STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 151587		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 00 COMPLETED B. WING 01/05/2022			ETED		
	PROVIDER OR SUPPLIE	R CE OF CENTRAL INDIANA LLC	•	1385 N	ADDRESS, CITY, STATE, ZIP COD BALDWIN AVE N, IN 46952		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION ID PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE				
L 0000							
Bldg. 00		Post Condition revisit of a tion and complaint survey.	L 00	000			
	Survey Date: 1/5/2	2					
	Facility Number: 0	003966					
	Provider Number:	151587					
	Unduplicated admissions past 12 months: 613 Current home patients: 47 Current facility patients: 72						
	Quality review con	npleted by area 2 on 1/10/22.					
L 0524 Bldg. 00	ASSESSMENT The comprehensi identify the physic emotional, and sp	OMPREHENSIVE ive assessment must cal, psychosocial, pritual needs related to the nat must be addressed in					
	well-being, comfo the dying process						
	interview, the hosp Registered Nurse f pain level and med comprehensive ass observations (#1). Findings include:	ion, record review, and pice failed to ensure the failed to assess the patient's lications, as part of the essment, for 1 of 1 home visit "Patient Assessments,"	L 05	24	The Executive Director will b responsible to help ensure the the comprehensive assessmidentifies the physical, psychosocial, emotional, and spiritual needs related to the terminal illness, to promote thospice patient's well-being comfort, and dignity through the dying process. Date the deficiency will be	nat ent d	02/09/2022

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

TITLE

(X6) DATE

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

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 151587		r í	JILDING	instruction 00	(X3) DATE COMPL 01/05/	ETED		
		ROVIDER OR SUPPLIEF	RE OF CENTRAL INDIANA LLC		1385 N	ADDRESS, CITY, STATE, ZIP COD BALDWIN AVE N, IN 46952		
	(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ιΤΕ	(X5) COMPLETION DATE
		identify physical, pospiritual needs related be addressed in ord well-being, comford dying process A assessment based of of practice will include treatment characted descriptors patter of pain frequency impact of pain from treatment that prostrategies and factor symptoms associated current medication. The clinical record 1/5/22 at 10:30 AM election date of 4/2 of cerebral atheroses hardening of the way. During a home visit Patient #1, Register completing wound assess the patient's the visit.	sychosocial, emotional, and ted to terminal illness that will er to promote the patient's t, and dignity throughout the comprehensive pain in accepted clinical standards ude history of pain and its eteristics of pain intensity erns location and radiation by timing duration actors such as activities, care, ecipitate or exacerbate pain ers to reduce pain additional ed with painnausea pain end with painnausea pain end indicated a hospice 1/21 with a primary diagnosis elerosis (thickening and ealls of the arteries in the brain). It on 1/6/22 at 12:00 PM with red Nurse B was observed care. The nurse failed to pain and medications during expansive assessment,			corrected 02/09/2022 The Area Clinical Manager (ACM) and/or Patient Care Manager (PCM) will in-service all nursing staff within 30 day on Policy PE.1 Patient Assessments related to assessment of pain/symptoms to include characteristics of pain/symptoms, such as: intensity of pain/symptoms, utilization of a standardized scale, descriptors of pain/symptoms, location and radiation of pain/symptoms, frequency of pain/symptoms, frequency of pain/symptoms timing and duration of pain/symptoms, impact of pain/symptoms, impact of pain/symptoms, on quality of life, factors such as activities care or treatment that precipitate or exacerbate pain/symptoms, strategies af factors that reduce pain/symptoms, amount of medication needed and additional symptoms associated with pain/symptoms. All nursing staff will have a supervisory visit 1:1 within 60 days with Area Clinical Manager (ACM) and/or Patient Care Manager (PCM) to ensure that the comprehensive assessment and reassessment of patient needs identified, to include it not limited to pain/symptoms such as intensity of	ys ms, d d s, fs, nd	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 151587		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 01/05/2022	
NAME OF I	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD BALDWIN AVE	
HEART 1	O HEART HOSPIC	E OF CENTRAL INDIANA LLC		N, IN 46952	_
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE DATE
				pain/symptoms, utilization of standardized scale, descript of pain/symptoms, patterns pain/symptoms, location and radiation of pain/symptoms, frequency of pain/symptoms timing and duration of pain/symptoms, impact of pain/symptoms on quality of life, factors such as activitie care or treatment that precipitate or exacerbate pain/symptoms, strategies a factors that reduce pain/symptoms, amount of medication needed and additional symptoms associated with pain/symptoms. Monitoring will include a 100 audit by the Area Clinical Manager (ACM) or designee all active patients and all new admissions to ensure all comprehensive assessment and reassessments address pain needs. When 100% compliance has been met for consecutive months, the Area Clinical Manager (ACM)/designee will audit 10 of all records quarterly. Trei identified during these audit will be reviewed in QAPI no less than quarterly and the plan of correction and/or training will be updated as indicated to ensure sustained improvement.	f a ors of d s,

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Event ID:

PD1P12 Facility ID: 003966

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 151587		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE A. BUILDING 00 COMPLETED B. WING 01/05/2022			ETED		
	PROVIDER OR SUPPLIER		1	1385 N	ADDRESS, CITY, STATE, ZIP COD BALDWIN AVE N, IN 46952		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	P	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.TE	(X5) COMPLETION DATE
L 0579 Bldg. 00	of practice to previnfections and conincluding the use of Based on observation interview, the hospitemployees followed policies and proceds for 1 of 1 home visions include: A policy titled "Inferindicated" The Aprogram will be base Current federal, statement federal, statem	ection Control Program," gency's infection control and on the following criteria are, and local laws and Infection Control Program will anting appropriate preventative amenting appropriate measures Management will be adinating all activities related atrol Program" and Hygiene," indicated "All ling patient/client care will at hygiene techniques if by soiled, staff may use an	L 05'	79	="" b=""> ="" b=""> b=""> b=""> /b> /b Monitoring will be completed by review of competencies completed on all new hires for 3 months of until 100%, compliance has be met. Results will be reported to the QAPI committee and report to the Governing Body annual Trends identified during these audits will be reviewed in QAPI less than quarterly and the placorrection and/or training will be updated as indicated to ensure sustained improvement.	leted or een to rted illy. PI no an of be	02/09/2022

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 151587		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	COMP	ESURVEY LETED 5/2022	
	PROVIDER OR SUPPLIE	R CE OF CENTRAL INDIANA LLC	1385 N	ADDRESS, CITY, STATE, ZIP CO I BALDWIN AVE DN, IN 46952	DD	
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION
IAU	Decontaminate har patient's/client's int worn Decontambody fluids or exernonintact skin, and not visibly soiled moving from a combody site during particular decontaminate har objects [including immediate vicinity] The clinical record 1/5/22 at 10:30 AM election date of 4/2 of cerebral atheroschardening of the way at the completing wound not completing wound not completing har changes four times Certified Nurse Aibath and feeding the observed putting so proceeded to feed to completing hand he decompleting hand he decompleting an interview asked if staff shoul changing gloves, a	ands after contact with sact skin, even when gloves are sinate hands after contact with etions, mucous membranes, wound dressings if hands are Decontaminate hands if staminated body sit to a clean stient/client care ands after contact with inanimate medical equipment] in the of the patient/client" of Patient #1 was reviewed on M and indicated a hospice 21/21 with a primary diagnosis clerosis (thickening and alls of the arteries in the brain). it on 1/6/22 at 12:00 PM with red Nurse B was observed care. The nurse was observed and hygiene between glove. During the same home visit, de C was observed completing a patient. The aide was ocks on the patient and then the same patient, without	TAG			DATE
S 0000 Bldg. 00	This was a state reand complaint surv	visit of a hospice re-licensure rey.	S 0000			

State Form Event ID: PD1P12 Facility ID: 003966 If continuation sheet Page 5 of 10

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 151587		A. BUILDING 00 COMPLETED B. WING 01/05/2022					
		101007	D. W.		DDDEGG CHTV GTATE TID GOD	01/00/	2022
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD BALDWIN AVE		
HEART T	O HEART HOSPIC	E OF CENTRAL INDIANA LLC			N, IN 46952		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	•	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	F	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION DATE
TAG	Survey Date: 1/5/22			TAU			DATE
	-						
	Facility Number: 00	03966					
	Provider Number: 1	51587					
	Unduplicated admis	sions past 12 months: 613					
	Current home patier						
	Current facility patie	ents: 72					
	Quality review com	pleted by area 2 on 1/10/22.					
S 0524	418.54(c)						
D. 1 . 00	CONTENT OF CO	MPREHENSIVE					
Bldg. 00	ASSESSMENT	/e assessment must					
	identify the physic						
		iritual needs related to the					
		at must be addressed in					
	-	he hospice patient's					
	the dying process.	t, and dignity throughout					
	,g p		S 0524		The Executive Director will b	e	02/09/2022
					responsible to help ensure that		
					the comprehensive assessm	ent	
					identifies the physical,	,	
					psychosocial, emotional, and spiritual needs related to the		
					terminal illness, to promote t		
					hospice patient's well- being		
					comfort, and dignity through	out	
					the dying process. Date the deficiency will be		
					corrected 02/09/2022		
					The Area Clinical Manager		
					(ACM) and/or Patient Care		
					Manager (PCM) will in-service		
					all nursing staff within 30 day on Policy PE.1 Patient	/S	
					Assessments related to		

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	IT OF DEFICIENCIES OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 151587	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 01/05/2022
	ROVIDER OR SUPPLIER	R CE OF CENTRAL INDIANA LLC	1385 N	ADDRESS, CITY, STATE, ZIP COI I BALDWIN AVE DN, IN 46952	D
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE COMPLETION DATE
				assessment of pain/sympto include characteristic pain/symptoms, such a intensity of pain/symptoms, such a intensity of pain/symptoms as action of pain/symptoms, location radiation of pain/symptoms, location radiation of pain/symptoms, impact pain/symptoms, impact pain/symptoms, impact pain/symptoms, on qual life, factors such as action care or treatment that precipitate or exacerbat pain/symptoms, strateg factors that reduce pain/symptoms, amount medication needed and additional symptoms associated with pain/symptoms. All nut staff will have a supervivisit 1:1 within 60 days. Area Clinical Manager (and/or Patient Care Man (PCM) to ensure that the comprehensive assessing and reassessment of pain/symptoms, utilizated standardized scale, desof pain/symptoms, location radiation of pain/symptoms, patting and duration of pain/symptoms, location radiation of pain/symptoms.	cs of s: oms, dized as of an and oms, otoms, t of lity of divities, te gies and at of l rsing isory with the ACM) mager e ment atient lude but ptoms dion of a scriptors erns of on and oms,

State Form Event ID: PD1P12 Facility ID: 003966 If continuation sheet Page 7 of 10

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	T OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER 151587	A. BUILDING B. WING	00	COMPLETED 01/05/2022
NAME OF PROVIDER OR SUPPLIER HEART TO HEART HOSPICE OF CENTRAL INDIANA LLC			1385 N	ADDRESS, CITY, STATE, ZIP COD BALDWIN AVE N, IN 46952	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
IAU	REGULATORI UK	LEC IDENTIF THE INTURNICATION	IAU	pain/symptoms, impact of pain/symptoms on quality of life, factors such as activities care or treatment that precipitate or exacerbate pain/symptoms, strategies at factors that reduce pain/symptoms, amount of medication needed and additional symptoms associated with pain/symptoms. Monitoring will include a 100 audit by the Area Clinical Manager (ACM) or designee all active patients and all new admissions to ensure all comprehensive assessments and reassessments address pain needs. When 100% compliance has been met for consecutive months, the Area Clinical Manager (ACM)/designee will audit 10 of all records quarterly. Treridentified during these audits will be reviewed in QAPI no less than quarterly and the plan of correction and/or training will be updated as indicated to ensure sustaine improvement. ="" span=""> bthe> bmonitoring> span=""> bthe> bmonitoring> span=""> bthe> bmonitoring> span=""> span	% of v s any r 3 a % nds s
				="" b=""> ="" b="">	

State Form Event ID: PD1P12 Facility ID: 003966 If continuation sheet Page 8 of 10

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 151587		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING (X3) DATE SURVE COMPLETED 01/05/2022			LETED		
	PROVIDER OR SUPPLIER	E OF CENTRAL INDIANA LLC		1385 N	ADDRESS, CITY, STATE, ZIP COD BALDWIN AVE N, IN 46952		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	NTE.	(X5) COMPLETION DATE
S 0579 Bldg. 00	of practice to previnfections and comincluding the use of Based on observation interview, the hospitemployees followed policies and procede for 1 of 1 home visions include: A policy titled "Inferindicated"The Aprogram will be base Current federal, state regulations The include Implement procedures implement to control infection responsible for coor to the Infection Control infection Control infection control infection responsible for coor to the Infection Control infection Con	ection Control Program," gency's infection control ed on the following criteria e, and local laws and infection Control Program will nting appropriate preventative ementing appropriate measures Management will be dinating all activities related trol Program" ad Hygiene," indicated "All ing patient/client care will I hygiene techniques if y soiled, staff may use an rub for routinely nds in all other clinical below Alternatively, staff th an antimicrobial soap and situations described below	S 03	579	="" b=""> The Executive Director will be responsible to help ensure the accepted standards of practice to prevent the transmission of infections at communicable diseases, including the use standard precautions are followed. The Executive Director will help ensure that all staff practice proper hand hygiene techniques in the prevention and spread of infection and communicable diseases. The Area Clinical Manager (ACM) and/or Patient Care Manager (PCM) will in-service all staff within 30 days on Policy IC.03 Hand Hygiene indicating the practice of proper hand washing or use hand sanitizer to include proper infection control before and after removing gloves. A staff will have a supervisory visit 1:1 within 60 days with Area Clinical Manager (ACM) and/or Patient Care Manager (PCM) and staff will demonstrate compliance with the standard compliance wit	of ore the	02/09/2022

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 151587		· /	ILDING	nstruction 00	(X3) DATE COMPL 01/05/	ETED	
NAME OF PROVIDER OR SUPPLIER HEART TO HEART HOSPICE OF CENTRAL INDIANA LLC			1385 N	ADDRESS, CITY, STATE, ZIP COD BALDWIN AVE N, IN 46952			
	SUMMARY (EACH DEFICIENT REGULATORY OF body fluids or exert nonintact skin, and not visibly soiled a moving from a combody site during part Decontaminate han objects [including rimmediate vicinity] The clinical record 1/5/22 at 10:30 AM election date of 4/2 of cerebral atherose hardening of the way During a home visit Patient #1, Register completing wound not completing wound not completing han changes four times. Certified Nurse Aid bath and feeding the observed putting so proceeded to feed to completing hand hy	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION etions, mucous membranes, wound dressings if hands are Decontaminate hands if taminated body sit to a clean tient/client care ds after contact with inanimate medical equipment] in the of the patient/client" of Patient #1 was reviewed on I and indicated a hospice 1/21 with a primary diagnosis elerosis (thickening and alls of the arteries in the brain). t on 1/6/22 at 12:00 PM with red Nurse B was observed care. The nurse was observed d hygiene between glove During the same home visit, le C was observed completing a e patient. The aide was cks on the patient and then the same patient, without				py a control or to control or	(X5) COMPLETION DATE
	asked if staff should changing gloves, ar	d complete hand hygiene when ad at any other appropriate or A indicated "Yes."					

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