NAME OF PF	OF CORRECTION ROVIDER OR SUPPLIE O HEART HOSPIG	IDENTIFICATION NUMBER 151561	A. BUILDING B. WING	00	COMPLETED
HEART TO					08/31/2022
(X4) ID	O HEART HOSPIC	ĸ		ADDRESS, CITY, STATE, ZIP COD REMONT COURT SUITE 2	
		CE OF EASTERN INDIANA LLC	ELKHA	RT, IN 46516	
TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY 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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
S 0000					
Bldg. 00	Deemed Hospice p		S 0000		
	Complaint Number State deficiencies v	0/2022-08/31/2022 r: IN003888787- Substantiated; vere cited.			
	Census: 65				
	Facility Number: 0	10002			
	Provider Number:	151561			
	QR: Area 2, 9/8/22				
S 0503 Bldg. 00	requirements of s chapter regarding hospice must info information to the policies on advan description of app Based on record re failed to ensure the medical power of a condition updates a participate in decis	IES nust comply with the ubpart I of part 489 of this advance directives. The symmetry and distribute written patient concerning its ce directives, including a blicable State law. view and interview, the agency patients' designated durable ttorney received patient and was permitted to ion making for the patient for 1 red of patients residing in	S 0503	The Executive Director (ED), Patient Care Manager (PCM) and/or the Area Clinical Manage (ACM) will educate all staff responsible for admissions, Registered Nurse Case Manage (RNCM) and Social Workers (SV on policy RI.2 titled Advanced Directives and policy RI.1 IN tilte Patient Rights and	r V)

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

TITLE

(X6) DATE

PRINTED:

09/29/2022

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 disclo 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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 151561	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 08/31/2022	
	PROVIDER OR SUPPLIE	R CE OF EASTERN INDIANA LLC	1178 F	ADDRESS, CITY, STATE, ZIP COD REMONT COURT SUITE 2 ART, IN 46516		
(X4) ID PREFIX TAG	(EACH DEFICIE	' STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBE COMPL	
	 Review of an ag 11/10/2015, titled stated on page 2, " document that enaisomeone they trust medical care, if the themselves ma appointment of a h Agency staff will i an advance directive assessment Ag effort to obtain a c directive and file to 2. Review of an ag 03/28/2022, titled Responsibilities R I, as the patient bee incompetent by a p have my health can family or legal rep 3. The clinical records canned document Representative Ap by witness on 06/1 Other A was appoint representative. A. Review of the r 06/27/22 signed by indicated individuation visit and failed to op patients' health can regarding the updata B. Review of the r 06/28/22 signed by 	gency policy with revised date of "Advance Directives RI.2" Medical Power of Attorney A bles the patient to appoint it to make decisions about their ey cannot make those decisions ay also be called nealth care agent 2 nquire whether the patient has we at the time of the initial gency staff will make every opy of any patient's advance his copy in the medical record." gency policy with revised date of "Patient Rights and L1 IN" Stated, "11. "In the event comes incapacitated or deemed obysician, have the right to re decisions carried out by my resentative." ord for Patient #3, included a titled "Indiana Health Care pointment," signed and dated 5/22, that relayed the individual inted as patient's health care		Responsibilities to ensure patient's designated durab medical power of attorney patient condition updates a able to participate in decis making. The Executive Director (EI Patient Care Manager (PC be responsible to ensure a medical power of attorney obtained when indicated a as honoring the durable m power of attorney when it i warranted regarding patien change in condition as we participating in decision m The Area Clinical Manage (ACM)/designee will audit active patient records with known durable medical po attorney to ensure the lega document is present as we well as to ensure, when we the durable medical power attorney is being notified o patients change of conditio included in decision makin the patient can no longer r decisions on their own unt of compliance is met. If non-compliance is identifier the audits, the employee v identified and one on one education will occur. After compliance has been met, ongoing audits of 10% of t records will occur through QAPI process. Audit findin	the ile receives and is ion D) and CM) will a durable is swell edical is swell edical is atking. If a saking. If a saking. If a saking. If a satisfies a swell edical is a state of the sta	

Event ID: U3MR11 Facility ID: 010002

If continuation sheet Page 2 of 12

PRINTED: 09/29/2022 FORM APPROVED

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) N	AULTIPLE CO	ONSTRUCTION	(X3) DAT	E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER	ì í	UILDING	<u>00</u>	. ,	PLETED
		151561	B. WING				1/2022
NAME OF	PROVIDER OR SUPPLIE	R		STREET	ADDRESS, CITY, STATE, ZIP COE)	
		CE OF EASTERN INDIANA LLC	;		REMONT COURT SUITE 2 ،RT, IN 46516	2	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORREC	TION	(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP	LD BE	COMPLETI
TAG	REGULATORY C	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	NOFRIATE	DATE
	new orders and failed to evidence the hospice				be reported through QAF	1	
		, patients' health care			quarterly and reviewed by		
		arding the patient's new orders.			Governing Body.	,	
		gency document titled					
		es Report" signed and dated					
		be a late entry for 06/28/2022					
	· · · ·	sit by RN #3 indicated "					
	-	ith update on patient condition					
		zed wanted no further					
		as surgery for the wound"					
		n failed to evidence the agency					
	-	health care representative,					
		g the patient update and failed					
	to evidence the par						
	representative mad						
	wound care.						
		gency document titled					
		es Report" signed and dated					
		3, indicated " would contact					
		records indicated Other D is					
	-	F at facility POA is Other A					
	"						
		gency document titled					
		es Report" signed and dated					
	-	l, indicated " Other D					
	· ·	" The documentation failed					
		spice contacted patients' health					
	update.	e, Other A, regarding the patient					
	F. During an inter	view on 08/30/22 at 11:08 AM,					
		at the time Patient #3 was					
		spice, the hospice had a					
		t included Other A and Other					
		copy of the patients' medical					
		paperwork to the hospice					
		ndicated this was the only time					
	ageney. Other Ath	areassa and was are only time					1

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY		
	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING B. WING	<u>00</u>	COMPLETED 08/31/2022		
	PROVIDER OR SUPPLIE	R CE OF EASTERN INDIANA LLC	STREET ADDRESS, CITY, STATE, ZIP COD 1178 FREMONT COURT SUITE 2 ELKHART, IN 46516				
(X4) ID PREFIX	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
TAG S 0512 Bldg. 00	the hospice agency phone about Patier made calls to hosp and had been told I would not speak w not have the medic for Other A. G. During an inter Other A indicated together, were not H. During an inter when asked why th the healthcare repr information, the cl agency must verify included in the pat hospice initially di power of attorney j 418.52(c)(1) RIGHTS OF THE The patient has a (1) Receive effect symptom control conditions related Based on record re failed to ensure the symptom control f related to the termin reviewed of patient facilities (Patient # Findings include: Review of an agen 03/28/2022, titled	view on 08/31/2022 at 2:40 PM, the agency would not contact esentative with patient inical supervisor indicated the vithe individual calling is ients' contact list and the d not have the durable medical paperwork. EPATIENT a right to the following: tive pain management and from the hospice for d to the terminal illness; view and interview, the agency e patient received timely rom the hospice for conditions nal illness in 1 of 3 records ts residing in skilled nursing	S 0512	The Executive Director (ED), Patient Care Manager (PCM) and/or the Area Clinical Manage (ACM) will educate all Registere Nurse Case Managers (RNCM) and on call staff on policy TX.2 titled On Call for Patient C and policy RI.1 Patients Rights and Responsibilities to ensure all patients will receive timely response after hours and timely symptom control from the hospi related to the terminal illness.	ed ,		

DEPARTMENT OF HEALTH AND HUMAN SERVICES

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 151561	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 08/31/2022	
	PROVIDER OR SUPPLIE	ER CE OF EASTERN INDIANA LLC	1178 F	ADDRESS, CITY, STATE, ZIP COD REMONT COURT SUITE 2 ART, IN 46516		
(X4) ID PREFIX TAG	(EACH DEFICIE REGULATORY C patient and family symptom control f conditions related Review of an agen 08/16/2007, titled indicated " purp care needs will be after agency office Review of an agen	A STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION has the right to receive from the hospice for the to the terminal illness" acy policy with revised date of "On Call for Patient Care" ose to ensure that patient met safely and appropriately e hours"	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) The Executive Director (EI Patient Care Manager (PC be responsible to ensure p will receive timely after ho services, and symptom co from the hospice related to terminal illness. The Area Clinical Manage (ACM)/designee will audit patient records to ensure p	D) and CM) will batients urs ontrol b the r 25% of	(X5) MPLETION DATE
	administrator india PM on 8/13/22, re was very lethargic up. No phone calls of the nurse was m nurse arrived to th after the phone cal	and dated 08/17/22 by the cated Other C called triage, at 3 garding Patient #1 due to Patient (sleepy) and would not wake is for the estimated time of arrival made to Other C. The on call is facility to see Patient 5 hrs 1 to triage. Patient #1, included an agency		are receiving timely respon- hours and timely symptom management from the host related to the terminal illne 100% of compliance is me noncompliance is identifier responsible employee will identified, and one on one education will occur. Ong	nse after p spice ess until et. If d, the be oing,	
	document dated 08 (interdisciplinary g indicated "pt has h benefit period and Lorazepam (to dec (milligrams) TID (then decreased to 1 8/15/22 following to report of pt bein new order for Keff	8/25/22 and titled "IDG group) Summary Report" that and increased anxiety over received new orders for routine crease anxiety) 0.5 mg (three times a day) on 8/8/22 and BID (twice a day) routine on a prn (as needed) visit for pt due ng lethargic pt also received lex (antibiotic) for possible UTI		10% of records will be reviewed through the QAPI process. Audi findings will be reported through QAPI quarterly and reviewed by the Governing Body.	. Audit rough	
	increased confusio " Review of an agen titled "Visit Note I 08/15/22 by LPN	etion) due to symptoms of on and increased drowsiness acy document dated 08/13/2022, Report" signed and dated #1, indicated " in-home time 22 08:05 PM OCV (on call				

Event ID:

U3MR11 Facility ID: 010002

If continuation sheet Page 5 of 12

PRINTED: 09/29/2022 FORM APPROVED

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 151561	(X2) MULTIPLE CO A. BUILDING B. WING		
	SUMMARY (EACH DEFICIE REGULATORY O		STREET	ADDRESS, CITY, STATE, ZIP COD REMONT COURT SUITE 2 RT, IN 46516 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATI DEFICIENCY)	(X5) COMPLETIO
S 0555 Bldg. 00	During an intervie administrator indic acceptable time per back regarding a P to a patient with sy 418.56(e)(2) COORDINATION [The hospice mussive system of commu- accordance with and procedures, (2) Ensure that the provided in accord Based on record re- failed to ensure ho- according to the pl reviewed of patient (Patient #3). Findings include: 1. Review of an ago 01/01/2020, titled indicated " purp provided is in accord care the POC (Indesignation of discord providing specific 2. The clinical record agency document to dated 06/07/22 for 08/12/22 with phy visit three times w	I OF SERVICES st develop and maintain a unication and integration, in the hospice's own policies to-] ue care and services are dance with the plan of care. view and interview, the agency spice services were provided an of care for 1 of 2 records ts receiving wound care ency policy with revised date of 'Plan of Care Process TX.06" ose to ensure that the care rdance with the written plan of olan of care) includes ipline(s) responsible for	S 0555	The Executive Director (ED), Patient Care Manager (PCM) and/or the Area Clinical Manag (ACM) will educate all Register Nurse Case Managers (RNCM and admission nurses on policy TX.06 titled Plan of Care Proce and on policy PE 1 "Patient Assessments" with a focus on identifying that the assessment will utilize standard assessment tools to include assessment of skin integrity, and to ensure hospice services are provided according to the plan of care. The Executive Director (ED) an Patient Care Manager (PCM) w be responsible to ensure patier will receive complete assessments and that services are provided according to the p of care.	ed) / ss s t t d /ill nts s

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 151561	A. E	MULTIPLE C BUILDING VING	ONSTRUCTION 00	СОМ	(X3) DATE SURVEY COMPLETED 08/31/2022	
	PROVIDER OR SUPPLIE	R CE OF EASTERN INDIANA LLC		1178 F	ADDRESS, CITY, STATE, ZIP C REMONT COURT SUIT ART, IN 46516			
(X4) ID PREFIX TAG	(EACH DEFICIE) REGULATORY O	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETIC DATE	
	 wound, the depth of ischial tuberosity (bottom of the pelv surface when a per gauze and wound of (mixture of two horder dressing, or wound once weekl) wound care, as ord (as needed) for soit 2)Hospice nurse to that looks like and to coccyx (tailbond cleanser, apply bar irritation from bod border dressing on once weekly and the wound care as order for soiled or disloct. A. Review of agen titled "Order 9052: pressure ulcer (dar caused by pressure technique, cleanser dry with gauze, apply (moisture-retention properties), cover vischium dressing to by facility skilled hweekly. B. The Skilled Nurcompleted by licer documented no prointegumentary (skifacility nurse chanter) 	alized in order to stage the of the wound) to the right sit bone, the bone at the is that makes contact with a son is sitting down) with clean cleanser, apply medihoney neys which act as an bund bed, cover wound with nee weekly, and measure y. Facility nurse to provide ered, every other day and prn led or dislodged dressing. • cleanse STII (stage 2 wound open wound or a blister) wound e) with clean gauze and wound rier cream (barrier against y fluids), cover wound with ce weekly and measure wound he facility nurse to provide ered every other day and prn lged dressing. • cy documents dated 06/14/2022, 58" indicated Right ischium nage to an area of the skin • on the area): using clean wound with normal saline, pat ply medihoney and aquacell h dressing with antimicrobial with gauze dressing. Right o be performed every other day nurse, hospice nurse to measure eres Visit Note dated 06/14/22 and used practical nurse (LPN) #2 oblems identified for the n) assessment, and that the ged the coccyx dressing early right ischium wound was			The Area Clinical Mana (ACM)/designee will au patient records that ha to ensure patient's wou treated according to th care until 100% of com met. If noncompliance during the audit, the re employee will be idention one on one education After compliance has b ongoing, 10% of record wounds will be reviewed Audit findings will be re through QAPI quarterly reviewed by the Gover	udit 100% of ve a wound unds are e plan of apliance is is identified seponsible ified, and will occur. been met, ds with ed quarterly. eported y and		

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 151561	(X2) MULTIPLE C A. BUILDING B. WING	construction 00	(X3) DATE SURVEY COMPLETED 08/31/2022	
	PROVIDER OR SUPPLIE	R CE OF EASTERN INDIANA LLC	1178 F	STREET ADDRESS, CITY, STATE, ZIP COD 1178 FREMONT COURT SUITE 2 ELKHART, IN 46516		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETI DATE
	 the hospice nurse a wounds nor measureare. C. The Skilled Nurcompleted by LPN wound dressing wareard and measured. The evidence the hospitor coccyx wounds, plan of care. D. The Skilled Nurcompleted by LPN were identified wireassessment and the was changed this reasured. The doot the hospice nurse a coccyx wounds, wiplan of care. 	umentation failed to evidence assessed the ischium or coccyx rements, as per the plan of rese Visit Note dated 06/15/22 and #2 relayed patient's coccyx as changed by the facility nurse e documentation failed to ce nurse assessed the ischium with measurements and per the rese Visit Note dated 06/16/22 and #2 documented no problems the the patient's integumentary e wound dressing to coccyx norning by facility nurse and pumentation failed to evidence assessed the ischium nor the ith measurements and per the				
	completed by regis problems were ide integumentary asso the hospice nurse a coccyx wounds, w according to the pl F. The Skilled Nun completed by LPN dressing to patient morning by facility documentation rela- the patient's right i	stered nurse #2 documented no ntified with Patient's essment and failed to evidence assessed the ischium nor the ith measurements and an of care. se Visit Note dated 06/20/22 and #2, documented the wound 's coccyx was changed that y nurse and was measured. The ayed the nurse did not assess schium wound nor the coccyx				
	The documentation	e caregiver completed the care. In failed to evidence the hospice ischium or coccyx wounds,				

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 151561	(X2) MULTIPLE CO A. BUILDING B. WING	<u></u>		(X3) DATE SURVEY COMPLETED 08/31/2022	
	NAME OF PROVIDER OR SUPPLIER HEART TO HEART HOSPICE OF EASTERN INDIANA LLC		1178 FF	ADDRESS, CITY, STATE, ZIP CO REMONT COURT SUITE RT, IN 46516			
(X4) ID PREFIX	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP	DULD BE	(X5) COMPLETI	
TAG		OR LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE	
	completed by LPN assess neither the wounds during the caregiver provided failed to evidence ischium or coccyx according to the p H. The Skilled Nu completed by RN wound nurse perfor and report was rec right ischium wou	The visit Note dated 06/23/22 and N#2, documented they did not coccyx nor the right ischium e visit, documented the dithe care. The documentation the hospice nurse assessed the twounds, with measurements lan of care. The visit Note dated 06/27/22 and #1, and documented staff formed wound care that morning, every every, patient's unstageable to and remained unchanged and ras provided by facility nurse.					
	nurse assessed the	n failed to evidence the hospice ischium wound, with d according to the plan of care.					
	completed by RN ischium wound w provided due to th The documentatio nurse assessed the	se Visit Note dated 06/28/22 and #3, documented the right ras not assessed nor was care the caregiver completed care. In failed to evidence the hospice ischium wound, including cording to the plan of care.					
	completed by RN ischium wound wa provided because wound care. The evidence the hosp	rse Visit Note dated 06/29/22 and #2 documented the right as not assessed, nor was care the caregiver completed the documentation failed to ice nurse assessed the ischium measurements, according to the					
	K. The Skilled Nu	rse Visit Note dated 7/05/22 and					

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE C A. BUILDING	construction c	X3) DATE SURVEY COMPLETED		
	of conduction	151561			08/31/2022		
	PROVIDER OR SUPPLIE	R R CE OF EASTERN INDIANA LLC	A LLC STREET ADDRESS, CITY, STATE, ZIP COD 1178 FREMONT COURT SUITE 2 ELKHART, IN 46516				
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY 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 APPROPRIATE DEFICIENCY)	(X5) COMPLETIC DATE		
S 0762 Bldg. 00	 wound nurse performand report was recent toright ischium word documentation fail nurse assessed the measurements, accent is a sessed the measurements, accent is a sesses and nordered. 418.112(b) PROFESSIONAL The hospice must professional mann hospice services the hospice plan conditions of part arrangements nerinpatient care in a Medicare/Medicare §418.100 and §4 Based on record refailed to maintain patient's plan of care patients residing in (Patient #3). Findings include: 1. Review of an ag date of 04/01/2016 Agreement" betwee indicated " provide the profession of the maintain profession is profession in the set of the patient's plan of the patient are in the patient's plan of the patient are in the patient and the patient are in the	t assume responsibility for agement of the resident's provided, in accordance with of care and the hospice icipation, and make any cessary for hospice-related a participating id facility according to 18.108. view and interview, the agency professional management of the re for 1 of 3 records reviewed of skilled nursing facilities ency document with revised , titled "Hospice Services en agency and facility B ision of services hospice	S 0762	The Executive Director (ED), Patient Care Manager (PCM) and/or the Area Clinical Manage (ACM) will educate all Registere Nurse Case Managers (RNCM) policy Tx.06 titled Plan of Care Process, policy PE.01 titled Patient Assessments and the document Hospice Service Agreement to ensure profession management is maintained of th patients plan of care. The Executive Director (ED) an Patient Care Manager (PCM) w be responsible to ensure	ed) on nal he		

DEPARTMENT OF HEALTH AND HUMAN SERVICES

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 151561	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 08/31/2022	
	NAME OF PROVIDER OR SUPPLIER HEART TO HEART HOSPICE OF EASTERN INDIANA LLC		1178 F	STREET ADDRESS, CITY, STATE, ZIP COD 1178 FREMONT COURT SUITE 2 ELKHART, IN 46516		
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE (X5) COMPLET DATE	
	" 2. Review of an ag 01/01/2020, titled indicated " purp provided is in accor care" 2. The clinical rec agency document dated 06/07/22 for 08/12/22 with phy visit three times w nurse to cleanse u that cannot be visu wound, the depth ischial tuberosity bottom of the pelv surface when a pe gauze and wound (mixture of two hd antibacterial) to w border dressing, o wound once week wound care, as ord (as needed) for so 2)Hospice nurse to that looks like an a to coccyx (tailbon cleanser, apply ba irritation from bod border dressing or once weekly and t wound care as ord for soiled or dislow	according to the plan of care gency policy with revised date of "Plan of Care Process TX.06" oose to ensure that the care ordance with the written plan of ord for Patient #3, included an titled "Order Number: 896635" • the benefit period 6/14/22 to sician orders for a skilled nurse eekly that relayed 1) Hospice nstageable wound (wound bed ualized in order to stage the of the wound) to the right (sit bone, the bone at the tis that makes contact with a rson is sitting down) with clean cleanser, apply medihoney oneys which act as an ound bed, cover wound with nce weekly, and measure ly. Facility nurse to provide dered, every other day and prn tiled or dislodged dressing. o cleanse STII (stage 2 wound open wound or a blister) wound e) with clean gauze and wound rrier cream (barrier against ly fluids), cover wound with nce weekly and measure wound he facility nurse to provide ered every other day and prn dged dressing.		professional management is maintained related to wound of assessments completed at lea every 7 days according to the of care. The Area Clinical Manager (ACM)/designee will audit 100 patient records that have a wo to ensure all nurses are maintaining professional management of wounds by completing a wound assessme at least according to the plan of care until 100% of compliance met. If noncompliance is ident during the audit, the responsite employee will be identified, an one on one education will occol After compliance has been me ongoing, 10% of records with wounds will be reviewed quart Audit findings will be reported through QAPI quarterly and reviewed by the Governing Bo	ent of is ified d ur. et, erly.	

PRINTED: 09/29/2022

FORM APPROVED

	R MEDICARE & MEDIC					OMB NO. 0938-039
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA		CONSTRUCTION	× ,	TE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00		MPLETED
		151561	B. WING		08/	31/2022
NAME OF I	PROVIDER OR SUPPLIE	R		ET ADDRESS, CITY, STATE, ZIP		
		CE OF EASTERN INDIANA LLC		FREMONT COURT SUIT IART, IN 46516	E 2	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CO	PRECTION	(X5)
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION S	SHOULD BE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE DEFICIENCY)	AFFROFRIATE	DATE
	on the area): using clean					
	technique, cleanse	wound with normal saline, pat				
dry with gauz	dry with gauze, ap	ply medihoney and aquacell				
	(moisture-retention	n dressing with antimicrobial				
	properties), cover	with gauze dressing. Right				
	ischium dressing to	b be performed every other day				
	by facility skilled 1	nurse, hospice nurse to measure				
	weekly.					
	B The Skilled Nu	rse Visit Notes dated 06/14/22,	isit Notes dated 06/14/22			
		6/19/22, 6/20/22, 6/23/22, 6/27/22,				
		5/29/22, and 7/05/22 failed to				
		ce nurse assessed the patient's				
	-	rements per the pan of care.				
	C. During an interv	view on 8/31/22 at 1 PM, RN #1				
	relayed they used t	he measurements of the facility				
	nurse on the skilled	d nurse visit notes of 6/2/22 and				
	7/05/22, and did no	ot did not assess, measure, nor				
	provide the wound	care for their patient.				
	D. During an inter-	view on 8/31/22 at 2:40 PM, the				
	clinical manager re	elayed the hospice was				
	responsible for the	professional management of a				
	hospice patients' w	round care, when patient				
	resides in a nursing	g facility, unless it is otherwise				
	agreed upon with t	he nursing facility. The clinical				
	manager relayed th	he hospice nurse was to assess	1			
	and measure the ho	ospice patient's wounds weekly				
	as ordered.					