its treatment evised 1/1/2020 titled s" indicated assessment ed to) " Evaluating they chosocial and emotion a patient-specific esment that identifies the spice care and services and needs of the patient ons pain dyspnea constipation skin distress support systopain patient/family's ge and their satisfaction we	e om  Pain in t's e if oal in e staff ng ess"  ts e is al es et se ial es et se ial es se is in es	L 512				

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, ,		(X1) PROVIDER/SUPPLIER/O IDENTIFICATION NUMBE		A. BUILDING		(X3) DATE SURVEY COMPLETED	
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L 512	9/15/2021, hospice election period 5/2  A document dated Start of Care" indicterm care (LTC) fato express her need continuous problem (a narcotic pain morelief.  A document dated 5/21/2021 titled "Subsequent Visit" administered over facility B's nurses, know how much magency RN P failed frequency the moreorder to determine management need During an interview Patient Care Mananot acceptable that much morphine was over the past 24 hr 5/21/2021, and showhat pain medicate hours.  7. Record review from 9/15/2021, hospice election period 8/1  A document titled of Care" for election 11/16/2021 indicated diagnosis of chronic results.	e election date 5/20/2021, 0/2021 - 8/17/2021.  5/20/2021 titled "RN Hospicated the patient resided acility B, the patient was uneds, pain was an active, m for the patient, and morpedication) was initiated for and signed by RN P on N [skilled nurse] Hospice indicated morphine was the past 24 hours by LTC LTC facility B's nurse didrorphine was administered to confirm the amount or phine was administered in the if the patient's pain	bice t long able  bhine pain  't , and  was ow ent  now 24  ed on for  Plan  art	L 512			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		1 ' '	LE CONSTRUCTION	(X3) DATE SUF COMPLET	
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L 512	well as it should, whi breath), other diagnot to) acute respiratory enough oxygen in the obstructive pulmonar inflammatory lung disairflow from the lung document indicated 'effectiveness of card measures including of document failed to in ordered for the patient.  A document dated and Northern (H2HN) has 8/19/2021 titled "RN indicated the patient failed to indicate oxygen treatment of shortnes was then modified or hospice agency RN I oxygen therapy was shortness of breath.  During an interview of H2HN RN R indicate oxygen, and she was was changed.  A document dated 8/ Subsequent Visit" increinforced use of sup by the physician"  A document dated 9/ Subsequent Visit" increinforced use of sup by the physician"	ch often causes shortners included (but not limited sisis (COPD- a chosease that causes obstricts). In the orders section, " Hospice nurse to assippulmonary symptom repaygen treatment" The dicate oxygen (O2) was not.  Indicate oxygen (O	ronic ucted , the sess elief ne s seart	L 512			

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L 512	Subsequent Visit" incodifficulty breathing will equipment was in the During a home visit of O2 or equipment was During an interview of family indicated she whome for her mother. A document dated 9/Coordination Note Reserved O2 for incompart of the Coordination	dicated the patient had th exertion, and no oxyge patient's home.  In 9/9/2021 at 10:05 AM is observed.  In 9/13/2021 at 1:45 PM would like to have O2 in scomfort.  14/2021 titled "Client eport" indicated family reased shortness of breased	ath.  1, RN he 8:00 - ed on for bice t of cate n at- od) v was failed ain  1,	L 512			

(X2) MULTIPLE CONSTRUCTION

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L 512	frequently, or what mutilized.  A document dated 8/Subsequent Visit" ind as needed (PRN) for or anxiety, and the nutility on use.  During an interview on PCM C confirmed the was prescribed at 2 lineeded", there was no 1002, and it was not incompared to the was prescribed at 2 lineeded to be at 100 and the was prescribed at 2 lineeded to the was not incompared to the was prescribed at 2 lineeded to the was not incompared to the was not incompared to be at 100 and the was in a compared to the following the nurse: 8/13/2021: 98% on room air, 8/15/2021: 98% on	ethod of administration also administration also indicated of administration are set it up and instruction 9/16/2021 at 2:31 PM applies plan of care indicated at the set in the visit note are constant pain, rated at a level and also indicated at a level and also indicated are of all constant pain, rated at a level and also indicated as expenses a constant pain, and her pain goal was "0".  19/2021 titled "Hospice and Care Update Report of Care Update Report o	poice night ning cted  1, O2 as the the cice tion: a "2" 10 =  IDG  rt" ed by on 2021: air, 87% kygen er  1, nted der	L 512			

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L 512	educated on the use control of shortness of A document dated 8/3 Subsequent Visit" indiconstant abdominal pher pain as sharp about stabbing" her, with interpretation also used heat for part A document dated 8/3 Subsequent Visit" incompared to the part of the	of oxygen for symptom of breath.  23/2021 titled "SN Hosp licated in the patient was bain, the patient describ dominal pain "knives termittent back pain, and in relief.  24/2021 titled "SN Hosp licated the patient report and her stomach felt I I her every time she ate on 9/16/2021 at 2:31 PN expatient's description of the low number reported have looked into it furthations.  patient #3 was completed the of 4/20/2021 for be 10/25/2021, which indicated Parkinson's Disease (as	oice as in ed ad she bice rted ike f pain d (2), her  ted enefit ted a ing).  TC) of 11 10 = sleep of 5 or	L 512			

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L 512	the physician. Additional included a goal that the acceptable to the pattern of t	onally, the document he pain level would be	nent ent ent pain, n  pain, n  pain led to  cord n on a vorst  g the ) pain d as a sician lue  cuss, PRN) orted  on got 3 21,	L 512				

(X2) MULTIPLE CONSTRUCTION

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L 512	on 8/25/2021, pain w. IDG, FN to give PRN reported as 7, discus 8/29/2021, pain was pain was reported as 10, discu on 9/3/21, pain was reported as 10, will di PRN morphine, MD rows reported as 10, will di PRN morphine, MD rows reported as 10, will di PRN morphine, MD rows reported as 10, vill di PRN reported as 10, vill di PRN reported as 10,	as reported as 10, discuest (1972) as in IDG, FN to give PR reported as 2; on 8/30/2 3; on 9/1/2021, pain was sin IDG, FN to give PR reported as 10, discuss it is in IDG, FN to give PR reported as 10, discuss it in IDG, FN to give protect of the	eN; on 2021, as RN; in re iin o 10, able o, FN t of n 221, n as pain 21, as 0; n was pain 21, as 8; n was pain 21, as 8; n was pain , pain , pain , pain	L 512			

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NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE	16/2021
TILANT TO TILANT TIOSPICE OF LASTENN INDIANAL TITOT NEWONT COUNT SUITE 2	
ELKHART, IN 46516	
ELICIAICI, III 40010	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY TAG OR LSC IDENTIFYING INFORMATION)  TAG OR LSC IDENTIFYING INFORMATION)  TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
L 512 Continued From page 10 L 512	
Assessment and Plan of Care Update Report[s]," dated 7/15/2021, 7/29/2021, 8/15/2021, 8/26/2021, and 9/9/2021. All reports identified uncontrolled pain as a problem. The documents dated 7/29/2021, 8/15/2021, 08/26/2021, and 9/9/2021, all identified a team goal of "getting pain under control."	
L 520   INITIAL & COMPREHENSIVE ASSESSMENT OF   L 520   PATIENT   CFR(s): 418.54	
This Condition is not met as evidenced by: Based on observation, record review and interview, the agency failed to ensure all patient/caregivers' current physical statuses was assessed to determine the patient/caregivers' needs (L524); failed to ensure the patient's medication profile included all prescription, over-the-counter drugs, and/or herbal remedies the patient was currently taking (L530); failed to ensure updates of the comprehensive assessment considered changes that took place since the previous assessment, included information on the patient's progress toward desired outcomes, and the patient's response to care provided (L533); and failed to ensure all patients' comprehensive assessments included data elements that allowed for measurement of outcomes (L534).  This practice had the potential to affect all agency patients.  The cumulative effect of this systemic problem resulted in the agency being out of compliance with the Condition of Participation 42 CFR §418.54 Initial and Comprehensive Assessment	

L 524 CONTENT OF COMPREHENSIVE

L 524

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L 524	physical, psychosoci needs related to the addressed in order to patient's well-being, of throughout the dying.  This Standard is not Based on observatio interview, registered manager (PCM) C far patient/caregivers' cut assessed to determine needs for 9 of 15 rec 9, 10, 14, 15).  Findings include:  1. An agency policy relation that the status will conduct comprehensive assepatient's needs for he ensure that the nursi identified in the patient.	assessment must identical, emotional, and spiritival, emotional, and spiritival terminal illness that must opromote the hospice comfort, and dignity process.  The met as evidenced by:  In, record review, and nurse (RN)/patient care illed to ensure all urrent physical statuses he the patient/caregivers fords reviewed (#4, 5, 6, or evised 1/1/2020 titled is indicated assessment that identifies the spice care and services in greeds of the patient int's initial comprehen	was s' 7, 8,	L 524	DEFICIENCY)			
	Current medical cond dyspnea [difficulty skin integrity emot systems Characte patient/family's goal	for pain management ar the current level of pair	on t					

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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L 524	frequency of services information ,,, to be u the patient/family need.  2. Record review for p 9/15/2021, hospice election period 5/20/2 A document dated 5/2 Start of Care" indicate term care (LTC) facility to express her needs continuous problem for (a narcotic pain media relief.  A document dated an 5/21/2021 titled "SN [ Subsequent Visit" indicadministered over the facility B's nurses, LT know how much morp agency RN P failed to frequency the morphi order to determine the management needs when the past 24 hour 5/21/2021, and she ewhat pain medication hours.  3. Record review for past 24 in the pa	to be provided Addised in planning care to sed in planning care to eds"  patient #5 was completed tection date 5/20/2021, 2021 - 8/17/2021.  20/2021 titled "RN Hosped the patient resided at y B, the patient was un, pain was an active, or the patient, and morporation) was initiated for distinct the patient was be past 24 hours by LTC C facility B's nurse didrothine was administered to confirm the amount on the was administered in the patient's pain were met.  In 9/15/2021 3:06 PM, or (PCM) C confirmed it the nurse did not know headministered to the paties during her visit on expected the nurse to krist were given in the last coatient #6 was completed to date 8/3/2021, for the patient #6 was completed to date 8/3/2021, for the patient #6 was completed to date 8/3/2021, for the patient #6 was completed to date 8/3/2021, for the patient #6 was completed to date 8/3/2021, for the patient #6 was completed to date 8/3/2021, for the patient #6 was completed to date 8/3/2021, for the patient #6 was completed to date 8/3/2021, for the patient #6 was completed to date 8/3/2021, for the patient #6 was completed to date 8/3/2021, for the patient #6 was completed to the patient #6 was completed to date 8/3/2021, for the patient #6 was completed to the patient #6	ed on for bice at long hable bhine pain was low ient how 24	L 524				

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L 524	A document dated 8/3 Start of Care" indicate general inpatient care had no wounds.  Documents dated 8/4 8/6/2021 titled "SN-G [visit]" indicated the p  A document dated 8/6 Physician Order" indireceived on 8/7/2021 wounds on coccyx (tas needed.  An additional docume "SN-GIP - SN - Gene additional visit was m reported the patient hrash to his groin area caused by prolonged coccyx, the dressing removed, the adhesiv skin. The document in patient, indicated he liblisters and two stage loss, which would also blisters) pressure ulcoindicate the appearar presence of drainage infection of the wound surrounding skin. The RN Q did not assess  Documents dated 8/7 8/10/2021, 8/11/2021 titled "SN-GIP - SN - the patient's wounds still the patient still the patien	a/2021 titled "RN Hospi ed the patient received e (GIP) at hospital D, and IP - SN - General Inpatiatient had no wounds.  a/2021 titled "Hospice cated a verbal order was at 12:53 PM to assess allbone) and do wound of the total inpatient" indicated ade) hospital D's nurse and water-filled blisters at a pressure ulcer (a worder pressure on the skin) of wouldn't stay on, and were on the dressing tore and various water-filled e 2 (partial-thickness skip of include intact or rupturers on his bottom, failed ace, measurements, or signs/symptoms of des, or the appearance of e document also indicate the wounds.	ient  ient  iss care  if (an and a bund on his when his ed the in irred if to  of the ed	L 524				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		` '	(X3) DATE SURVEY COMPLETED	
		151561		B. WING		09/1	6/2021	
	OVIDER OR SUPPLIER  O HEART HOSPICE O	F EASTERN INDIANA	1178 FR	ESS, CITY, STA EMONT CO RT, IN 4651	URT SUITE 2			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	(EACH CORRECTIVE ACTION	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
L 524	Discharge from Agentassessment) indicate were not assessed, a supposed to assess to the During an interview of RN/PCM C confirmed were made by agency agency's responsibility. A Record review for present the property of Care's responsibility. A document titled "Hoof Care" for election producted assisted living facility laxative for constipation. A document dated 7/2 Subsequent Visit" industry bowel movement (BN documents with the strange of the product	cy" (comprehensive d wounds remained, but not the agency nurse with patient's wounds were patient's wounds were patient's wounds were patient #7 was complete ection date 7/19/2021, 2021 - 10/16/2021.  Despice Certification and period 7/19/2021 - the patient resided at (ALF) E, and took a daton.  20/2021 titled "SN Hospicated the patient's last BM and indicated for the patient's last BM and indicated the patient's last BM and indicated sess the for patient's last BM, and indicated the nurse did not a size of the patient's last BM, and indicated the nurse did not patient's last BM, and indicated the nurse did not patient's last BM, and indicated the nurse did not patient's last BM, and indicated the nurse did not patient's last BM, and indicated the nurse did not patient's last BM, and indicated the nurse did not patient's last BM and indicated the nurse did not patient's la	as seekly.  If, ts ed on for  Plan  illy  bice sicional 21, the M.  bice s BM  d "SN staff ated t BM.  bice staff ated t BM.	L 524				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	151561 B. WING			09/16/2021				
	OVIDER OR SUPPLIER  O HEART HOSPICE O	F EASTERN INDIANA			URT SUITE 2			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATE OR LSC IDENTIFYING INFORMATION)		GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
L 524	A document dated 9/7 Subsequent Visit" ind track the patient's last nurse did not assess.  During an interview of RN/PCM C confirmed assessed for the patient assessment.  5. Record review for pg/15/2021, hospice election period 8/19/2  A document dated 8/2 Subsequent Visit" ind patient's right great to nail was clipped, the stop the bleeding, app (anti-bacterial gel) and pressure to area (per 8/26/2021).  Documents dated 9/1 titled "SN Hospice Suindicate the toe woun resolved.  During a home visit of 10:25 AM, there were present on the patient were not accurate.  6. Record review for position of the patient of the patient were not accurate.	7/2021 titled "SN Hospi icated ALF E staff did r t BM, and indicated the for the patient's last BM in 9/15/2021 at 3:35 PM It the nurses should havent's last BM as part of patient #8 was completed to date 8/19/2021, 2021 - 11/16/2021.  26/2021 titled "SN Hospicated a new wound to be, skin was clipped whourse applied pressure polied medihoney digauze dressing with physician order received be a seen of the distribution of the patient's feet.  29/15/2021 at 3:40 PM It the patient's assessment	not  1.  1.  1.  1.  1.  1.  1.  1.  1.  1	L 524				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
	151561			B. WING		09/1	6/2021
	OVIDER OR SUPPLIER  D HEART HOSPICE O	F EASTERN INDIANA	1178 FF	RESS, CITY, STA REMONT CO RT, IN 4651	URT SUITE 2		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	IATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REG ENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
L 524	A document dated 8/7 Start of Care" indicate wounds were to be as nurse weekly, the patinjury (full thickness woressure) with bone earea, two shin skin tevaginal wound, an unvagina. The document assessed the tailbone indicate the other worfailed to indicate oxygoxygen is being carried assessed, how much frequently, or what moused, and did not asselved of pain.  During an interview on PCM C confirmed the failed to indicate oxygos assessed, how much frequently, or what moused, and did not asselved of pain.  During an interview on PCM C confirmed the failed to indicate oxygos assessed, how much frequently, or what mousessed, nurse did rit was not acceptable severity, tailbone wou wounds were assessed visits for the election pindicate assessments lower extremities or vortically and the properties of the confirmed several to the patients of th	at 2/2021 titled "RN Hosp and the patient used oxy assessed by the hospice ient had a stage 4 presequent had a stage 4 presequent had a stage 4 presequent from un-relieved exposed on her tailbone ars on both legs, an intestageable wound in the attindicated the nurse awound, but failed to unds were assessed, and all the blood) was oxygen was used, how ethod of administration was expensed the patient's accept a point of assess patient pain to write "okay" for pain and was assessed, no ceed, and all other nursing period reviewed failed to were completed on the aginal wound.  The patient #10 was completed election date 8/25/2021 and all other nursing period reviewed failed to aginal wound.	gen, sure e ernal e ond ch / was table  I, t / was goal, other g to e eted 21,	L 524			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		151561		B. WING		09/1	6/2021
	OVIDER OR SUPPLIER  D HEART HOSPICE O	F EASTERN INDIANA	1178 FF	RESS, CITY, STA REMONT CO RT, IN 4651	URT SUITE 2		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RECENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE ROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
L 524	Start of Care" indicate and took sips of water and took sips of water by nurse reported the wound on the outside skin tear to the inside document also indicate assess the wounds.  A document dated 8/2 Subsequent Visit" indicate assessed by the nurse of A document dated 8/3 Subsequent Visit" indicate as "healed" by the nurse of the action of the actio	25/2021 titled "RN Hosped the patient was offer reduring the visit, and Lie patient had a surgical of the left lower leg, ar of the left lower leg. The ted the agency nurse dicated the wounds were e.  26/2021, titled "SN Hospicated the wounds asserse.  2/2021, titled "SN Hospicated the wounds asserse.  2/2021, titled "SN Hospicated the patient had and, they were left "opersessed by the nurse, ar reported the patient was uested a broda chairing chairs which preven patient had difficulty may start crushing ument also indicated the a chair, and would requial lift to transfer a patie of Care Update" indicated perform wound care 3 to indicate the current oindicate the current oindicate the current oindicate the current oindicate the current	ed TC  Ind a  ne id not  pice e not  pice essed  ice a skin  n to  nd unted  tts  ne iire a  nt)  DG  ated  ar,	L 524			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		151561		B. WING 09/16/202		6/2021		
NAME OF PROVIDER OR SUPPLIER HEART TO HEART HOSPICE OF EASTERN INDIANA					URT SUITE 2			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REC OR LSC IDENTIFYING INFORMATION)		GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPE DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
L 524	A document dated 9/3 Subsequent Visit" inditear and surgical wou by the nurse, and failt assessment was comdifficulty swallowing on 9/2/2021.  A document dated 9/3 Subsequent Visit" indineeded a hoyer lift, howound, they were "he assessed by the nurse follow up assessment report of difficulty swavisit made on 9/2/202  A document dated 9/3 Subsequent Visit" inditear and surgical wou by the nurse, and failt assessment was comdifficulty swallowing on 9/2/2021.  A document dated 9/3 Subsequent Visit" inditear and surgical wou by the nurse, and failt assessment was comdifficulty swallowing on 9/2/2021.  A document dated 9/3 Subsequent Visit" inditear and surgical wou swollen and red, no owere documented, and up assessment was a difficulty swallowing on 9/2/2021.  8. During an interview the administrator and comprehensive assess thoroughly, and they see thoroughly.	3/2021, titled "SN Hosp icated the patient had a nd, they were not assed to indicate a follow upleted for the report of luring the nursing visit red/2021, titled "SN Hosp icated the patient still ad a skin tear and surgicaling well", they were re, and failed to indicate the was completed for the allowing during the nurs	a skin ssed up made ice ical iot a a ing pice a skin ssed up made  pice a skin ssed up made  PM, me eleted c.	L 524				

		(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
	151561			B. WING	<del></del>	09/	/16/2021
	ROVIDER OR SUPPLIER  O HEART HOSPICE (	OF EASTERN INDIANA	1178 FR	ESS, CITY, STA EMONT CO RT, IN 4651	URT SUITE 2		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MU	STATEMENT OF DEFICIENCIES IST BE PRECEDED BY FULL RE DENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
L 524	benefit period 8/23/2 terminal diagnosis of pumping blood as we Review of a docume [skilled nurse] Hosp completed by Perso indicated patient has section of the assest documented wound Review of documented wound Review of documented wound Review of an agenct Wounds - Patient De Administrator A on Shad two elbow wour During an interview Clinical Manager Cohave a skin tear and know the difference pressure ulcer. Clin confirmed the nurse the discrepancy in diversus pressure ulcer. 10. Record review fon 9/10/2021, election of 9	2021 - 11/20/2021, with a feart failure (heart not rell as it should).  ent dated 9/14/2021, title ice Subsequent Visit" wan CC. The assessment daskin tear. In the wousment, the nurse care for pressure ulcers ts "SN Hospice Subsequent 21, 9/1/2021, 9/3/2021, 2021, completed by RN 12 thad two pressure ulcers by document titled "Clinic etail," received from 1/7/2021 indicated the pands, both pressure ulcers on 9/15/2021, at 10:50 Acconfirmed patient did not at the nurse was expected between a skin tear and ical Manager C also was expected to recognicumentation of a skin ters.  For patient #14 was component at the 8/29/2021, for be 1/26/2021, with a terminolic encephalopathy (brailic encephalopathy (brailice)	d "SN as as and	L 524			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
	151561			B. WING		09/10	6/2021
	OVIDER OR SUPPLIER  D HEART HOSPICE O	F EASTERN INDIANA			URT SUITE 2		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		GULATORY	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
L 524	known as a feeding to interpreter enhanced interpreter was not us.  During an interview or Patient Care Manage assessment was incompared in the part of the agency of the tissue below the tissue below the Review of a document Capital of the agency of the tissue below the tissue time tissue	ube) and use of an communication when a sed.  In 9/10/2021 at 2:09 PM or C confirmed the rrect has the patient did or patient #15 was composed to date of 5/12/2021 for 121 - 10/8/2021, with a rectal cancer.  It dated 9/3/2021, titled Visit," completed by RN cumentation of a wound RN E documented the Poor Turgor [skin poretic [abnormally sweath dated 9/7/2021, titled Visit," completed by Pelocumentation of a would visit," completed by Pelocumentation of a would visit," completed by Pelocumentation of a would visit, "completed by Pelocumentation of a would visit," completed by Pelocumentation of a would visit, "completed by Pelocumentation of a would visit," completed by LTC facility's clinical record) print Wound Management Dowound on the patient's sidentified on 8/31/202 e deep tissue injury (ingelocumentation of a would on the patient's sidentified on 8/31/202 e deep tissue injury (ingelocumentation of a would be patient's sidentified on 8/31/202 e deep tissue injury (ingelocumentation of a would be patient's sidentified on 8/31/202 e deep tissue injury (ingelocumentation of a would be patient's sidentified on 8/31/202 e deep tissue injury (ingelocumentation of a would be patient's sidentified on 8/31/202 e deep tissue injury (ingelocumentation of a would be patient's sidentified on 8/31/202 e deep tissue injury (ingelocumentation of a would be patient's sidentified on 8/31/202 e deep tissue injury (ingelocumentation of a would be patient's sidentified on 8/31/202 e deep tissue injury (ingelocumentation of a would be patient's sidentified on 8/31/202 e deep tissue injury (ingelocumentation of a would be patient's sidentified on 8/31/202 e deep tissue injury (ingelocumentation of a would be patient be patient a would be patient a w	"SN N E d on e skin ented Dry, ety M eed eetail left 1 and jury ety M d 021 -	L 524			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
	151561			B. WING		09/1	6/2021	
	OVIDER OR SUPPLIER  D HEART HOSPICE O	F EASTERN INDIANA	1178 FR	RESS, CITY, STA REMONT CO RT, IN 4651	URT SUITE 2			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REI ENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
L 524	for the left heel. The of 09/03/2021.  Review of a document Hospice Subsequent failed to evidence docton the skin assessment. The elasticity of a document Hospice Subsequent Cool."  Review of a document Hospice Subsequent Cool.	order indicated a start of the dated 9/3/2021, titled Visit," completed by Ricumentation of a wound RN E documented the Poor Turgor [skin oretic [abnormally sweath dated 9/7/2021, titled Visit," completed by Pedocumentation of a wound Parent Pale, Poor Turgor, ew on 9/10/2021 at 10: nager C confirmed the Power the location of wound PREHENSIVE  assessment must take owing factors:] view of all of the patient the counter drugs, her lternative treatments the patient of the following: ug therapy  I drug interactions erapy	"SN N E d on e skin e s	L 524				
	laboratory monitoring							

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· · ·		(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		151561		B. WING		09/	16/2021
	OVIDER OR SUPPLIER  O HEART HOSPICE O	F EASTERN INDIANA	1178 FR	RESS, CITY, STA REMONT CO RT, IN 4651	URT SUITE 2		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES IT BE PRECEDED BY FULL REG ENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
L 530	Based on observation interview, the registed the patient's medication prescription, over-the herbal remedies the proscription for 7 of 15 records reserving include:  1. An agency policy reserving included (but not limit will conduct a patient assessment that ident prescription and over remedies, bowel registreatments that could including Any non interventions"  2. An agency policy reserving indicated " To ensu medication managements."	met as evidenced by: n, record review, and red nurse failed to ensu on profile included all -counter drugs, and/or patient was currently tal viewed (#2, 3, 5, 7, 8, 9)  evised 1/1/2020 titled s" indicated assessmen ted to) " registered nu ent-specific comprehens tifies medicationsthe-counter drugs, her men and other alternativ affect drug therapy, pharmacological  evised 8/21/2015 titled ration and Managemen re competent and safe nent and to maintain a st for each patient ord	ts rse sive bal	L 530			
	9/15/2021, hospice e election period 4/27/2 A document titled "Ho of Care" for election pindicated " O2 [oxystiter [route] Oxystiter Oxystiter Oxystiter Oxystiter Oxystiter [route] Oxystiter Oxystiter Oxystiter Oxystiter Oxystiter Oxystiter Oxystiter Oxystiter Ox	ospice Certification and period 4/27/2021 - 6/25/ gen] - Oxygen [dose] gen [frequency] order failed to indicate tl	Flan 2021 5				

(X2) MULTIPLE CONSTRUCTION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		151561		B. WING		09/1	6/2021
	OVIDER OR SUPPLIER			RESS, CITY, STA			
HEARI I	O HEART HOSPICE O	F EASTERN INDIANA		RT, IN 4651	URT SUITE 2 6		
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
L 530	4. Record review for p 9/15/2021, hospice el election period 5/20/2  A document titled "Ho of Care" for election p indicated " Hospice effectiveness of cardi measures including o document failed to inc medication list with do in the order section or route and frequency.  5. Record review for p 9/15/2021, hospice el election period 7/19/2  A document titled "Ho of Care" for election p 10/16/2021 indicated effectiveness of cardi measures including o document failed to inc medication list with do in the order section or route and frequency.  6. Record review for p 9/15/2021, hospice el election period 8/19/2  A document titled "Ho of Care" for election p 11/16/2021 indicated effectiveness of cardi measures including o document failed to inc medication list with do medication list with do of care" for election p 11/16/2021 indicated effectiveness of cardi measures including o document failed to inc medication list with do medication list with do of care" for election p	coatient #5 was complete lection date 5/20/2021, 2021 - 8/17/2021.  Dispice Certification and period 5/20/2021 - 8/17/2021 - 8/17/2021 - 8/17/2021 - 8/17/2021 - 8/17/2021 - 8/17/2021 - 10/16/2021.  Dispice Certification and frequency of the plan of care with display and the pla	Plan (2021 elief ne cy, or lose, ed on for  Plan essess elief ne cy, or lose, ed on for  Plan essess elief ne cy, or	L 530			

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		(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		151561		B. WING		09/	09/16/2021	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STA	TE, ZIP CODE	•		
HEART TO	O HEART HOSPICE O	F EASTERN INDIANA		REMONT CO RT, IN 4651	URT SUITE 2 6			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES BY BE PRECEDED BY FULL REG ENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO	ER'S PLAN OF CORRECTION RRECTIVE ACTION SHOULD BE ERENCED TO THE APPROPRIATE DEFICIENCY)		
L 530	9/16/2021, hospice e election period 8/12/2 A document titled "Ho of Care" for election pindicated " O2 - Ox [route] Oxygen [order failed to indicate was inhalation, or the A document dated 8/Start of Care" indicate and failed to indicate used, how frequently administration was used. A document dated 8/Subsequent Visit" indicate prescription for mirals A document dated 8/Subsequent Visit" indicated to the subsequent Visit indicated gel) for the A document dated 8/Subsequent Visit indicated gel) for the A document dated 8/Subsequent Visit indicated gel) for the A document dated 8/Subsequent Visit indicated gel) for the A document dated 8/Subsequent Visit indicated gel) for the A document dated 8/Subsequent Visit indicated gel) for the A document dated 8/Subsequent Visit indicated gel) for the A document dated 8/Subsequent Visit indicated gel) for the A document dated 8/Subsequent Visit indicated gel for the A document dated 8/Subsequent Visit indicated gel for the A document dated 8/Subsequent Visit indicated gel for the A document dated 8/Subsequent Visit indicated gel for the A document dated 8/Subsequent Visit indicated gel for the A document dated 8/Subsequent Visit indicated gel for the A document dated 8/Subsequent Visit indicated gel for the A document dated 8/Subsequent Visit indicated gel for the A document dated 8/Subsequent Visit indicated gel for the A document dated 8/Subsequent Visit indicated gel for the A document dated 8/Subsequent Visit indicated gel for the A document dated 8/Subsequent Visit indicated gel for the A document dated 8/Subsequent Visit indicated gel for the A document dated 8/Subsequent Visit indicated gel for the A document dated 8/Subsequent Visit indicated gel for the A document dated 8/Subsequent V	patient #9 was completed lection date 8/12/2021, 2021 - 11/9/2021.  Dispice Certification and period 8/12/2021 - 11/9/ygen [dose] 2 Liter [frequency] Daily" the the correct route, while a actual frequency.  12/2021 titled "RN Hosped the patient used oxynhow much oxygen was, or what method of sed.  13/2021, titled "SN Hosped the patient had a fax (taken for constipation of the patient took dicated the patient took on, and used medihoney patient on a wound.	Plan /2021 The ch  pice gen, pice a new on). pice extra	L 530				

(X2) MULTIPLE CONSTRUCTION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		151561		B. WING		09/1	09/16/2021	
	OVIDER OR SUPPLIER  D HEART HOSPICE O	F EASTERN INDIANA	1178 FF	RESS, CITY, STA REMONT CO RT, IN 4651	URT SUITE 2			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REC ENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OI (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
L 530	A document dated 9/3 Subsequent Visit" ind strength tylenol for particles of contents of the subsequent Visit" industrength tylenol for particles of the partic	3/2021, titled "SN Hospicated the patient took ain.  10/2021, titled "SN Hospicated the patient took ain, the patient took ain, the patient took at attent on use.  13/2021, titled "SN Hospicated the patient took ain.  13/2021, titled "SN Hospicated the patient took ain.  13/2021 - 11/22/2021.  13/2021 - 11/22/2021.  15/2021 - 11/22/2021.  15/2021 - 11/22/2021 - " Hospice nurse to in:	pice extra mg e pice extra mg e pice extra eted 21, Plan struct licate ose, of the eart CTI She eith"	L 530				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1	LE CONSTRUCTION	` '	(X3) DATE SURVEY COMPLETED	
		151561		B. WING		09/16/2021		
	OVIDER OR SUPPLIER  D HEART HOSPICE O	F EASTERN INDIANA	1178 FF	RESS, CITY, STA REMONT CO .RT, IN 4651	URT SUITE 2			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RECENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
L 530	tylenol, medihoney, and benadryl were not on the patient's medication profile for patient #9  10. Record review for patient #3 was completed on 9/7/2021, 4/20/2021 for benefit period 7/28/2021 - 10/25/2021, with terminal diagnosis of Parkinson's Disease (a brain deterioration causing involuntary movements and progressive loss of functioning).  Review of a medication list signed by Patient Care Manager C on 7/18/2021 indicated two orders for cephalexin (an antibiotic) 500 MG (milligrams) capsule. One order was a start date of 6/13/2021 and no stop date, for one capsule every 12 hours, for a urinary tract infection. The second order was for one capsule 3 times daily, to be taken 7/15/2021 - 7/22/2021, for a urinary tract infection. The agency failed to review medications for duplicate therapy.  During an interview on 9/10/2021 at 10:50 AM, Patient Care Manager C confirmed the cephalexin started on 6/13/2021 and lacked a stop date.		L 530					
L 533	UPDATE OF COMPREHENSIVE ASSESSMENT CFR(s): 418.54(d)  The update of the comprehensive assessment must be accomplished by the hospice interdisciplinary group (in collaboration with the individual's attending physician, if any) and must consider changes that have taken place since the initial assessment. It must include information on the patient's progress toward desired outcomes, as well as a reassessment of the patient's response to care. The assessment update must be accomplished as frequently as the condition of the patient requires, but no less frequently than every 15 days.		L 533					

, ,	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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L 533 Continued From page 27			L 533			
Based on observation, reconterview, the agency's interview, the agency's interview, the agency's interview, the agency's interview, the agency's interview assessment that took place since the preincluded information on the toward desired outcomes, a response to care provided for records reviewed (#5, 7, 8, 15).  Findings include:  1. An agency policy revised "Interdisciplinary Group Rol Responsibilities" indicated "the comprehensive assessment be patient's progress toward"  2. An agency policy revised "Patient Assessments" indicated "Patient Assessments" indicated the comprehensive assessments accomplished by the IDG that have taken place since or last comprehensive asses patient's progress toward downled the patient's response to the patient's response to the patient's response to the patient of patient project of patient of project of patient of period 5/20/2021 - A document dated 5/24/202 nurse] Hospice Unattended	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 27  This Standard is not met as evidenced by: Based on observation, record review, and interview, the agency's interdisciplinary group (IDG) failed to ensure updates of the comprehensive assessment considered changes that took place since the previous assessment, included information on the patient's progress toward desired outcomes, and the patient's response to care provided for 4 of 15 clinical records reviewed (#5, 7, 8, 9).  Findings include:  1. An agency policy revised 2/26/2021 titled "Interdisciplinary Group Roles and Responsibilities" indicated " The IDG will update the comprehensive assessment and will note the patient's progress toward outcomes and goals					

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` '			(1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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L 533	A document dated 5/2 Comprehensive Asse Update Report" indicated the patient 5/23/2021 at 10:40 P for treatment and ser weeks, and indicated agreement with the p  4. Record review for 9/15/2021, hospice e election period 7/19/2  A document dated 7/ Start of Care" indicate pain, difficulty breath of breath, disoriented frequency and contact unknown, and the plawith assisted living facility as a cardiopulmonary included (but not limit /demonstrate reductic cardiopulmonary sympatient/caregiver vert anorexia/dehydration caregiver demonstrate food/fluids to the patient was a "new a	27/2021 titled "Hospice essment and Plan of Ca ated the reason for the admission". The docum date/time of death was M, but included future pvices for the next two patient/caregiver was illan of care.  patient #7 was complete lection date 7/19/2021, 2021 - 10/16/2021.  19/2021 titled "RN Hosped the patient had modeing with exertion, was self, cognitively impaired, but with family/friends was an of care was discussed in the patient resided at (ALF) E's nurse.  Despice Certification and period 7/19/2021 - the patient resided at (ALF) E, received oxygon y symptom relief, and geted to) patient will verballon or relief of inptoms, and palizes understanding of in the terminal patient ites offering, but not force	re ent clans n ed on for cice erate hort s d Plan gen coals alize f and cing IDG re ent	L 533				

(X2) MULTIPLE CONSTRUCTION

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IIL/AIXI I	o near noon oe o	. LAGIERIVIIIDIAIVA		RT, IN 4651				
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L 533	progress toward desin patient's response to admission compreher completed.  5. Record review for p 9/15/2021, hospice el election period 8/19/2  A document with an e "Aide Care Plan Report Heart Northern (H2HI patient needed assist transfers.  A home visit was obstad, with H2HN home present, family report because it was very compatient, last night (9/8 patient was too heavy and she texted the nuto let her know. Reviewidenced a documer Certification and Plan 8/19/2021 - 11/16/202 declined volunteer se was never offered volvery overwhelmed, who some help, and would to stay for a couple of could attend to anotheneeds, and no one elstime, H2HN HHA W surveyors titled "Aide approved by PCM C, 9/8/2021, which indicassistance of 1 personalizations."	red outcomes, and the care provided since the care provided since the care provided since the care provided since the sive assessment was patient #8 was complete ection date 8/19/2021, 2021 - 11/16/2021.  Iffective date 8/20/2021 ort" approved by Heart on PCM X indicated the ance of 2 people for erved on 9/9/2021 at 10 to the health aide (HHA) Wed she bought a gait be difficult to transfer the 6/2021) during a transfer the 6/2021) during a transfer the 6/2021) during a transfer the 6/2021 during a transfer to the home folder of Care" for election provided in the care of the hours twice weekly so the hours twice weekly so the services, she would greatly appreciate of the hours twice weekly so the services available. During the care Plan Report", with an effective date atted the patient needed.	ed on for  titled to  2:25  elt  r, the por, 021)  eriod ly d she as  able she dical g this o the	L 533				

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L 533	from 10:21 AM - 11:4 sustained a fall, and a sustained a fall was not reported, patient's daughter caservices 1 hour per was a document dated 9/Comprehensive Asset Update Report" was a director meeting sumpatient had not had a declined due to a hol coordinator section in were not requested, a agreed with the plan.  During an interview of family indicated she is the agency today abovere going into a meget back to her. Whe would like the volunte Thursdays from 2:10 resume picking up he take her to therapy, since the patient mover ally like to meet hell husband could be the volunteer. During this never knew there we mother's care and treat to be involved.  During an interview of PCM C indicated fam asked about volunteer.	2 AM indicated the pati- the nurse was notified. ing was observed on for patient #8, the patie and PCM C indicated t lled and requested volu- veek.  9/2021 titled "Hospice II essment and Plan of Ca reviewed. The medical mary section indicated iny falls, one HHA visit v iday, the volunteer indicated volunteer servicand the patient/caregive	nt's he nteer  DG re the was ces er m hey uld d she s and could and erapy lld her e the d she like  M, and aybe	L 533				

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Gontinued From page 31 ground was not considered a fall, families were all aware of IDG meetings and when they had them, and if there was anything special, they did a care conference, During this time, the administrator indicated " Sometimes I think the families don't understand."  During an interview on 9/13/2021 at 12:56 PM, family indicated she declined a HHA visit once on a Friday, because she waited all day, no one called, she was going to go out for a bit after her husband and daughter got home, and they finally called and said they'd be there around 7:00 PM. She further indicated she declined the visit because she wouldn't be there, and her husband wouldn't know what to do, and she never canceled a HHA visit due to a holiday.  6. Record review for patient #9 was completed on 9/16/2021, hospice election date 8/12/2021, for election period 8/12/2021 - 11/9/2021.  A document dated 8/12/2021 titled "RN Hospice Start of Care" indicated the patient had a stage 4 pressure injury (full thickness wound from un-relieved pressure) with bone exposed on her tailbone area, two skin tears on both legs (shins), an internal vaginal wound, an unstageable wound in the vagina, an indwelling catheter (a tube inserted into the bladder to drain urine), and the patient's place of worship was church J.  A document signed by attending physician K on 8/24/2021 titled "Hospice Certification and Plan of Care" indicated to Junursing visits were ordered daily, and indicated " Goals: Pain will be managed at a level acceptable to the patient Anxiety/agitation is minimized/controlled Patient/Caregiver understands/demonstrates proper   wound j care and skin integrity		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		` '	(X3) DATE SURVEY COMPLETED	
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L 533	management"  A document dated 8/ worker] Hospice Initia Made referral for volu companionship col [interdisciplinary team A document dated 8/ Subsequent Visit" ind prescription for mirala A document dated 8/ Subsequent Visit" ind strength tylenol for pa A document dated 8/ Comprehensive Asse Update Report" was r "Current Meeting Sun pastoral/counselor se had no church affiliati progress toward mea response to services registered nurse secti pain, multiple wounds occurred since admis no new or changed m indicate no nursing vi the medications that v admission, the patien outcomes, or the patie provided. The social v family was looking for not want to use other social worker encoura church and ask friend recommendations, ar services was referred	13/2021 titled "SW [social Evaluation" indicated inteer services for laborated with IDT in]"  13/2021, titled "SN Hosicated the patient had a ax (taken for constipation in the patient took aix.  17/2021, titled "SN Hosicated the patient took aix.  19/2021 titled "Hospice is sment and Plan of Careviewed. In the section indicated the patient on, and failed to indicate surable goals, or patier already provided. The ion indicated the patients, no missed nursing vision (8/12/2021), there is in the progress toward design the progress toward the progress to	pice a new in). pice extra  IDG re it titled ent te it thad sits were o 2021, sired id it did the it o unteer	L 533				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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L 533	requested, and the fa accepted the plan of control of the plan of the pla	mily was aware and care.  2/2021 titled "Hospice II ssment and Plan of Ca ated volunteer services difailed to indicate the sin family request for more tient's progress toward the patient's response of the Hospice IDG ssment and Plan of Ca 9/2021 failed to indicate und care orders, the vard desired outcomes, care, and indicated the tion that a volunteer was or, and the patient did revices.  Despice Certification and period 8/25/2021 - 11/22/2021.  Despice Certification and period 8/25/2021 - the patient resided at Lifed (but not limited to) "I at a level acceptable to the services and indicated the tient was completed at Lifed (but not limited to)."	re social re in to  I, re e the the sn't not  Plan TC o the e ient.	L 533				
	and took sips of wate	r during the visit, and L	TC					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	` '	(X3) DATE SURVEY COMPLETED	
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L 533	F's nurse reported the wound on the outside skin tear to the inside document indicated the assess the wounds, of swallowing water.  A document dated 8// Subsequent Visit" incomes "healed" by the nurse was "healed" by the nurse to get out of bed, requitility for swallowing, and they medications. The document dated 9// Subsequent Visit" incomes to get out of bed, requitility for swallowing, and they medications. The document dated 9// Interdisciplinary group was ordered a broad hoyer lift (a mechanic for transfers.  A document dated 9// Interdisciplinary group was sessment and Planthe patient had a surgificated to indicate the patient's wounds or condicate the patient's the report of difficulty interventions to address.  B. During an interview H2H corporate area of indicated all nursing was comprehensive assessed.	e patient had a surgical of the left lower leg, are of the left lower leg. The agency nurse did not the patient's tolerance of the patient had a property of the patient had a property of the patient was uested a broda chair ing chairs which prevent patient had difficulty may start crushing cument also indicated the patient had officially of the patient of the patient had officially of the patient had officially of the patient	nd a ne nt ne to te to spice essed  ice a skin n to nd anted ats  DG ated ar, to l, or	L 533				
L 534	PATIENT OUTCOME	MEASURES		L 534				

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L 534	CFR(s): 418.54(e)(1)  (1) The comprehensi data elements that all outcomes. The hosp document data in the The data elements maspects of care related. This Standard is not Based on record reviregistered nurse (RN comprehensive assertlements that allowed outcomes for 7 of 15 7, 8, 9, 10).  Findings include:  1. An agency policy repatient Assessment included (but not limit comprehensive assertlements in agency's registered standardized assessions assessment baseline symptoms and to colon patient level mease ensure that the nursification in the patient and updated assess Current medical conductives and updated assessment control systems Character patient/family's goal of their satisfaction with control Care, treating the symptom of the control Care, treating the control Care, trea	ve assessment must inclow for measurement or ice must measure and a same way for all patient and to hospice and pallial met as evidenced by: ew and interview, the ) failed to ensure all patiessments included data d for measurement of records reviewed (#2, \$ evised 1/1/2020 titled is indicated assessment that identifies the patient that identifies the patient tool to document a data for review of lect required Medicare of sures includes includes includes includes includes includes includes includes includes breathing] constipational distress supportistics of pain for pain management ar the current level of pair includes of pair the current level of pair includes of pair management ar the current level of pair	f ints. ition tion. itients' itients' itients' itients' itients' itients itien	L 534				

(X2) MULTIPLE CONSTRUCTION

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L 534	information ,,, to be up the patient/family need allow for measurement.  2. An agency policy of Management indicate will be recorded using assessed as part of educate asp	sed in planning care to be as Data elements that of patient outcomes Patient of patient outcomes Patient of patient outcomes Patient of patient outcomes Patient of a pain scale Pain we very patient contact for Biotechnology eb-based reference: nih.gov/pmc/articles/PN sessment in Adult Palliative Care . Palliative care patient nable to self-report theincreased risk for d under-treated pain. Usessment tools significant od of effective pain proved pain-related patient #2 was completed to attent #2 was completed patient #2 was completed pat	at a	L 534				
	election period 5/20/2	2021 - 8/17/2021.						

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L 534	Continued From pag	je 37		L 534		
	Start of Care" indicate term care (LTC) facility unresponsive and unpain was an active, or patient, and morphin medication) was initial document also indicate severity was: moor standardized pain too Patient's pain sever" The document fastandardized tool was unresponsive patient.	hable to express her need continuous problem for the (a narcotic pain pated for pain relief. The lated " The patient's paterate Type of collused: Staff observaterity OK All of the trilled to indicate a	t long  ds, he  in ation ime			
	5/21/2021 titled "SN Subsequent Visit" ind no pain, no standard completed for an unr morphine was admin hours by LTC facility nurse didn't know ho administered, and ag the amount or frequent	nd signed by RN P on [skilled nurse] Hospice dicated the patient reportized pain assessment we esponsive patient, indicistered over the past 24 B's nurses, LTC facility we much morphine was gency RN P failed to correct the morphine was in data for measurable	ras ated B's			
	Patient Care Manage not acceptable that the	on 9/15/2021 at 3:06 PM or (PCM) C confirmed it the nurse did not know h administered to the pati rs during her visit on	was ow			
	PCM C indicated it w	on 9/15/2021 at 2:31 PM asn't acceptable to atient's pain severity.	1,			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		, ,	(X3) DATE SURVEY COMPLETED	
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L 534	5. Record review for p 9/15/2021, hospice el election period 8/3/20 A document dated 8/3 Start of Care" indicate general inpatient care had no wounds.  Documents dated 8/4 8/6/2021 titled "SN-G [visit]" indicated the p  A document dated 8/6 Physician Order" indicated on 8/7/2021 wounds on coccyx (ta as needed.  An additional docume "SN-GIP - SN - Gene visit was made) indicate reported the patient has to his groin area caused by prolonged coccyx, the dressing removed, the adhesiv skin, and failed to indicate in the start of the start	patient #6 was complete ection date 8/3/2021, for 21 - 10/31/2021.  8/2021 titled "RN Hospi ed the patient received e (GIP) at hospital D, and IP - SN - General Inpatient had no wounds.  6/2021 titled "Hospice cated a verbal order was at 12:53 PM to assess illbone) and do wound of the dated 8/6/2021 titled ral Inpatient" (an additionated hospital D's nurse ad water-filled blisters at a pressure ulcer (a word pressure on the skin) of wouldn't stay on, and we can the dressing tore in the dressing tore in the sessment (the appears	ce  ient  ient  as care  donal and a bund on his chen his ied	L 534				
	appearance of the su data for measurable of Documents dated 8/7 8/10/2021, 8/11/2021	/2021, 8/8/2021, 8/9/20 , 8/12/2021, and 8/13/2 General Inpatient" indic	n 021, 021					

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L 534	A document dated 8 Discharge from Ager assessment) indicate were not assessed.  During an interview of RN/PCM C confirme were made by agenc agency's responsibil  6. Record review for 9/15/2021, hospice of election period 7/19/  A document dated 7 medical director on order] Hospice CT illness" indicated " 100% of meals to meals lost 47 pou patient is not able to A document dated 7 Start of Care" indicate severity was: mos standardized pain to Patient's pain sev Level continue to" The document fa assessed the patien assessed with a star for measurable outco A document titled "H of Care" for election 10/16/2021 indicated patient resided at as	did/14/2021 titled "RN Hospincy" (comprehensive ed wounds remained, but on 9/15/2021 at 3:26 PM of no wound assessmently nurses, and it was the tity to do so.  patient #7 was completed election date 7/19/2021, 2021 - 10/16/2021.  //19/2021 and signed by //29/2021 titled " [physical patient has gone from each only eating 25 to 50% on the last 4 months express her needs" //19/2021 titled "RN Hospited" The patient's pain derate Type of ol used: Staff observative if your conditional nearly served to evidence the nurse baseline MAC or pain dardized tool to obtain ones.  It is baseline MAC or pain dardized tool to obtain ones.  It is completed tool to obtain of the sisted living facility (ALF to the sisted living fa	ed on for the sician eating f oice n I Risk eeds se was data  Plan  ) E,	L 534			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		151561		B. WING		09/	16/2021	
	ROVIDER OR SUPPLIER  O HEART HOSPICE O	F EASTERN INDIANA	1178 FR	RESS, CITY, STA REMONT CO RT, IN 4651	URT SUITE 2			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REI ENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE	
L 534	8/3/2021, and 8/6/2021 Hospice Subsequent not assess for the para Documents dated 8/1 9/7/2021 titled "SN H indicated ALF E staff last BM, and indicate the for patient's last E During an interview of RN/PCM C confirmed assessed for the patient assessments.  7. Record review for 19/15/2021, hospice effection period 8/19/22 A document dated 8/2 Subsequent Visit" indicated the toe wound titled "SN Hospice Suindicate the toe wound During an interview of RN/PCM C confirmed were not accurate.  8. Record review for 19/16/2021, hospice effection period 8/12/22 A document dated 8/15/2021, hospice effection period 8/12/22 A document dated 8/15/2021, hospice effection period 8/12/22 A document dated 8/15/21/21/21/21/21/21/21/21/21/21/21/21/21/	21, and 8/31/2021 titled Visit" indicated the nurstient's last BM.  7/2021, 8/24/2021, and ospice Subsequent Visit did not track the patient of the nurse did not assess.  In 9/15/2021 at 3:35 PM of the nurses should have ent's last BM as part of patient #8 was completed ection date 8/19/2021, 2021 - 11/16/2021.  26/2021 titled "SN Hospicated a new wound to be, and failed to indicate objective wound assess asurable outcomes.  1/2021, 9/3/2021, 9/7/20 absequent Visit" failed to did was assessed.  In 9/15/2021 at 3:40 PM of the patient #9 was completed ection date 8/12/2021, patient #9 was completed ection ecti	se did  dit" t's ess  1, ee their ed on for bice the enthe enthe ment  1, ents ed on for	L 534				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	LE CONSTRUCTION	` '	(X3) DATE SURVEY COMPLETED	
		151561		B. WING		09/1	6/2021	
	OVIDER OR SUPPLIER  D HEART HOSPICE O	F EASTERN INDIANA	1178 FF	RESS, CITY, STA REMONT CO RT, IN 4651	URT SUITE 2			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RECENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
L 534	injury (full thickness we pressure) with bone of area, two shin skin tervaginal wound, an un vagina. The document assessed the tailbone indicate the other work failed to indicate oxygoxygen is being carried assessed, how much frequently, or what mused, and did not asselved of pain.  A document dated 8/2 Subsequent Visit" indepain level a "2" (0-10 and 10= worst pain events as "sharp, stabbing pain level a "2" (0-10 and 10= worst pain events as "sharp, stabbing pain level a "company of the failed to indicate oxygossessed, how much frequently, or what musessed, nurse did round it was not acceptable severity, tailbone wound the wounds were as visits for the election indicate assessments lower extremities or ventile patient's numeric pair been addressed to oboutcomes.  9. Record review for patients of the present the second review for patients of the second review for patients.	ient had a stage 4 pres wound from un-relieved exposed on her tailbone ars on both legs, an intestageable wound in the at indicated the nurse wound, but failed to unds were assessed, and in the blood) was oxygen was used, howethod of administration less the patient's acception scale, with 0= no poer), and described her ain".	e ernal e ernal e ernal e e ernal e e ernal e e en ernal e e en ernal e e en ernal e e e en ernal e e e e e e e e e e e e e e e e e e e	L 534				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		151561		B. WING		09/	16/2021	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDRI	ESS, CITY, STA	TE, ZIP CODE	<b>,</b>		
HEART TO	HEART HOSPICE O	F EASTERN INDIANA		EMONT CO RT, IN 4651	URT SUITE 2 6			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULAT OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
L 534	Continued From page	e 42		L 534				
	for election period 8/2							
	Start of Care" indicate and took sips of water F's nurse reported the wound on the outside skin tear to the inside document also indicate assess the wounds, of patient's tolerance to A document dated 8/2 Subsequent Visit" indicates assessed by the nurse A document dated 9/2 Subsequent Visit" indicate and surgical would by the nurse, and LTC the patient had difficut start crushing medicates.	the sips of water. 26/2021, titled "SN Hos icated the wounds were	red TC  and a  ne id not  pice e not  ice a skin ssed rted y may iiled					
	A document dated 9/9/2021, titled "SN Hospice Subsequent Visit" indicated the patient had a skin tear and surgical wound, they were "healing well", they were not assessed by the nurse, and failed to indicate a follow up assessment was completed for the report of difficulty swallowing during a nursing visit made on 9/2/2021.		a aling and s					
	Subsequent Visit" ind tear and surgical wou swollen and red, no o were documented, an up assessment was o	13/2021, titled "SN Hos icated the patient had a nd, the inner left calf w ther assessment detail a failed to indicate a formpleted for the report uring the nursing visit r	a skin as s sllow t of					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		151561		B. WING		09/16/2021
	OVIDER OR SUPPLIER  O HEART HOSPICE	OF EASTERN INDIANA	1178 FF	RESS, CITY, STATE REMONT CO RT, IN 46510	URT SUITE 2	
(X4) ID PREFIX TAG	(EACH DEFICIENCY M	STATEMENT OF DEFICIENCIES UST BE PRECEDED BY FULL REG IDENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION
L 534	on 9/2/2021.  During an interview administrator and F comprehensive ass thoroughly, and the 10. During an interview manager) G indicated considered compressive and facilities [LTC] of that was unacceptad IDG, CARE PLANN SERVICES CFR(s): 418.56  This Condition is no Based on observation interview, the interview, the interview and family-specific interdisciplinary group and family-specific interdisciplinary group and family-specific interdisciplinary group and family-specific interventions (L545 plans of care included patients' plans of care included all droup and family and failed to care included all droup and family and failed to care included all droup and family and failed to care included all droup and family and failed to care included all droup and family and failed to care included all droup and family and failed to care included all droup and family and failed to care included all droup and family and failed to care included all droup and family and failed to care included all droup and family and failed to care included all droup and family and failed to care included all droup and family and failed to care included all droup and family and failed to care included all droup and family and failed to care included all droup and family and failed to care included all droup and family and failed to care included all droup and failed to care included all droups and failed to care included all dr	on 9/16/2021 at 1:40 PMRN/PCM C indicated the sessments were not compay were not patient specification on 9/8/2021 at 2:52 Fel) ACM (area clinical ted all nursing visits were chensive assessments.  View on 9/15/2021 at 3:06 ted " we can't control wildo", and PCM C indicated in the control of the c	eleted c.  PM,  PM,  hat ted  DF  silled the ent  all had  ents' ge re all  s of sary	L 536		

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		7	CONSTRUCTION	(X3) DATE S COMPLE	
		151561		B. WING		09/	16/2021
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STATE	, ZIP CODE		
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(X4) ID PREFIX TAG	(EACH DEFICIENCY M	Y STATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL REC CIDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
L 536	patients.  The cumulative efforesulted in the age with the Condition	ect of this systemic proble ncy being out of complian of Participation 42 CFR plinary Group, Care Plann	ce	L 536			
L 538		NING, COORDINATION C	)F	L 538			
	and services neces family-specific nee comprehensive ass to the terminal illne This Standard is n Based on observat interview, the interview, the interview on the spice services n	nust specify the hospice cassary to meet the patient and identified in the sessment as such needs research and related conditions not met as evidenced by: tion, record review, and disciplinary group (IDG) fants' plans of care included ecessary to meet the paties needs for 2 of 15 records	relate . siled the ent				
	of Care Process" ir ensure that the car with the written Pla patient and family's initial and update assessments wil necessary A rev information from th comprehensive ass	Il include all services ised POC will include ne patient's updated sessment"	ce et the				
		or patient #8 was complete e election date 8/19/2021,					

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE			LE CONSTRUCTION	(X3) DATE SU COMPLE	
		151561		B. WING		09/1	16/2021
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STA	TE, ZIP CODE		
HEART TO	O HEART HOSPICE O	F EASTERN INDIANA		EMONT CO RT, IN 4651	URT SUITE 2 6		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES ST BE PRECEDED BY FULL REG ENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
L 538	election period 8/19/2 A home visit was obs AM. Family reported after the patient came difficult to transfer the (9/8/2021) during a tr heavy, was lowered to the nurse this mornin During this time, the which included (but notitled "Hospice Certificelection period 8/19/2 document indicated for services, and failed to transferred with use of indicated she was neservices, she was vecome a services, she was vecome a services, she was vecome a services.  A document dated 8/ Subsequent Visit" incompatient was not bear in transferring her was of A document dated 9/ from 10:21 AM - 11:4 sustained a fall, and subsequent visit in the patient was not bear in transferring her was of A document dated 9/ from 10:21 AM - 11:4 sustained a fall, and subsequent visit in the patient was not bear in transferring her was of A document dated 9/ from 10:21 AM - 11:4 sustained a fall, and subsequent visit in the patient was not bear in transferring her was of A document dated 9/ from 10:21 AM - 11:4 sustained a fall, and subsequent visit in the patient was not bear in the p	gerved on 9/9/2021 at 10 she bought a gait belt rie home because it was a patient, last night ransfer, the patient was to the floor, and she text of (9/9/2021) to let her knome folder was review not limited to) a documer cation and Plan of Care 2021 - 11/16/2021. The ramily declined voluntee to indicate the patient of a gait belt. Family ever offered volunteer ry overwhelmed, and warme help.  26/2021 titled "SN Hosp dicated family reported ng weight well, and difficult.  9/2021 for a HHA visit may be a supplementation of the patient of the	ight very too ted cnow. ved, nt "for ould bice made ent  bt vices  DG re	L 538			

(X2) MULTIPLE CONSTRUCTION

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		` ′	E CONSTRUCTION	(X3) DATE SURV COMPLETE	
		151561		B. WING		09/16/	/2021
NAME OF PF	ROVIDER OR SUPPLIER		STREET ADDRI	ESS, CITY, STA	TE, ZIP CODE		
HEART T	O HEART HOSPICE (	OF EASTERN INDIANA		EMONT CO RT, IN 4651	URT SUITE 2 6		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MU	STATEMENT OF DEFICIENCIES ST BE PRECEDED BY FULL REI DENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
L 538	coordinator section i were not requested, due to a holiday -per patient/caregiver agriculture of amily indicated she services on Monday. PM - 4:20 PM, and in there were meetings treatment, and she with the end of the period of	a HHA visit was canceled family request, and the reed with the plan of card on 9/9/2021 at 2:12 PM, would like the volunteers and Thursdays from 2 addicated she never knew a about her mother's card would like to be involved on 9/10/2021 at 11:05 A mily called her yesterday er services, for about may eek, lowering a patient of sidered a fall, families were services, for about may eek, lowering a patient of sidered a fall, families were services, they did a thing special, they did a his time, the administrations I think the families of the point of the point of the side and they find be there around 7:00 for the side and they find they have they are services and they find they are services are they do not serve they do not for a bit after the side of the	ed e.	L 538			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		` '	(X3) DATE SURVEY COMPLETED	
	151561			B. WING		09/1	6/2021	
	OVIDER OR SUPPLIER  D HEART HOSPICE O	F EASTERN INDIANA	1178 FR	RESS, CITY, STA REMONT CO RT, IN 4651	URT SUITE 2			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RECENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
L 538	one visit.  3. Record review for py/16/2021, hospice election period 8/12/2  A document signed by 8/24/2021 titled "Hospicated (but not limit were declined.  A document dated 8/2 worker] Hospice Initiated Made referral for volucompanionship col [interdisciplinary teams.]  A document dated 8/2 Comprehensive Asset Update Report was refurrent Meeting Sunsection indicated fams home support, did not care agencies, the softhem to reach out to a family for recomment volunteer services was The volunteer section services wasn't request aware and accepted to A document dated 9/2 Comprehensive Asset Comprehensive Asset Asset Comprehensive Asset Adocument dated 9/2 Comprehensive Asset	patient #9 was completed lection date 8/12/2021, 2021 - 11/9/2021.  By attending physician K pice Certification and Plicod 8/12/2021 - 11/9/2021 ted to) volunteer serviced level was local Evaluation" indicated anteer services for laborated with IDT in 19/2021 titled "Hospice issment and Plan of Calleviewed. In the section mary", the social work illy was looking for more toward to use other homographic worker encourage of church and ask friends a dations, and failed to include the section of the s	on lan of 21 es ial "  IDG re titled er e in ne d and dicate 1.	L 538				
	worker followed up or home support.	d failed to indicate the s n family request for mor n 9/16/2021 at 2:31 PM	e in					

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		1 1	LE CONSTRUCTION	(X3) DATE SU COMPLE	
		151561		B. WING		09/1	16/2021
	OVIDER OR SUPPLIER  O HEART HOSPICE O	OF EASTERN INDIANA		ESS, CITY, STA	TE, ZIP CODE URT SUITE 2		
			ELKHAI	RT, IN 4651	6		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	STATEMENT OF DEFICIENCIES ST BE PRECEDED BY FULL REGENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
L 538	RN/PCM C confirmed documentation on the IDG reports should not have indicated volunteer services was declined, and the patient did not receive volunteer services.			L 538			
L 545	CONTENT OF PLAN OF CARE CFR(s): 418.56(c)			L 545			
	written plan of care for care must reflect pati interventions based of the initial, comprehen comprehensive asses must include all servi palliation and manage	evelop an individualized or each patient. The platent and family goals and on the problems identified asive, and updated assments. The plan of clices necessary for the dement of the terminal illus, including the following	d ed in are Iness				
	Based on observation interview, the interdisto to ensure all patients' individualized and income.	sciplinary group (IDG) fa ' plans of care were cluded patient/family sp ntions for 7 of 15 records	ecific				
	Findings include:						
	of Care Process" indi develop an individual care] for each patient	revised 1/1/2020 titled "I icated " The hospice v lized written POC [plan t. The POC must reflect als and interventions	will of				
		patient #2 was completelection date 4/27/2021, 2021 - 6/25/2021.					
	A document dated 7/2	29/2021 titled "Hospice	IDG				

(X2) MULTIPLE CONSTRUCTION

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE			LE CONSTRUCTION	(X3) DATE SU COMPLE	
		151561		B. WING		09/	16/2021
NAME OF PF	OVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STA	TE, ZIP CODE		
HEART T	O HEART HOSPICE	OF EASTERN INDIANA		EMONT CO RT, IN 4651	URT SUITE 2 6		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MU	STATEMENT OF DEFICIENCIES JST BE PRECEDED BY FULL REG IDENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
L 545	[interdisciplinary growsessment and Plaindicated (but not lirindwelling urinary careontinuous oxygen, minimal activity, was a skin tear on 7/15/2 urinary tract infection history of medication take medications as failed to identify patturinary catheter carecessation, use of oxrisks/precautions, where the prevention, signs/sy improve medication patient/family specification period 5/20  A document titled "Hof Care" for election indicated (but not lirlong term care (LTC actively dying patient state of deep unconincluded (but not limassess effectivenes symptom relief meattreatment assess and provide interpatient's well being instruct in measures assessment of patier violence" Additio indicate the family's	oup] Comprehensive an of Care Update Repormited to) the patient had a atheter, was dependent of had difficulty breathing was a current smoker, susta 2021, started an antibiotic of (UTI) on 7/25/2021, and mis-use and 2 warnings prescribed. The docume ient specific interventions e/management, smoking and round care/treatment, inferment with the compliance, or any fice goals and interventions or patient #5 was completed election date 5/20/2021, 1/2021 - 8/17/2021.  Hospice Certification and in period 5/20/2021 - 8/17/2021.  Hospice Certification and in period 5/20/2021 - 8/17/2021.  Hospice Certification and in period 5/20/2021 - 8/17/2021 - 8/17/2021.  Hospice Certification and in period 5/20/2021 - 8/17/20	an on vith sined cofor das to ent sofor section sto section for Plan (2021) ed at e (a as e to ent section should be and do to	L 545			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		151561		B. WING		09/1	6/2021
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STA	TE, ZIP CODE	•	
HEART TO	O HEART HOSPICE C	OF EASTERN INDIANA		REMONT CO RT, IN 4651	URT SUITE 2 6		
(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 COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
L 545	nurse] Hospice Unat upon arrival for visit, agency nurse the par 5/23/2021 at 10:40 F  A document dated 5/Comprehensive Asse Update Report" indicated the patient 5/23/2021 at 10:40 F for treatment and ser weeks, and indicated agreement with the psection titled "Curren spiritual counselor/cr plan for the next 2 w times per week in permeeting: none. The rindicated the plan for nursing visits, (goals scheduled comfort mexhibit physical signs.  An additional docume. "Hospice IDG Compipelan of Care Update for the meeting was a last IDG meeting was indicated the patient 5/23/2021 at 10:40 F meeting included ""	tended Death" indicated LTC facility B staff infortent passed away on PM.  277/2021 titled "Hospice essment and Plan of Casted the reason for the admission". The docum date/time of death was PM, but included future process for the next two dispatient/caregiver was in plan of care. Review of the Meeting Summary", the palain (SCC) indicated eeks was to visit the particular forms, changes since last registered nurse (RN) so the theory of the next 2 weeks was to patient would receive redications, and would reso of distress.  Lent dated 5/27/2021 title rehensive Assessment and Report" indicated the real "death at home", and so 5/27/2021. The docum date/time of death was PM, changes since last I Patient is deceased	IDG are aent blans in the ne tient 2 st IDG ection daily not ed and eason the eent DG "	L 545	DEFICIENCY)		
		patient #6 was complet election date 8/3/2021, f 021 - 10/31/2021.					
	Start of Care" indicat	/3/2021 titled "RN Hospi ted the patient received e (GIP) at hospital D du					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		151561		B. WING		09/1	6/2021	
	OVIDER OR SUPPLIER  O HEART HOSPICE O	F EASTERN INDIANA	1178 FR	ESS, CITY, STA EMONT CO RT, IN 4651	URT SUITE 2	•		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL RE OR LSC IDENTIFYING INFORMATION)		GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AID DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
L 545	uncontrolled pain and 16french/5cc (cubic of catheter, bowel inconfluids by mouth (NPO unresponsive, opened and had no wounds.  A document dated 8/4 General Inpatient [vis a PICC line in his left catheter that is inserted often in the arm, into used when intravenous a long period), and the A document titled "Ho of Care" for election pfailed to indicate the preceived GIP care duanxiety, foley cathete care/management, over family specific goals.  5. Record review for pg/15/2021, hospice election period 7/19/2  A document dated 7/7 Start of Care" indicate patient lost 47 pounds had difficulty breathin breath, at risk for falls and used a rollator wallegs) with another period 10/16/2021 indicated assisted living facility	anxiety, had a size entimeter) indwelling untimence, took no nutrition), had Diabetes, nonver dependence, took no nutrition), had Diabetes, nonver dependence of the entity of the entit	on or rbal, puch, SN - thad ng , y, lover Plan (2021 and ns, ed on for bice e petic, ort of s, he Plan	L 545				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		151561		B. WING		09/1	6/2021
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STA	TE, ZIP CODE	•	
HEART T	O HEART HOSPICE O	F EASTERN INDIANA		EMONT CO RT, IN 4651	URT SUITE 2 6		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES ET BE PRECEDED BY FULL RECENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
L 545	thinner/anticoagulant monitoring) daily, and respiratory symptom to indicate oxygen do administration, or free monitored/managed alaboratory values and the patient was diabefor walking with a roll increase nutritional in specific goals.  6. Record review for 9/15/2021, hospice e election period 8/19/2  A home visit was obs AM. Observed Heart home health aide (Hiftom the bed to a whole belt. No oxygen was indicated she bought since the day the pattern of Care" indicated cigarettes, had continuous the delevated for relief, dra (nutritional supplement falling, experienced as she currently took and A document titled "Hoof Care" for election period and titled "Hoof Care" for election period and complete bedrest" and document failed to impain level, the dose and administration of the dose and complete bedrest" and document failed to impain level, the dose and administration of the dose and complete bedrest" and document failed to impain level, the dose and th	which required lab direceived oxygen for relief. The document false, method of quency, who the patient's anticoagulated frequency of blood testic, required another peator walker, intervention take, or patient/family patient #8 was completed lection date 8/19/2021, 2021 - 11/16/2021.  Berved on 9/9/2021 at 10 to Heart North (H2HN) HA) W transfer the patient electhair with the use of present in the home. False the gait belt and used in itent got home.  19/2021 titled "RN Hosped the patient smoked hous pain, was short or head of the bed to be ank 2 cans of ensure nt) daily, was at risk for anxiety, used oxygen, an antibiotic for UTI.  Despice Certification and period 8/19/2021 - the patient was on	ant sts, erson ns to  ed on for  0:25 ent a gait amily it  pice f	L 545			

(X2) MULTIPLE CONSTRUCTION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		151561		B. WING		09/1	6/2021
	OVIDER OR SUPPLIER  D HEART HOSPICE O	F EASTERN INDIANA	1178 FF		URT SUITE 2		
			ELNHA	RT, IN 4651			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REC ENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
L 545	Continued From page	e 53		L 545			
	patient smoked, risks and oxygen use, she interventions/education interventions for prevereduce anxiety, or the	associated with smokir was not bedbound, on for UTI, fall precaution enting falls, intervention was of the gait belt.	ons or ns to				
	During an interview on 9/15/2021 at 3:39 PM, PCM C confirmed interventions to prevent falls, nutritional supplements, specific oxygen orders, smoking status, UTI status and interventions, interventions to reduce anxiety, and patient pain goal should all be on the plan of care.						
	7. Record review for patient #9 was completed on 9/16/2021, hospice election date 8/12/2021, for election period 8/12/2021 - 11/9/2021.  A document dated 8/12/2021 titled "RN Hospice Start of Care" indicated the patient had a stage 4 pressure injury (full thickness wound from un-relieved pressure) with bone exposed on her tailbone area, two skin tears on both legs (shins), an internal vaginal wound, an unstageable wound in the vagina, and an indwelling urinary catheter (a tube inserted into the bladder to drain urine).						
			ge 4 her nins), round eter				
	of Care" failed to indic pain level, the patient injury with bone expo- two skin tears on both vaginal wound, an un vagina, or treatment of document also failed	ospice Certification and cate the patient's prefer had a stage 4 pressure sed on her tailbone are legs (shins), an internstageable wound in the orders for the wounds. To indicate the size of the ter, or treatment order of the catheter.	rred e a, al e The				
	PCM C confirmed the	n 9/16/2021 at 2:31 PM patient's preferred pair POC, the POC was not	n				

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		151561		B. WING		09/1	6/2021
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STA	TE, ZIP CODE		
HEART TO	) HEART HOSPICE O	F EASTERN INDIANA		EMONT CO RT, IN 4651	URT SUITE 2 6		
(X4) ID PREFIX TAG	SUMMARY S' (EACH DEFICIENCY MUS OR LSC ID	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
L 545	individualized, it had and had no patient/fa interventions related care.  8. Record review for pon 9/15/2021, hospic for election period 8/2 A document dated 8/2 Start of Care" indicate wound on the outside skin tear to the inside A document titled "Ho of Care" for election post 11/22/2021 failed to inskin tear to the inside interventions to treat indicate patient/family interventions.  9. During an interview the administrator and care were not patient they were missing trepatient/caregiver goamissing.  10. Record review for on 9/7/2021, election period 7/28/2021 - 10 diagnosis of Parkinson deterioration causing progressive loss of fur failed to ensure the pand interventions bas assessment findings locations and treatments.	no wound treatment ord milly specific goals or to the wounds or cathet  patient #10 was complete election date 8/25/202 25/2021 - 11/22/2021.  25/2021 titled "RN Hosped the patient had a sure of the left lower leg, are of the left lower leg.  Dispice Certification and period 8/25/2021 - ndicate the presence of the left lower leg, the wound, and failed to y specific goals or  I PCM confirmed the plates of the left lower leg, the wound, and failed to y specific or individualized the presence of the left lower leg, the wound, and failed to y specific or individualized the plates at the	eted 21,  Dice regical and a  Plan  Fithe  D  PM  ans of ed, e  eted  hefit  s and y  oals ive  und	L 545			
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(X2) MULTIPLE CONSTRUCTION

		(X1) PROVIDER/SUPPLIER/O IDENTIFICATION NUMBE	LIA		DING		(X3) DATE SURVEY COMPLETED	
		151561		B. WING		09	/16/2021	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STATE	, ZIP CODE	•		
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULA  OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
L 545	"Hospice Recertification on the coccypischial tuberosity (Review of a docur Hospice Recert [reidentified 3 skin won the upper right heel.  Review of an ager Wounds - Patient Administrator A on evidenced patient upper buttock wou During an interview Patient Care Mana expected to know Review of a docur "Hospice Recertification Update," indicated catheter. The plar size of the catheter the catheter. The goal that included During an interview E confirmed patier interpreter. During an interview Patient Care Mana care failed to evide interventions.  11. Record review on 9/14/2021, election of the period 8/14/2021, el	cation and Plan of Care I the patient had 3 skin wo k (tailbone) and one on the sit bone). Inent dated 7/13/2021, title ecertification] Assessment, bunds. One on the coccy buttock, and one on the right accy document titled "Clinical Detail," received from 19/7/2021. The document had 2 coccyx wounds and	e right d RN " k, one ght al - 1 AM e was b. ling e the ange a RN M, of	L 545				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		151561		B. WING		09/1	6/2021
	OVIDER OR SUPPLIER  O HEART HOSPICE O	F EASTERN INDIANA	1178 FF	RESS, CITY, STA REMONT CO RT, IN 4651	URT SUITE 2		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RECENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
L 545	care failed to be indivaled needs.  12. Review of a docu of 8/14/2021, titled "A indicated personal casuch as showering, hand dressing.  13. Review of docum Visit" dated 8/17/2022 9/8/2021 indicated the Notes dated 8/27/202 patient declined most indicated patient did running an interview of Patient Care Manage interventions should have the patient's current in 14. Record review for on 9/10/2021, for ben 11/26/2021, with a ter metabolic encephalog often resulting in com Review of a document 8/29/2021 - 11/26/2020 Certification and Plan for oxygen safety meanot use oxygen.  During an interview of Patient Care Manage care was not individuated.	idualized to reflect accument with an effective aide Care Plan Report" re assistance with task air and skin care, shaving the stitled "Aide Hospid 1, 8/19/2021, 9/3/2021, e patient declined all care. The note on 9/3, most tasks himself.  In 9/10/2021 at 1:07 PM or C confirmed the nave been updated to reflect the seeds.  In patient #14 was completit period 8/29/2021 - minal diagnosis of pathy (brain damage mean).  In the for certification period 21, titled "Hospice of Care" indicated the asures. The patient down 9/10/2021 at 10:37 Ar C confirmed the plantalized.  The won 9/14/2021, at 1:4 B confirmed goals should be assured to reflect the second of the plantalized.	date s ng, ce are. ed //2021 I, efflect bleted ost I need es M, of	L 545			

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		(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		151561		B. WING		09/16/2021		
	OVIDER OR SUPPLIER  O HEART HOSPICE O	DF EASTERN INDIANA	1178 FR	ESS, CITY, STA EMONT CO RT, IN 4651	URT SUITE 2	•		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	STATEMENT OF DEFICIENCIES ST BE PRECEDED BY FULL REI DENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
L 546 L 546	CONTENT OF PLANCER(s): 418.56(c)(1)  [The plan of care munecessary for the pathe terminal illness a including the followin (1) Interventions to multiple of the patheter interventions to man for 7 of 15 records references interventions to man for 7 of 15 records references includes Interventions includes Interventions and includes Intervention of the patheter includes Intervention of the patheter includes Intervention of the patheter includes and symptoms and includes Intervention of the patheter includes and symptoms and includes Intervention of the patheter includes and symptoms and includes Intervention of the patheter includes and symptoms and includes and symptoms and includes and symptoms are underventional symptoms are underventional symptoms and includes and symptoms are underventional symptoms are underventional symptoms and includes and symptoms are underventional symptoms.	Ist include all services alliation and management related conditions, ag:] Inanage pain and sympton and sevidenced by: In record review, and sciplinary group (IDG) factions of care included age pain and/or sympton eviewed (#2, 5, 6, 7, 8, 9) In revised 1/1/2020 titled "I licated " The POC [platerventions to manage paid antified issues/problem patient #2 was completed election date 4/27/2021, 2021 - 6/25/2021. In 1/2021 titled "RN ospice Recert Assessmental constant severe pairrent smoker, he was shind he used 3-5 liters of	oms.  illed  ms  i, 10).  Plan  n of  iin  is"  ed on  for  ent"  in,  oort of	L 546 L 546				

(X2) MULTIPLE CONSTRUCTION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		' '	(X3) DATE SURVEY COMPLETED	
		151561 B. WING 09/16/20:		6/2021				
NAME OF PROVIDER OR SUPPLIER STREE			ESS, CITY, STA		•			
HEART TO	O HEART HOSPICE O	F EASTERN INDIANA		EMONT CO RT, IN 4651	URT SUITE 2 6			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REGENTIFYING INFORMATION)	I	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
L 546	shortness of breath.  A document dated 7/2 [interdisciplinary grou Assessment and Plar indicated (but not limi ongoing pain, anxiety continuous oxygen, h minimal activity, and odcument failed to ide managing pain, anxiety of oxygen while smok or interventions to recof breath.  3. Record review for p9/15/2021, hospice el election period 5/20/2  A document dated 5/2 Start of Care" indicate breath at rest, she ha lungs were coarse (in she made "gurgling" sthe nurse to be in concomatose (a state of Care" for election pindicated (but not limi long term care (LTC) actively dying patient, document failed to indinterventions to mitigate breath, excessive secomatose patient.  4. Record review for patients.	29/2021 titled "Hospice p] Comprehensive of Care Update Reported to) the patient had was dependent on ad difficulty breathing was a current smoker. The patient #5 was completed ection date 5/20/2021, 2021 - 8/17/2021.  20/2021 titled "RN Hosped the patient was shorted labored breathing, he dicating presence of fluor breathing, and she was deep unconsciousness as a patient was an and she was comatos dicate patient specific ate pain, shortness of cretions, and care of a patient #6 was completed to the patient specific ate pain, shortness of cretions, and care of a patient #6 was completed to the patient #6 was completed to t	vith The use ns, ness ed on for oice t of er uid), by s ). Plan (2021 led at e; the	L 546				
	9/15/2021, hospice el election period 8/3/20	ection date 8/3/2021, fo 21 - 10/31/2021.	or					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		` '	(X3) DATE SURVEY COMPLETED	
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NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STA	TE, ZIP CODE	•		
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(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REI ENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
L 546	6 Continued From page 59			L 546				
	Start of Care" indicate general inpatient care uncontrolled pain and	8/2021 titled "RN Hospi ed the patient received (GIP) at hospital D du anxiety, was nonverba ened his eyes for pain	e to					
	A document titled "Hospice Certification and Plan of Care" for election period 8/3/2021 - 10/31/2021 failed to indicate the patient received GIP care due to uncontrolled pain and anxiety, or patient specific interventions to mitigate pain and anxiety.							
		patient #7 was complete ection date 7/19/2021, 021 - 10/16/2021.						
	Start of Care" indicate		ounds					
	of Care" for election p 10/16/2021 indicated assisted living facility laxative for constipation respiratory symptom to indicate patient spen mitigate increased nu constipation, reduction	the patient resided at (ALF) E, took a daily on, and received oxyge relief. The document fa	en for iled					
		patient #8 was complete ection date 8/19/2021, 021 - 11/16/2021.						
	A document dated 7/1	19/2021 titled "RN Hosp	oice					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			1` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	151561			B. WING		09/16/2021
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDRE	SS, CITY, STA	TE, ZIP CODE	
HEART TO	O HEART HOSPICE (	OF EASTERN INDIANA		EMONT CO RT, IN 4651	URT SUITE 2 6	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MU	STATEMENT OF DEFICIENCIES ST BE PRECEDED BY FULL REG DENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
L 546	Start of Care" indica cigarettes, had contibreath, required the elevated for relief, droutritional supplements falling, experienced she currently took and A document titled "Hof Care" for election 11/16/2021 was revisindicate patient specific pain, shortness of broutritional intake, the elevated, smoking on with smoking and ox reduction/managements and interview of PCM C confirmed in supplements, interverbatient pain should a complement of the patient pain should a complement of Care" indicate pain, was short of brought of Care" indicate pain, was short of brought of Care" failed to indicate interventions to mitigate breath, methods to it elevation of the head control of the he	ted the patient smoked nuous pain, was short or head of the bed to be rank 2 cans of ensure ent) daily, was at risk for anxiety, used oxygen, an antibiotic for UTI.  Iospice Certification and period 8/19/2021 - ewed. The document failific interventions to mitigine the pain, increasing the head of the bed should essation, risks associate exygen use, or ent of anxiety.  Ion 9/15/2021 at 3:39 PM terventions for nutritional entions to reduce anxiety all be on the plan of care are patient #9 was completed the patient had consteath, required the head end to relieve shortness of the short of the patient had consteath, required the head end to relieve shortness of the short of the patient was constant.	Plan led to gate be d l, l l, and led to gate be d Plan Plan Plan e,	L 546		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		` '	(X3) DATE SURVEY COMPLETED	
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(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RECENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
L 546	Continued From page	e 61		L 546				
	admission compreher	nsive assessment.						
	PCM C the plan of ca had no wound treatm patient specific interven	on of head of the bed, o	ed, it					
	8. Record review for patient #10 was completed on 9/15/2021, hospice election date 8/25/2021, for election period 8/25/2021 - 11/22/2021.							
	A document dated 8/25/2021 titled "RN Hospice Start of Care" indicated the patient was recently involved in a motor vehicle accident and sustained multiple injuries including (but not limited to) a fractured sternum (breastbone) and ribs, had difficulty breathing at rest, pain that required increasing doses of major pain medications more than briefly, required continuous oxygen, had a surgical wound on the outside of the left lower leg, and a skin tear to the inside of the left lower leg.							
	of Care" for election p 11/22/2021 failed to in interventions to mitigate breath at rest, the pre- inside of the left lower the wound, oxygen us dose, method of delive a patient with fracture 9. During an interview the administrator and of care were not patient they were missing tree	ndicate patient specific ate severe pain, shortne esence of the skin tear t r leg or interventions to se and specific orders for ery or frequency, or cal	ess of to the treat or re of					

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(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES ST BE PRECEDED BY FULL RE ENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
L 546	, , ,	e 62 ventions, and they were	e not	L 546			
L 548	CONTENT OF PLAN CFR(s): 418.56(c)(3)			L 548			
	the terminal illness ar including the following (3) Measurable outco	liation and managemen nd related conditions, g:]					
	This Standard is not met as evidenced by: Based on record review and interview, the interdisciplinary group (IDG) failed to ensure all patients' plans of care included measurable outcomes to meet the needs of the patient for 13 of 15 records reviewed (#1, 2, 3, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14).						
	Findings include:						
	1. An agency policy revised 1/1/2020 titled "Plan of Care Process" indicated " The POC [plan of care] includes Measurable outcomes anticipated from implementing and coordinating the plan of care"						
		patient #2 was complete lection date 4/27/2021, 2021 - 6/25/2021.					
	of Care" for election p indicated goals includ Pain will be managed	ospice Certification and period 4/27/2021 - 6/25/ded (but not limited to) "d at a level acceptable tor relief of cardiopulmors"	/2021  o the				

(X2) MULTIPLE CONSTRUCTION

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		` '	(X3) DATE SURVEY COMPLETED	
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	OVIDER OR SUPPLIER  O HEART HOSPICE O	F EASTERN INDIANA	1178 FR	ESS, CITY, STA EMONT CO RT, IN 4651	URT SUITE 2			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REI ENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
L 548	3. Record review for 19/15/2021, hospice e election period 5/20/2 A document titled "Ho of Care" for election pindicated goals included patient Reduction of symptomsanxiety/aminimized/controlled  A physician's order dotitled "Hospice Add-Concluded " Patient will express an increase peacefulness at the experience a sense of having supported the Patient/Caregiver will concerns"  A physician's order dotitled "Hospice Add-Concerns"  4. Record review for 19/15/2021, hospice e election period 8/3/20  A document titled "Hospica Add-Concerns for election period 8/3/20  A document titled "Hospica Add-Concerns for election period 8/3/20  A document titled "Hospica Add-Concerns for election period 8/3/20  A document titled "Hospica Add-Concerns for election period 8/3/20  A document titled "Hospica Add-Concerns for election period 8/3/20  A document titled "Hospica Add-Concerns for election period 8/3/20  A document titled "Hospica Add-Concerns for election period 8/3/20  A document titled "Hospica Add-Concerns for election period 8/3/20	patient #5 was complete lection date 5/20/2021, 2021 - 8/17/2021.  Dispice Certification and period 5/20/2021 - 8/17/2021 - 8/17/2021 - 8/17/2021 - 8/17/2021 - 8/17/2021 - 8/17/2021 - 8/17/2021 - 8/17/2021 - 8/17/2021 - 8/17/2021 - 8/17/2021 - 10	Plan (2021 o the hary  21 oals het nd s) will  I  21 ker ress hess hes a ted  Plan (2021  Plan (2021	L 548				

FXOI11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		, ,	(X3) DATE SURVEY COMPLETED	
	151561			B. WING		09/1	6/2021	
	OVIDER OR SUPPLIER  O HEART HOSPICE O	F EASTERN INDIANA	1178 FR	RESS, CITY, STA REMONT CO RT, IN 4651	URT SUITE 2			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REI ENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
L 548	appropriately as evide"  A physician's order do titled "Hospice Add-O included " Patient will express an increase peacefulness at the experience a sense of having supported the Patient/Caregiver will concerns"  A physician's order do titled "Hospice Add-O goals included " Paran increased sense of at the end of life Casense of accomplishing the dying person"  5. Record review for physician's order do for election period 7/19/2  A document titled "Hospice election period 7/19/2  A physician's order do titled "Hospice Add-O included " Patient we patient/Caregiver will concerns"	comment dated 8/4/202 on" indicated chaplain grill have safety needs maked sense of closure and of life Caregiver(soft accomplishments at dying person feel relief from spiritual ocument dated 8/4/202 on" indicated social world tient/Caregiver will experience and peaceful aregiver(s) will experience at having support ocument #7 was completed ection date 7/19/2021, 2021 - 10/16/2021.	1 oals net nd s) will last will last will last last last last last last last la	L 548				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		151561		B. WING		09/1	6/2021
	OVIDER OR SUPPLIER  O HEART HOSPICE O	F EASTERN INDIANA	1178 FF	RESS, CITY, STA REMONT CO RT, IN 4651	URT SUITE 2		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REC ENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
L 548	titled "Hospice Add-O goals included " Pat decreased fear/anxiet process"	n" indicated social work tient/Caregiver will have ty regarding death and	e dying	L 548			
		patient #8 was complete lection date 8/19/2021, 2021 - 11/16/2021.					
	A document titled "Hospice Certification and Plan of Care" for election period 8/19/2021 - 11/16/2021 indicated goals included (but not limited to) " Pain will be managed at a level acceptable to the patient Reduction or relief of cardiopulmonary symptoms anxiety/agitation is minimized/controlled medications will be managed appropriately as evidenced by symptom control"						
	titled "Hospice Add-O included " Patient w	ocument dated 8/23/202 nn" indicated chaplain go vill have safety needs m feel relief from spiritual	oals et				
	titled "Hospice Add-O goals included " Pat	ocument dated 8/23/202 on" indicated social work tient/Caregiver will have ty regarding death and	ker e				
	PCM C confirmed inte supplements, interver	n 9/15/2021 at 3:39 PM erventions for nutritiona ntions to reduce anxiety I be on the plan of care	l , and				
		patient #9 was complet e election date 8/12/202 2/2021 - 11/9/2021.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	` '	(X3) DATE SURVEY COMPLETED	
		151561		B. WING		09/1	16/2021	
	OVIDER OR SUPPLIER  O HEART HOSPICE O	F EASTERN INDIANA	1178 FF	RESS, CITY, STA REMONT CO RT, IN 4651	URT SUITE 2			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REC ENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
L 548	of Care" indicated goato) " Pain will be may to the patient anxie minimized/controlled cardiopulmonary sym.  A physician's order do titled "Hospice Add-O included " Patient w Patient/Caregiver will concerns"  A physician's order do titled "Hospice Add-O goals included " Patient we process Patient/Ca increased fear/anxiet process Patient/Ca increased sense of clube end of life Care sense of accomplishing the dying person"  8. Record review for pron 9/15/2021, hospicated for election period 8/2  A document titled "Hospice and complete the dying person sense of accomplishing the dying person sense of accomp	ospice Certification and als included (but not limit anaged at a level accept sty/agitation is Reduction or relief of ptoms"  ocument dated 8/13/202 or indicated chaplain grill have safety needs made feel relief from spiritual ocument dated 7/21/202 or indicated social work the tregiver will express an osure and peacefulness are giver(s) will experience ments at having support opatient #10 was complete election date 8/25/2021 or 11/22/2021.  Ospice Certification and period 8/25/2021 or goals included (but not	aited table  21 coals aet  21 coals aet	L 548	DEFICIENT			
	exhibits signs of symp Pain will be managed patient Pain will be A physician's order do titled "Hospice Add-O	enced by symptom contour reduction or relief at a level acceptable to controlled"  Document dated 8/27/202 on indicated chaplain gotill have safety needs metals.	 o the 21 oals					

Printed: 10/01/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CL AND PLAN OF CORRECTION IDENTIFICATION NUMBER			1 1	LE CONSTRUCTION	(X3) DATE SUF COMPLET		
	151561			B. WING		09/1	6/2021
	OVIDER OR SUPPLIER			ESS, CITY, STA		•	
HEART TO	HEART HOSPICE O	F EASTERN INDIANA		RT, IN 4651	URT SUITE 2 6		
(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 CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
L 548	Patient/Caregiver will concerns"  A physician's order de titled "Hospice Add-C goals included " Pa decreased fear/anxie process"  9. During an interview the medical director in measurable outcome wanted them quantific quantity), and added slept more, she wantover how long of a tin 10. During an interview the administrator and of care goals were not 11. Record review foon 9/7/2021, election benefit period 7/28/20 terminal diagnosis of brain.  Review of a documer 7/28/2021, titled "Hospic Care" indicated of would be met.  During an interview of Patient Care Manage measurable goal.  12. Record review foon 9/7/2021, election benefit period 7/28/2021, election benefit period 7/28/2021.	ocument dated 8/27/2020 on" indicated social worktient/Caregiver will have the regarding death and work on 9/14/2021 at 1:45 Indicated she needed mes, over what time frame able (measured as a the example that if a pared to know how much noneframe.  Bew on 9/16/2021 at 3:40 Indicated she needed messured as a the example that if a pared to know how much noneframe.  Bew on 9/16/2021 at 3:40 Indicated she pared to the par	21 ker e dying  PM, ore e, atient more  Plans eted athe ate of Plan is  M, not a  eted	L 548			
	DIAIII UELEHOIALION CA	using involuntary					

(X2) MULTIPLE CONSTRUCTION

Printed: 10/01/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		151561		B. WING		09/16/2021
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDRE	ESS, CITY, STA	TE, ZIP CODE	•
HEART TO	O HEART HOSPICE O	F EASTERN INDIANA		EMONT CO RT, IN 4651	URT SUITE 2 6	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RE ENTIFYING INFORMATION)	I	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE COMPLETION
L 548	Continued From pag	e 68		L 548		
	movements and prog	ressive loss of function	ing).			
	Review of a document dated 7/4/2021, titled "Hospice Recertification and Plan of Care Update," indicated a goal that patient's neurologic status would be addressed appropriately.					
	Patient Care Manage	n 9/10/2021 at 10:50 A r C confirmed this was plan of care goal and th	а			
	nurse did not adjust it	. •	ie			
	13. Record review for patient #11 was completed on 9/13/2021, election date of 7/24/2021, for benefit period 7/24/2021 - 10/21/2021, with terminal diagnosis of prostate cancer.					
	7/24/2021 - 10/21/202 Certification and Plan	nt for certification period 21, titled "Hospice of Care" indicated of g ty regarding death and	oal of			
	•	n 9/10/2021 at 2:26 PN r C confirmed that was				
	on 9/14/2021, election benefit period 8/14/20 terminal diagnosis of pumping blood as we Review of a documer "Hospice Certification indicated a goal of".	heart failure (heart not ill as it should). nt dated 8/14/2021, title n and Plan of Care,"	d			
	During an interview o Person G indicated th measurable.	n 9/10/2021 at 1:07 PM nis was somewhat	1,			

(X2) MULTIPLE CONSTRUCTION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		151561		B. WING		09/16/2021	
	OVIDER OR SUPPLIER  D HEART HOSPICE O	F EASTERN INDIANA	1178 FR	ESS, CITY, STA EMONT CO RT, IN 4651	URT SUITE 2		
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REG		I	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
L 548	Continued From pag	e 69		L 548			
L 549	on 9/14/2021, election certification period 8/1 terminal diagnosis of (heart problems relate pressure).  Review of a documer "Hospice Certification evidenced a goal that minimized/controlled effects/origin/treatmed effects/origin/treatmed patient Care Manage measurable or patient 16. Record review for on 9/10/2021, election benefit period 8/29/20 terminal diagnosis of (brain damage most of the service of a documer 8/29/2021 - 11/26/2020 Certification and Plant patient needs would be patient Care Manage measurable goal.  17. During an interview of PM, Medical Director be measurable.  CONTENT OF PLAN	ht dated 8/10/2021, titled and Plan of Care," anxiety/agitation understanding of its nt."  n 9/10/2021at 1:49 PM r confirmed this was not t specific goal.  r patient #14 was composed at the force of 8/29/2021, for 221 - 11/26/2021, with a metabolic encephalopa of the resulting in coma) at for certification period 21, titled "Hospice of Care" indicated of goe met.  n 9/10/2021 at 10:37 A or C confirmed that was sew on 9/14/2021, at 1:48 B confirmed goals should be a con	ith a ease pood d d	L 549			
	CFR(s): 418.56(c)(4)  [The plan of care mus	st include all services					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		' '	(X3) DATE SURVEY COMPLETED	
151561			B. WING		09/16/2021			
	OVIDER OR SUPPLIER  D HEART HOSPICE O	F EASTERN INDIANA			URT SUITE 2			
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L 549	necessary for the pall the terminal illness ar including the following (4) Drugs and treatmeneeds of the patient.	liation and managemen nd related conditions, g:] ent necessary to meet t		L 549				
	This Standard is not met as evidenced by: Based on observation, record review, and interview, the interdisciplinary group (IDG) failed to ensure all patients' plans of care included all drugs and treatment necessary to meet the needs of the patient for 2 of 15 records reviewed (#3, 9).							
	Findings include:  1. An agency policy revised 1/1/2020 titled "Plan of Care Process" indicated " Drug profile including all prescription and over-the-counter drugs, herbal remedies and other alternative treatments that could affect drug therapy The POC [plan of care] includes drugs and treatment necessary to meet the needs of the patient"							
	on 9/16/2021, hospice for election period 8/1 A document dated 8/2 Start of Care" indicate pressure injury (full the un-relieved pressure) tailbone area, two shi internal vaginal wound the vagina. A document dated 8/2	12/2021 titled "RN Hosped the patient had a stanickness wound from with bone exposed on n skin tears on both legd, an unstageable would 13/2021, titled "SN Hos	pice ge 4 her gs, an nd in					
	Subsequent Visit" ind	licated the patient had a	a new					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		, ,	(X3) DATE SURVEY COMPLETED	
		151561		B. WING		09/	16/2021	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STA	TE, ZIP CODE			
HEART T	O HEART HOSPICE O	F EASTERN INDIANA		REMONT CO RT, IN 4651	URT SUITE 2 6			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES IT BE PRECEDED BY FULL REI ENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
L 549	A document dated 8/Subsequent Visit" inconstrength tylenol for particular and strength tylenol for particular and subsequent Visit" incolace for constipation medicated gel) for tree.  A document dated 9/Subsequent Visit" incomg (milligrams) of between titled "Hoof Care" for election pailed to indicate the Tylenol, colace, medicated visits.	ax (taken for constipation 17/2021, titled "SN Hos dicated the patient took pain.  23/2021, titled "SN Hos dicated the patient took part on a wound.  10/2021, titled "SN Hos dicated the patient took patient on a wound.	pice extra  pice / (a  pice 25  Plan /2021	L 549				
	PCM C confirmed the Tylenol, colace, medi wound car treatments care.  3. Record review for on 9/7/2021, election period 7/28/2021 - 10 diagnosis of Parkinso deterioration causing progressive loss of full A home observation at 10:00 AM, at LTC twound care to the rig to cleanse and applie film-forming dressing to help reduce friction	involuntary movements inctioning). was completed on 9/8/2 facility A. RN E perform ht heel using normal sa	ted nefit s and 2021 ned nline film ne did					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		151561		B. WING		09/10	6/2021
	OVIDER OR SUPPLIER  O HEART HOSPICE C	OF EASTERN INDIANA	1178 FR	RESS, CITY, STA REMONT CO RT, IN 4651	URT SUITE 2		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	STATEMENT OF DEFICIENCIES ST BE PRECEDED BY FULL RED DENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
L 549 L 555	heel wound. During to RN E and LTC facility wound care orders, a not know.  Review of a docume "Hospice IDG [interd Comprehensive Asset Update" failed to evid a the right heel wound During an interview of Person G confirmed coordinated with the wound care orders.  COORDINATION OF	the provision of wound of y RN L discussed the current dated 8/26/2021, titled lisciplinary group] essment and Plan of Cadence wound care ordered.  on 9/10/2021 at 10:17 A the nurse should have facility to verify the current services.	urrent did d re rs for M,	L 549			
	system of communic accordance with the procedures, to-] (2) Ensure that the communication provided in accordance of the standard is not be assed on record revision provided in accordance of the system of the syst	evelop and maintain a cation and integration, in hospice's own policies a care and services are nee with the plan of care to the thickness of	and				
	on 9/7/2021, election period 7/28/2021 - 10 diagnosis of Parkinso	r patient #3 was complet n date 4/20/2021, for ber 0/25/2021, with terminal on's Disease (a brain g involuntary movements	nefit				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	E CONSTRUCTION	` '	(X3) DATE SURVEY COMPLETED	
		151561		B. WING		09/1	6/2021	
	OVIDER OR SUPPLIER  D HEART HOSPICE O	F EASTERN INDIANA	1178 FF	RESS, CITY, STATE REMONT CO RT, IN 4651	URT SUITE 2			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REG ENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
L 555	at 10:00 AM, at LTC f wound care to coccy. After wound care was she did not know the (despite just performithe facility nurse told treatment.  During an interview a E confirmed there we orders.  2. Record review for on 9/14/2021, election certification period 8/terminal diagnosis of (heart problems relate pressure).  Review of a documer "Hospice Certification an order to teach about Review of a documer [skilled nurse] Hospic indicated patient had she got tangled up in document failed to evoxygen safety.  During an interview o Patient Care Manage documentation of fall	was completed on 9/8/2 facility A. RN E perform of the performance of the perfo	ed e). cated lers leters ward  I, RN are eted leted leters leted leters leted leters l	L 555	DEFICIENC			
L 588	~	fety should include fall		L 588				

NAME OF PROVIDER OR SUPPLIER  HEART TO HEART HOSPICE OF EASTERN INDIAN  SUMMARY STATEMENT OF DEPTICIENCES  (EACH DEPTICIENCY MUST BE PRECEDED BY PILL REGULATORY TAG  OR LSC DENTIFYING INFORMATION)  L 588  Continued From page 74  CFR(s): 418.64  A hospice must routinely provide substantially all core services include nursing services, medical social services, and counseling. The hospice may contract for physician services as specified in paragraph (a) of this section.  This Standard is not met as evidenced by: Based on record review and interview, the agency failed to ensure all core nursing services were routinely and directly provided by its own employees.  Findings include:  1. An agency policy revised 8/1/2010 titled "Personnel Classifications and Back-Up Coverage" Indicated ** Agency will routinely provide substantially all core services directly by hospice employees.  Findings include:  1. An agency policy revised 8/1/2010 titled "Personnel Classifications and Back-Up Coverage" Indicated ** Agency will routinely provide substantially all core services directly by hospice employees. However, an agency may use contracted staff, if necessary, to supplement hospice employees. However, an agency may enter into a written arrangement for the provision of core services include Unantifylated periods of high patient loads Staffing shortages due to illness, or other short-term temporary situations Temporary travel of a patient outside of the agency's service area*	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		, ,	(X3) DATE SURVEY COMPLETED	
HEART TO HEART HOSPICE OF EASTERN INDIANA    T178 FREMONT COURT SUITE 2   ELKHART, IN 48516			151561		B. WING		09/1	6/2021	
SUMMARY STATEMENT OF DEFICIENCIES   DEFICIENCY   PREFIX TAG   PROVIDERS PLAN OF CORRECTION   CAMPACTURE   CACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY   PREFIX TAG   PROVIDERS PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE      L 588			E EASTEDN INDIANA			•			
L 588  Continued From page 74  CFR(s): 418.64  A hospice must routinely provide substantially all core services directly by hospice employees. These services include nursing services, medical social services, and counseling. The hospice may contract for physician services as specified in paragraph (a) of this section.  This Standard is not met as evidenced by: Based on record review and interview, the agency failed to ensure all core nursing services were routinely and directly provided by its own employees.  Findings include:  1. An agency policy revised 8/1/2010 titled "Personnel Classifications and Back-Up Coverage" Indicated " Agency will routinely provide substantially all core services directly by hospice employees. However, an agency may use contracted staff, if necessary, to supplement hospice employees in order to meet the needs of patients under other non-routine circumstances Circumstances under which an agency may enter into a written arrangement for the provision of core services include. Unanticipated periods of high patient loads Staffing shortages due to illness, or other short-term temporary situations Temporary travel of a patient outside of the agency's service area"	HEART IC	D HEART HOSPICE O	F EASTERN INDIANA						
CFR(s): 418.64  A hospice must routinely provide substantially all core services directly by hospice employees. These services must be provided in a manner consistent with acceptable standards of practice. These services include nursing services, medical social services, and counseling. The hospice may contract for physician services as specified in paragraph (a) of this section.  This Standard is not met as evidenced by: Based on record review and interview, the agency failed to ensure all core nursing services were routinely and directly provided by its own employees.  Findings include:  1. An agency policy revised 8/1/2010 titled "Personnel Classifications and Back-Up Coverage" Indicated " Agency will routinely provide substantially all core services directly by hospice employees. However, an agency may use contracted staff, if necessary, to supplement hospice employees in order to meet the needs of patients under other non-routine circumstances Circumstances under which an agency may enter into a written arrangement for the provision of core services include Unanticipated periods of high patient loads Staffing shortages due to illness, or other short-term temporary situations Temporary travel of a patient outside of the agency's service area"	PRÉFIX	(EACH DEFICIENCY MUS	T BE PRECEDED BY FULL REG		PREFIX	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A	HOULD BE	COMPLETION	
2. During an interview with the business office manager (BOM) K on 9/10/2021 at 12:00 PM, a sample of employee records and the document titled "Eastern Indiana Phone List" were reviewed.  BOM K confirmed the "Eastern Indiana Phone	L 588	CFR(s): 418.64  A hospice must routing core services directly. These services must consistent with accept These services included social services, and commay contract for physical paragraph (a) of the This Standard is not Based on record reviet failed to ensure all concutinely and directly employees.  Findings include:  1. An agency policy re "Personnel Classification Coverage" Indicated provide substantially shospice employees. Hospice employees in patients under other into a written are of core services included for this patient loads illness, or other short. Temporary travel of a agency's service area.  2. During an interview manager (BOM) K on sample of employeer titled "Eastern Indiana."	nely provide substantiall by hospice employees be provided in a manne stable standards of pracede nursing services, me counseling. The hospice sician services as specific section.  met as evidenced by: ew and interview, the agree nursing services were provided by its own  evised 8/1/2010 titled tions and Back-Up  " Agency will routinely all core services directly however, an agency may if necessary, to suppler norder to meet the needer non-routine circumstate which an agency may rangement for the provide Unanticipated per Staffing shortages dusterm temporary situation patient outside of the a"  w with the business official 9/10/2021 at 12:00 PM records and the docume a Phone List" were reviewed.	gency re  / y by ay ment ds of ances ay ision iods ate to ons  re  //, a ent ewed.	L 588				

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NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STA	TE, ZIP CODE		
HEART TO	D HEART HOSPICE O	F EASTERN INDIANA			URT SUITE 2		
			ELKHA	RT, IN 4651	<b>6</b>		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	FATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REC ENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
L 588	Continued From page	e 75		L 588			
		list of all agency employ	yees,				
		was not a direct agend					
	employee, the agency	y shared staff with Entit	y H,				
		wouldn't be on the emp	- 1				
		ey've always done it. W	hen				
	queried, she also indi						
	•	no unusual circumstanc					
	H2H agencies shared	of outside staff, and the	9				
	•	age nurses, on-call staf	fand				
		onally, she confirmed the					
		tient care manager (PC					
	was an employee of e	• ,	,				
	at 10:00 AM, framed on the agency's lobby. Heart Hospice letterhous Authority" indicated ". Manager (PCM)/Superto carry out the day-to include oversight of the components for this at the Patient Care Man. Nurse, [person X]. Alternate Supervising 4. A document receive "Eastern Indiana Pho-	ed on 9/7/2021 titled ne List" included name:	ved t to f are ated s to linical of g				
	contact information fo	r 15 agency employees	S.				
	titled "Agency Visits F visit schedules with vi (out of current census 7/28/2021 - 9/14/2022 23 of 78 nursing visits H2HN nurses.	1. The document indica s (29%) were made by	ents' nes ted				
	6. During an interview	on 9/10/2021 at 10:17	AM,				

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		151561		B. WING		09/1	6/2021	
	OVIDER OR SUPPLIER  O HEART HOSPICE O	F EASTERN INDIANA	1178 FR	ESS, CITY, STA EMONT CO RT, IN 4651	URT SUITE 2	·		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REG ENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH	ROVIDER'S PLAN OF CORRECTION H CORRECTIVE ACTION SHOULD BE E-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
L 588	when queried, PCM Cemployees was alread.  7. During an interview when queried if H2HN employee, BOM K inconthern [H2HN] licenters.  8. During an interview H2HN RN R indicated admission nurse, they Valparaiso, Mishawak opened the Loganspos saw patients for the Moffices.  9. During an interview the document "Agency range 7/28/2021 - 9/1 BOM K, who confirme non-agency nurses produring that date range this was how it was a extraordinary caused.  10. Review of an age signed by the agency on behalf of both age Services Contract Agency and Heart to Heart Hold LLC [H2HE]" indicate provided (but not limit nursing services, inclusion, and licensed provided (but not limit nursing services, inclusion, and licensed provided (but not limit nursing services, inclusion, and licensed provided (but not limit nursing services, inclusion, and licensed provided (but not limit nursing services, inclusion). Review of an agency being surveyed A was the administrated.	C indicated the list of ag dy submitted.  v on 9/13/2021 at 2:29 In RN R was an agency dicated " She is under the seem of t	PM, r our  PM, art, ey just arily  PM, e with d 12 ts hat g staff. ad 021, hal t to city H] ha, ey d sto the strator	L 588				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		151561		B. WING		09/1	6/2021	
	OVIDER OR SUPPLIER O HEART HOSPICE O	F EASTERN INDIANA	1178 FR	ESS, CITY, STA EMONT CO RT, IN 4651	URT SUITE 2			
(X4) ID PREFIX TAG			GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
L 588	on behalf of both age Services Contract Agi Heart Hospice of Nord and Heart to Heart Ho LLC" indicated Entity (but not limited to) so services, including RN being surveyed, and at the administrator for but 12. Review of an age signed by administratillegible signature dat Heart to Heart Hospic (Entity N), titled "Profe Agreement Between Northeast Indiana, LL Hospice of Eastern In N hospice agency prosocial worker and nur and LPNs to the ager 13. Record review fo on 9/7/2021, election period 7/28/2021 - 10 diagnosis of senile de Review of a documen "RN Hospice Start of completed by Person During an interview of Business Office Mananot an employee of Heastern Indiana.  14. Record review fo on 9/7/2021, election period 7/28/2021 - 10 diagnosis of Parkinson Par	ncies, titled "Profession reement Between Hear thwest Indiana, LLC [Enospice of Eastern Indianal I hospice agency provincial worker and nursing Ns and LPNs to the age agency administrator A both agencies.  Incy document dated arror A 2/26/2021, and an ed 3/3/2021 on behalf of the of Northeast Indianal essional Services Control Heart to Heart Hospice C and Heart to Heart diana, LLC" indicated Envided (but not limited to sing services, including the property of the provided (but not limited to sing services, including the provided (but not limited to sing services, including the provided (but not limited to sing services, including the provided (but not limited to sing services, including the provided (but not limited to sing services, including the provided (but not limited to sing services, including the provided (but not limited to sing services, including the provided (but not limited to sing services, including the provided (but not limited to sing services, including the provided (but not limited to sing services, including the provided (but not limited to sing services, including the provided (but not limited to sing services, including the provided (but not limited to sing services, including the provided (but not limited to sing services, including the provided (but not limited to sing services and the provided (but not limited to sing services) and the provided (but not limited to sing services) and the provided (but not limited to sing services) and the provided (but not limited to sing services) and the provided (but not limited to sing services) and the provided (but not limited to sing services) and the provided (but not limited to sing services) and the provided (but not limited to sing services) and the provided (but not limited to sing services) and the provided (but not limited to sing services) and the provided (but not limited to sing services) and the provided (but not limited to sing services) and the provided (but not limited to sing services) and the provided (but not limited to sing servi	t to ntity I] na, ded ency was  nd of LLC ract of Entity o) g RNs eted nefit al t d t f, the R is of	L 588				

` '		(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE			LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		151561		B. WING		09/	16/2021	
	OVIDER OR SUPPLIER  O HEART HOSPICE O	F EASTERN INDIANA	1178 FR	ESS, CITY, STA EMONT CO RT, IN 4651	URT SUITE 2			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES BY BE PRECEDED BY FULL RE JENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
L 588	progressive loss of full Review of a documer On Call PRN Visit" ever Person JJ. During an interview of Business Office Manaemployee of Heart to Indiana.  15. Record review foon 9/15/2021, election period 8/23/2021 - 11 diagnosis of heart fail blood as well as it should review of a documer "SN Hospice Subseque completed by Person During an interview of Business Office Manaemployee of Heart to Indiana.  16. Record review foon 9/13/2021, election benefit period 7/24/20 terminal diagnosis of Review of a documer "RN Hospice Start of completed by Person During an interview of Business Office Manawas not an employee of Eastern Indiana.  17. Record review for Eastern Indiana.	anctioning).  Int dated 8/1/2021, titled videnced a visit completion 9/14/2021 at 2:44 PM ager Person HH was not Heart Hospice of Eastern Heart Heart Hospice of Eastern Heart Heart Hospice of Eastern Heart	ted by  I, the ot an ern  eted enefit eal  ed a visit  I, the ot an ern  bleted enefit end  I, the ot an ern  d t  I, the JJ.  blice	L 588				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	LE CONSTRUCTION	` '	(X3) DATE SURVEY COMPLETED	
		151561		B. WING		09/1	6/2021	
	OVIDER OR SUPPLIER O HEART HOSPICE O	F EASTERN INDIANA	1178 FR	ESS, CITY, STA EMONT CO RT, IN 4651	URT SUITE 2	·		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REI ENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
L 588	certification period 8/r terminal diagnosis of (heart problems relate pressure).  Review of a documer and Plan of Care" dat visit completed by Pe  During an interview o Business Office Mana was not an employee of Eastern Indiana.  18. Record review fo on 9/10/2021, election benefit period 8/29/20 terminal diagnosis of (brain damage most of Review of a documer "RN Hospice Start of completed by Person  During an interview o Business Office Mana was not an employee of Eastern Indiana.  19. Record review fo on 9/10/2021, election benefit period 8/10/20 terminal diagnosis of Review of a documer Hospice Subsequent completed by Person  During an interview o During an interview o on 9/10/2021, election benefit period 8/10/20 terminal diagnosis of	not dated 8/29/2021, title Care" evidenced a visit v.  n 9/14/2021 at 2:44 PM ager confirmed person of Heart to Heart Hosp of the resulting in coma) at dated 8/29/2021, title Care" evidenced a visit v.  n 9/14/2021 at 2:44 PM ager confirmed person of Heart to Heart Hosp of the resulting in coma) at dated 8/29/2021, title Care" evidenced a visit v.  n 9/14/2021 at 2:44 PM ager confirmed Person of Heart to Heart Hosp of the resulting in coma) at dated 8/29/2021, title Care" evidenced a visit v.  n 9/14/2021 at 2:44 PM ager confirmed Person of Heart to Heart Hosp of the art to Heart Hosp of t	cation da  If, the Roice  Deted dathy  If, the Voice  Deted dathy  If, the Voice	L 588				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIEF AND PLAN OF CORRECTION IDENTIFICATION NUM			1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		151561		B. WING		09	/16/2021
NAME OF PR	OVIDER OR SUPPLIER	•	STREET ADDR	ESS, CITY, STA	TE, ZIP CODE		
HEART TO	O HEART HOSPICE	OF EASTERN INDIANA		EMONT CO RT, IN 4651	URT SUITE 2 6		
(X4) ID PREFIX TAG	(EACH DEFICIENCY M	/ STATEMENT OF DEFICIENCIES UST BE PRECEDED BY FULL REI IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
L 588	was not an employ of Eastern Indiana.  Review of a docum Hospice Subseque completed by Person During an interview Business Office Mawas not an employ of Eastern Indiana.  20. During an inter AM, with Person Goprovided on call se Indiana and was not Heart Hospice of Eprofessional Market Professional Market	nent dated 9/7/2021, titled nt Visit" evidenced a visit on C.  y on 9/14/2021 at 2:44 PM anager confirmed Person ee of Heart to Heart Hosp crview on 9/15/2021, at 10: confirmed Person QQ rvices for the entire state of an employee of Heart to astern Indiana.	"SN  1, the C pice  25	L 588			
	professional manage hospice services purificipation, and necessary for hospication participating Medic to §418.100 and §4  This Standard is in Based on observation interview, the agen medical management care for 1 of 1 patie in a Long Term Care  Findings include:	assume responsibility for gement of the resident's rovided, in accordance with and the hospice condition of make any arrangements sice-related inpatient care are/Medicaid facility account 18.108.  ot met as evidenced by: ion, record review and cy failed to maintain over ent, as detailed in the plarents who received a home	ons s in a rding  all n of visit				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	LE CONSTRUCTION	` '	(X3) DATE SURVEY COMPLETED	
		151561		B. WING		09/1	6/2021	
	OVIDER OR SUPPLIER  D HEART HOSPICE O	F EASTERN INDIANA	1178 FR	RESS, CITY, STA REMONT CO RT, IN 4651	URT SUITE 2			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REC ENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
L 762	"Hospice Services Ag agreement with LTC f Conditions 1.2 Plar of care would be a co IDT [Interdisciplinary in patient, and the physi indicated the hospice medical direction and patient". Section 1.3 would maintain profes responsibility/coordinatensure services are ful and effective manner. Care."  Record review for pat 9/7/2021, election dat period 7/28/2021 - 10 diagnosis of Parkinso deterioration causing progressive loss of ful A home visit observat 9/8/2021 at 10:00 AM Facility A. The patien (on a 0-10 pain scale, worst pain ever), and and daily routine. He less.  Review of documents {interdisciplinary ground Assessment and Plar dated 7/15/2021, 7/29 8/26/2021, and 9/9/20 continued to experient During an interview of Patient Care Manage	greement" indicated an facility A. The "Terms a an of Care," indicated the ollaboration with " Hosteam], the facility staff, ician. Section 1.3(a) was responsible for the management of the 3(d) indicated the hosp essional management ation of Facility services urnished in a safe, time according to the Plantation of Facility services urnished in a safe, time according to the Plantation of Facility services urnished in a safe, time according to the Plantation of Facility services urnished in a safe, time according to the Plantation of Facility services urnished in a safe, time according to the Plantation of Facility services (a brain involuntary movements inctioning).  Ition was completed on a treported a pain score and that pain disrupted his identified a pain goal of that pain disrupted his identified a pain goal of the plantation of Care Update Report 2/2021, 8/15/2021, 2/21 indicated patient #3 are uncontrolled pain.	e plan spice the e "	L 762				
	Patient Care Manage		3's					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		151561		B. WING		09/1	6/2021	
	OVIDER OR SUPPLIER  O HEART HOSPICE O	F EASTERN INDIANA	1178 FR	ESS, CITY, STA EMONT CO RT, IN 4651	URT SUITE 2			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REI ENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
L 762	allow the hospice to it dosage unless there to pain medications take evidence the professi management of patie.  During an interview of Medical Director B condificulty with LTC facility.	ncrease the pain medic were a number of as ne en. The agency failed t onal and medical	eeded o	L 762				