STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	151507	A. BUILDING _____ B. WING _____	08/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPASSUS-INDIANAPOLIS METRO	**8450 N PAYNE RD STE 100 INDIANAPOLIS, IN 46268**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An emergency preparedness survey was conducted by the Indiana Department of Health in accordance with 42 CFR 418.113 for a Hospice Agencies. Survey Dates: 8-22-22, 8-23-22, and 8-24-22. Census: 50 At this Emergency Preparedness Survey, Compassus-Indianapolis Metro (Hospice) was found to have been in compliance with 42 CFR 418.113 for a Medicare Participating Hospice. QR by Area 3 on 8-29-22	E 000		
L 000	INITIAL COMMENTS This visit was for a Federal Recertification survey of a hospice agency. The investigation was initiated by the Indiana Department of Health. Survey Dates: 08-22, 08-23 and 08-24-2022 CCN: 151507 Current home hospice census: 50 Inclusive of: GIP: 1 ALF: 4 SNF: 7 EOS: 2 Respite: 1 Compassus Indianapolis- Metro (Hospice) was found to have been IN COMPLIANCE with 42	L 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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L 000	Continued From page 1 CFR 418 et seq. for participating Hospice providers. QR by Area 3 on 8-29-22	L 000		