

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

PRINTED: 01/07/2021  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>151523</b>		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>12/22/2020</b>	
NAME OF PROVIDER OR SUPPLIER  <b>FRANCISCAN HOSPICE CARE</b>				STREET ADDRESS, CITY, STATE, ZIP CODE <b>1300 ALBANY STREET</b> <b>BEECH GROVE, IN 46107</b>			
(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>A Focused Infection Control survey was conducted by the Indiana Department of Health in accordance with 42 CFR 418.113, for Hospice.</p> <p>Survey Date: 12-22-2020</p> <p>Facility Number: 006347</p> <p>Provider Number: 151523</p> <p>At this Focused Infection Control Survey, Franciscan Hospice Care, was found to have been in compliance with the requirements of the Condition for Coverage of Hospice, 42 CFR 418.113, in relation to implementation of emergency staffing and emerging infectious organism infection prevention and infection control (COVID-19 pandemic.)</p>			E 000			
L 000	<p>INITIAL COMMENTS</p> <p>Quality Review completed on 01/07/2021 by Area 3</p> <p>This visit was for a Federal Complaint survey of a deemed Hospice provider.</p> <p>Complaint #: IN00341290 - Unsubstantiated</p> <p>Survey Date: 12-22-2020</p> <p>Facility Number: 006347</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.

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

PRINTED: 01/07/2021  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>151523</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>12/22/2020</b>
NAME OF PROVIDER OR SUPPLIER  <b>FRANCISCAN HOSPICE CARE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1300 ALBANY STREET</b> <b>BEECH GROVE, IN 46107</b>		
(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	
L 000	Continued From page 1 Provider Number: 151523  During this survey, Franciscan Hospice Care was found to be in compliance with Condition for Participation, 42 CFR 418.60 Infection Control.  Quality Review completed on 01/07/2021 by Area 3	L 000			