PRINTED: 12/06/2021 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00		(X3) DATE SURVEY COMPLETED			
AND PLAN OF CORRECTION IDENTIFICATION 151561		IDENTIFICATION NUMBER 151561	A. BUILDING 00 B. WING			11/10/2021		
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP COD REMONT COURT SUITE 2			
HEART T	O HEART HOSPIC	CE OF EASTERN INDIANA LLC		ELKHA	RT, IN 46516			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION			ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG			PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION DATE	
L 0000							22	
Bldg. 00	This was a revisit for a federal hospice recertification survey conducted on 9/16/21. September 7, 8, 9, 10, 13, 14, 15, and 16, 2021		L 0000					
	Survey dates: Nove	mber 8, 9, and 10, 2021						
	Provider ID: 15156	1						
	corrected, 12 Stand	2 of 2 Conditions were ards were corrected, and 1 ed. 1 new standard was cited.						
L 0550 Bldg. 00	necessary for the of the terminal illn including the follo (5) Medical suppli	must include all services palliation and management ess and related conditions, wing:] es and appliances						
	necessary to meet the needs of the patient. Based on observation, record review and interview, the agency failed to ensure all durable medical equipment was included in the plan of care for 2 of 3 records reviewed (#1, 3). Findings include:		L 05	550	The Executive Director will be responsible to help ensure this standard has been met ensurin that the all durable medical equipment will be included on to patient's plan of care. The Executive Director (ED) ar	s ing the	ng the	
	Process" indicated equipment" are 1 2. Observed a nurs on 11/9/2021 at 9:0	icy titled "Care Planning" " medical supplies and required on the plan of care. ing visit with patient number 1 0 am. The patient had a air, a hospital bed, a specialty			Patient Care Manager (PCM) educated all RNCMs on 11/10/2021 and 11/11/2021 Policy TX .06 "Plan of Care Process" indicating the plan of care will be individualized to meet all needs of the patient including, but not			

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

TITLE

(X6) DATE

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

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: FXOI12 Facility ID: 010002 If continuation sheet Page 1 of 4

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AND PLAN OF CORRECTION STREET ADDRESS, CITY, STATE, ZIP COD	STATEMENT OF DEFICIENCIES X1) P		X1) PROVIDER/SUPPLIER/CLIA	X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
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Event ID:

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Facility ID: 010002

If continuation sheet

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PRINTED: 12/06/2021 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 11/10/2021 151561 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1178 FREMONT COURT SUITE 2 HEART TO HEART HOSPICE OF EASTERN INDIANA LLC ELKHART. IN 46516 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE L 0579 418.60(a) PREVENTION Bldg. 00 The hospice must follow accepted standards of practice to prevent the transmission of infections and communicable diseases. including the use of standard precautions. Based on observation, record review, and L 0579 The Executive Director will be 12/15/2021 interview, the hospice failed to ensure all staff responsible to help ensure this followed infection control practices for 1 of 1 standard has been met ensuring home visits observed (#1). that the all staff will practice proper hand hygiene techniques in Findings include: the prevention and spread of infection. Review of an agency policy dated 11/01/2020 titled "Hand Hygiene" indicated " ... practice The Executive Director (ED) and proper hand hygiene techniques in the prevention Patient Care Manager (PCM) and spread of infection per CDC guidelines ... if educated all staff on 11/11/2021 hands are not visibly soiled, staff may use an IC.03 "Hand Hygiene" indicate the alcohol-based hand rub ... in the clinical practice of proper hand washing or situations described ... after removing gloves" use of hand sanitizer after removing gloves. 1:1 Review of the CDC web page reference, competencies with each RNCM https://www.cdc.gov/handhygiene/providers/gui that is providing wound care to deline.html stated "... Healthcare personnel should multiple wound sites to ensure use an alcohol-based hand rub or wash with soap hand washing is occurring or the and water for the following clinical indications ... use of hand sanitizer when Immediately after glove removal" removing gloves will be completed by 12/15/2021. During a home visit on 11/9/2021 at 9:30 AM, RN (registered nurse) B was observed completing an Monitoring will be completed by a assessment of and providing wound care to review of competencies completed patient #1. RN B failed to wash hands or use on all new hires for 3 months or hand sanitizer in between glove changes, as until 100%, compliance has been follows: met. Results will be reported the QAPI committee and reported to RN B was observed donning gloves, removed the Governing Body annually. vaginal fistula (an abnormal opening that connects vagina to another organ) dressing and cleaned wound. Removed gloves. Rolled patient

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to left side. Applied gloves. Removed dressing to

Event ID:

FXOI12

Facility ID: 010002

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

PRINTED: 12/06/2021 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 151561	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 11/10/2021		
NAME OF PROVIDER OR SUPPLIER HEART TO HEART HOSPICE OF EASTERN INDIANA LLC			STREET ADDRESS, CITY, STATE, ZIP COD 1178 FREMONT COURT SUITE 2 ELKHART, IN 46516				
(X4) ID PREFIX		SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5) COMPLETION
TAG	REGULATORY OR			TAG DEFICIENCY)		TUTTE	DATE
	clean dressings. RN use hand sanitizer a	nd cleaned wound. Applied N B failed to wash hands or fter removing gloves.					
	when asked if staff	should wash hands or use removing gloves, patient care					

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