

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

PRINTED: 07/02/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151606		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/29/2021	
NAME OF PROVIDER OR SUPPLIER HERITAGE HOSPICE AND PALLIATIVE CARE				STREET ADDRESS, CITY, STATE, ZIP CODE 7215 E 21ST STREET, SUITE A INDIANAPOLIS, IN 46219			
(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	<p>Initial Comments</p> <p>An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 418.113. In conjunction with the Emergency Preparedness survey, a Focused Infection Control Survey was also conducted.</p> <p>Facility #: 012203</p> <p>CCN: 151606</p> <p>Survey Dates: 6-22, 6-23, 6-24, 6-25, 6-28, and 6-29-2021</p> <p>At this Emergency Preparedness survey, Heritage Hospice and Palliative Care, was found to have been in compliance with the Emergency Preparedness Requirements for Medicare Participating Providers and Suppliers, 42 CFR 418.113; and was found to have been in compliance with the Focused Infection Control requirements in regards to staffing and implementation of staffing during a pandemic.</p>			E 000			
L 000	<p>Quality Review Completed on 07/02/2021 by Area 3</p> <p>INITIAL COMMENTS</p> <p>This visit was for a Federal Recertification and State Relicensure survey of a Hospice provider.</p> <p>Survey Dates 6/22/21 , 6/23, 6/24, 6/25, 6/28, and 6/29/21</p> <p>Facility # 012203</p>			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.

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L 000	<p>Continued From page 1</p> <p>Provider # 151606</p> <p>Medicaid # 201179100</p> <p>Heritage Hospice and Palliative Care was found to be IN COMPLIANCE with 42CFR 418, in regards to recertification of a hospice agency.</p> <p>Heritage Hospice and Palliative Care was also found to have been IN COMPLIANCE with the state licensure requirements at Indiana Code 16-25-3.</p> <p>Quality Review Completed on 07/02/2021 by Area 3</p>	L 000			