PRINTED: 03/30/2022 FORM APPROVED OMB NO. 0938-039

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

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 151511		A. BU	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY  COMPLETED  03/08/2022	
		101011	B. WI			03/08/	2022
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD MERIDIAN ST, SUITE 700		
INDIANA	UNIVERSITY HEA	LTH HOSPICE			APOLIS, IN 46204		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE	IATE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
L 0000							
Bldg. 00					POC accepted on 3	/30/2022	<u> </u>
Diag. 00			L 00	000	'		
	This visit was to de	termine the removal/abatement		700			
	of the Immediacy co	omponent of an Immediate					
	Jeopardy identified	on 2/15/2022 at 9:47 AM,			Deborah F	TARMS	A
		removed upon survey exit on			2 acoust	unc	
		on to failure to implement					
		vestigate Patient #13's					
	allegation of sexual	abuse (42 CFR 418.52.)					
	Survey Dates 3-7-22 and 3-8-22.						
	On 2/28/2022, the agency's 3rd Removal Plan was						
		npletion date of 3/4/2022. The					
	components of the l	Immediacy Removal plan were					
		ied on-site to include:					
		nerable patients and					
	_	ency determined there were no					
	-	ons of sexual abuse, 8 patient					
		wed for clinical notes reflecting creening, interviews with					
	_	etaker were conducted in					
		ge of Indiana University					
		icies and Procedures for					
	_	orting suspected abuse or					
		with contracted entities to					
	_	nd all branches, and					
		iana University Health Hospice					
	_	at and all branches. The review					
		ew of weekly huddle notes					
		policy, procedure, and					
	· ·	of the quality managers' view of new employee					
		, complaint log, adverse event					
		d to the appropriate protective					
		nt #13. The risk of harm to					
		s determined to be removed.					
	I						

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 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.

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 151511	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 03/08/2022
	ROVIDER OR SUPPLIER		950 N	ADDRESS, CITY, STATE, ZIP COD MERIDIAN ST, SUITE 700 NAPOLIS, IN 46204	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	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
	to have implemente The Immediacy con Jeopardy was abated The agency remove Participation which 418.52; Patient Righ Standard level defice	had been cited at 42 CFR hts. iencies at 42 CFR 418.52 (b)(4) 52 (ii) were determined to have			
L 0502 Bldg. 00	advance of furnish provide the patient verbal (meaning s the patient's rights	ITS AND	L 0502	L502 NOTICE OF RIGHTS AN RESPONSIBILITIES CFR(s): 418.52(a)(1) (1) During the initial assessment visit in advance of furnishing of the hospice must provide the patient or representative with verbal (meaning spoken) and written notice of the patient's rights and responsibilities in a language and manner that the patient understands. This STANDARD is not met a evidenced by: Based on recorreview and interview, the agei	ent care

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 151511	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 03/08/2022
	ROVIDER OR SUPPLIE UNIVERSITY HEA		950 N	ADDRESS, CITY, STATE, ZIP COD MERIDIAN ST, SUITE 700 NAPOLIS, IN 46204	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ION (X5) D BE COMPLETION DPRIATE DATE
				failed to ensure all patients patient representatives we provided with written notice patient's rights and responsing a language they understuding the initial assessment in advance of providing care (Patient #8) of 1 record responsions and/or patient representatives with limite English proficiency, out of sample of 16 patients.  Plan of Correction:  (1) Specific nature of the corrective actions included completion dates, description of the corrective actions included completion dates, description of the communication tool "Hosp Huddle Hot Topics" which contained the Hospice 2/1 Federal Survey results was verbally reviewed with Host team members: an email of was also provided to team members for independent lincluded in the results sum was detail concerning the deficiency identified on sure a patient or representative receive written notice of parights and responsibilities language they understood the initial assessment and advance of providing care team members aware of the survey	ere e of the e sibilities tood ent, and ere, for 1 viewed  d a  ee ing ption revent ible  the ice  5/2022 s spice copy review. nmary rvey that e did not atient's in a during in . Making

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 151511	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 03/08/2022
	ROVIDER OR SUPPLIEF		950 N	ADDRESS, CITY, STATE, ZIP COD MERIDIAN ST, SUITE 700 NAPOLIS, IN 46204	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY 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)	(X5) COMPLETION DATE
				finding is essential to prevent recurrence and will ensure that hospice patients and/or representatives are provided written notice of the patient's rights and responsibilities in a language they understand due the initial assessment and in advance of providing care.  Completion date: March 18, 2 Responsible party: The Hospit Administrator  b. The hospice policy "Sen Impaired/Limited English Prof Clients" is being updated to include the requirement that patients and/or patient representative will be provided verbal (meaning spoken) and written notice of patient's right and responsibilities in a language and manner that they underst Updating this policy is require ensure that during the initial assessment visit in advance of furnishing care patients or representatives will be provided with verbal and written notice patient rights and responsibilitien a language and manner that they understand.  Completion date: April 8, 2022 Responsible party: The Hospit Administrator  c. The hospice census was reviewed for all non-English speaking patients and found thave three Spanish speaking	with  ring  022 ce  sory icient  d with  s age and. d to  of ed of cies it  2 ce

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(X2) MULTIPLE CONSTRUCTION       (X3) DATE SUR         A. BUILDING       00       COMPLETE         B. WING       03/08/202		
STREET ADDRESS, CITY, STATE, ZIP COD 950 N MERIDIAN ST, SUITE 700 INDIANAPOLIS, IN 46204		
CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETION DATE	
patients receiving services, no other non-English speaking patients were identified. A copy of the Spanish version of the Hospid Admission Packet which includes all consents as well as a copy of the Spanish version of the Hospid Caregiver Guide including Notice of Patient Rights and Responsibilities will be delivered each of the three identified Spanish speaking patients and/or representatives. This will ensure that all non-English speaking patients currently on census have been provided verbal and written information concerning patient's rights and responsibilities in a language they understand. Delivering the  Spanish Hospice Admission Packet and Spanish Caregiver Guide for any Spanish speaking patients currently on census is essential to ensure that current patients and/or representatives have been provided with the required written material. Completion date: April 8, 2022 Responsible party: The Hospice Administrator  d. The notification process for admission alert has been adjuste to include alerts related to non-English speaking patients or	of ice	
	STREET ADDRESS, CITY, STATE, ZIP COD 950 N MERIDIAN ST, SUITE 700 INDIANAPOLIS, IN 46204  ID REFIX TAG  PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  patients receiving services, no other non-English speaking patients were identified. A copy of the Spanish version of the Hospical Admission Packet which include all consents as well as a copy of the Spanish version of the Hospical Caregiver Guide including Notice of Patient Rights and Responsibilities will be delivered each of the three identified Spanish speaking patients and/or representatives. This will ensure that all non-English speaking patients currently on census have been provided verbal and writter information concerning patient's rights and responsibilities in a language they understand. Delivering the  Spanish Hospice Admission Packet and Spanish Caregiver Guide for any Spanish speaking patients currently on census is essential to ensure that current patients and/or representatives have been provided with the required written material. Completion date: April 8, 2022 Responsible party: The Hospice Administrator  d. The notification process for admission alert has been adjusted to include alerts related to	

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DEPARTMENT	T OF HEALTH AND HUN	MAN SERVICES				FOF	RM APPROVED
CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES				OM	B NO. 0938-039
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	JILDING	00	COMPL	ETED
		151511	B. W	ING		03/08/	2022
	PROVIDER OR SUPPLIER		<u> </u>	950 N I	ADDRESS, CITY, STATE, ZIP COD MERIDIAN ST, SUITE 700 IAPOLIS, IN 46204		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID			(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	interpreter and confirm available of written material to include notification of patient rights an responsibilities in a language to patient or representative understands. The Hospice Intateam will include in their email notification of admission to the admitting clinician that the paties is non-English speaking and we provide contact information for interpreter. The Hospice Intake team will also include where to access written admission materical including notice of patient's rigure and/or representatives' appropriate and/or representatives' appropriate and/or representatives in the paties and responsibilities in the paties and material will also include confirmation of appropriate and availability of required written material will prevent the possibility of recurrence of non-English speaking patient and/or family members not receiving verbal written notice of patient's right and responsibilities in a languate they understand.  Completion date: April 8, 2022 Responsible party: The Central Region Business Operations Manager	d the ake ent vill the e orial hts ent oriate to riate	DATE

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A four-hour hospice education summit is scheduled to occur in each region. All team members are required to attend. During the education summit, a

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NAME OF PI	ROVIDER OR SUPPLIEF			DDRESS, CITY, STATE, ZIP COD ERIDIAN ST, SUITE 700		
INDIANA	UNIVERSITY HEA	LTH HOSPICE		APOLIS, IN 46204		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL	ID PREF	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		(X5) COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE
				review of the requirement that patients and/or representative		
				must be provided verbal (mea		
				spoken) and written notice of		
				patient's rights and responsibi		
				in a language they understand		
				during the initial assessment a		
				in advance of providing care, voccur. In-person education	WIII	
				concerning this requirement w	rill	
				prevent recurrence of failure to		
				provide to the patient and or		
				representative, verbal, and wr	itten	
				notice of the patient's rights ar	nd	
				responsibilities in a language	they	
				understand during the initial	_	
				assessment and in advance o	Ť	
				providing care.	<b>)</b>	
				Completion date: April 8, 2022 Responsible party: The Hospid		
				Administrator		
				(2) Monitoring and		
				Sustainability		
				a. The IU Health Hospice		
				warehouse will deliver five cop	oies	
				of the Spanish version of the		
				Hospice Admission Packet to	tha	
				each regional office including IU Health Hospice House. The		
				Spanish Hospice Admission	•	
				Packet is added to the hospice	Э	
				supply order document and		
				additional copies are available	for	
				re-order. On-site access to the		
				Spanish admission folder will		
				improve access to these		
				documents for the most freque	-	
			1	occurring non-English speaking	ıq	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING 00 COMPLETI					
		151511	B. W	B. WING			2022
NAME OF F	PROVIDER OR SUPPLIER		-		ADDRESS, CITY, STATE, ZIP COD		
					MERIDIAN ST, SUITE 700		
INDIANA	UNIVERSITY HEA	LIH HOSPICE		INDIAN	IAPOLIS, IN 46204		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG			DATE
					language being served by the hospice agency. Access to the		
					printed documents is an esser		
					step in preventing failure to pr		
					to the patient or representative		
					written and verbal notice of the		
					patient's rights and responsibi		
					in a language they understand		
					in advance of the initial		
					assessment and delivery of ca	ire.	
					Completion date: April 8, 2022		
					Responsible party: The Hospi	ce	
					Administrator		
					<b>b</b> . The Hospice Quality		
					Manager or designee will pull	<u> </u>	
					query report on the first busine		
					day of each week that will ider		
					all non-English speaking patie	-	
					on census. The Hospice Quali		
					Manager or designee along w	-	
					the appropriate telephone		
					translation service will contact		
					each patient and/or representa	ative	
					who has not been contacted in	n a	
					prior week to confirm that the		
					patient and/or representative	.	
					received verbal and written no	tice	
					of patient's rights and	.	
					responsibilities in a language	-	
					understand. The quality mana	ger	
					will ensure that any patients identified as not having receiv	od	
					the materials in their preferred		
					language will have those mate		
					delivered to them on or before		
					next scheduled visit. Follow up		
					contact with non-English spea		
					patients and or representative	•	
					confirm each patient was prov		

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	T OF DEFICIENCIES  OF CORRECTION	IDENTIFICATION NUMBER  151511	A. BUILDING  B. WING	00	COMPLETED 03/08/2022
	ROVIDER OR SUPPLIER UNIVERSITY HEAI		950 N N	ADDRESS, CITY, STATE, ZIP COD MERIDIAN ST, SUITE 700 APOLIS, IN 46204	_
(X4) ID PREFIX TAG	(EACH DEFICIENCE	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
				with required information and it essential step to prevent recurrence of failure to provide any hospice patient or representative verbal and writt notification of the patient's right in a language they understand Completion date: April 8, 2022 Responsible party: The Hospic Quality Manager	e to en ets I.
				Plan of correction requirements: It clearly states the specific na of the corrective actions for ea deficiency. (2) It sets reasonal completion dates for all deficiencies prior to the termination date unless an extension is requested and approved. (3) It describes how your plan/action will prevent recurrence. And (4), it describe who will be the person(s) responsible for implementing a monitoring the plan for future compliance with the regulation response to each deficiency o the CMS-2567 is required.	ch ble es and
L 0520					
Bldg. 00			L 0520	L520 INITIAL & COMPREHENSIVE ASSESSMENT OF PATIENT CFR(s): 418.54 This CONDITION is not met a	04/08/2022

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	T OF DEFICIENCIES DF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 151511	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 03/08/2022
	ROVIDER OR SUPPLIER		950 N	ADDRESS, CITY, STATE, ZIP COD MERIDIAN ST, SUITE 700 NAPOLIS, IN 46204	
(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 BI CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	5.112
				evidenced by: Based on recovereview and interview, the age failed to ensure all patients received a patient-specific comprehensi assessment that included the patient's need for physical, psychosocial, emotional, and spiritual care, and accurately included all areas of hospice related to the palliation and management of the patient's terminal illness and related conditions. The cumulative e of these systemic problems resulted in the agency's inabe ensure patients received appropriate services which cresult in the agency not proviquality health care, thus result in non-compliance with 42 C 418.54 Condition of Participal Initial and Comprehensive Assessment of the Patient.  Plan of Correction  (1) Specific nature of the corrective actions including completion dates, description of how each action will previewed.  A special edition of the communication tool "Hospice Huddle Hot Topics" which contained the Hospice 2/15/2 Federal Survey results was verbally reviewed with Hospi	ency  ive e d f care  iffect ility to ould iding ilting FR ation:

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	ROVIDER OR SUPPLIE		950 N I	ADDRESS, CITY, STATE, ZIP COD MERIDIAN ST, SUITE 700 JAPOLIS, IN 46204	
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				team members; an email copy was also provided to team members for independent revinculated in the results summa was detail concerning the cumulative impact of the agentinability to ensure a patient-specific comprehensive assessment which could result the agency not providing qualithealth care, thus resulting in non-compliance with the Concof Participation: Initial and Comprehensive Assessment of the Patient.  Completion date: March 18, 2 Responsible party: The Hospit Administrator  b. To ensure all hospice patients receive a patient-speciment receive a patient-speciment receive assessment the includes the patient's need for physical, psychosocial, and spiritual care that accurately includes all areas of hospice or related to the palliation and management of the patient's terminal illness and related conditions, the Hospice Administrator, and the Hospic Infection Preventionist complete a Comprehensive Assessment and Care Planning Risk Assessment. The primary objective of the risk assessment was to identify the areas of greatest risk for deficiency in tagency's ability to recognize a deliver care and services to eliver care and services to eliver care and services to eliver care and services to eliments.	iew. icy's e e it in ity dition of 022. ce ceific nat care e eted it the ind

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	ROVIDER OR SUPPLIE UNIVERSITY HEA		950 N I	ADDRESS, CITY, STATE, ZIP COD MERIDIAN ST, SUITE 700 IAPOLIS, IN 46204	•
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				patients receive appropriate services. Components of the assessment were ranked in probability, risk, and prepared categories with combined soo of 9 and higher determined to deficient. Identifying the area greatest risk for deficiency in agency's ability to recognize deliver needed care and servito every patient is required to prioritize mitigation efforts an meet each hospice patient's identified needs through comprehensive assessment care planning in order to previously recurrence of the agency's fato meet this condition of participation.  Completion date: March 18, 28 Responsible party: The Hospid Infection Preventionist  c. Education was developed for the following areas identified the Comprehensive Assessment and Care Planning Risk Assessment tool: Pediatric Assessment and Care Planning Bereavement Risk, Language Barrier, General Safety, Hom Safety,  Abuse/Neglect/Exploitation, For Oxygen Safety, and Medication Management. While developed education on these topics the agency's state and national hospice organizations were consulted and a comprehensive care approach and comprehensive consulted and a comprehensive care approach and comprehensive care approach and comprehensive care approach and care planning approach an	risk dness ores o be as of the and vices o d and vent ailure  2022 oice ee oed ied in nent ing, e he Fire Falls, on ing ee

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	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD  950 N MERIDIAN ST, SUITE 700 INDIANAPOLIS, IN 46204		
(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 B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	E COMPLETION DATE
				review of available literature undertaken by the Hospice Administrator. Education may was selected based on relevant timeliness. Selected education material will be deat four-hour Hospice Educat Summits for clinical employed the hospice including Clinical Managers, Supervisors, RN: LPNs, Social Workers, Chapter Therapists, Bereavement Coordinators, Volunteer Coordinators, and Aides. Education will be interactive relevant examples provided each topic. Team members be given the opportunity to a questions throughout the education presentation. Teamembers will be given a writexam covering each topic presented to confirm understanding of the material Developing and delivering interactive, in-person educations through effective compreheassed on the agency's identify high-risk areas for failure to thorough effective compreheassessment and care plannian necessary step to ensure all patients' physical, psychosocial, and spiritual confirmed this condition for all hospice patients. Completion date: April 8, 20 Responsible party: The Hoshadministrator.	eterial vancy elivered ion ees of al s, olains, with for will ask am eten al. tion iffied ensure ensive ensive ensive ensive ensive ent ailure 22.

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY  A. BUILDING 00 COMPLETED  B. WING 03/08/2022				
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 950 N MERIDIAN ST, SUITE 700 INDIANAPOLIS, IN 46204			
(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 APPROPRI. DEFICIENCY)	(X5) COMPLETION DATE	
				(2) Monitoring and Sustainability  a. All education content the was delivered at the Hospice Education Summit has been added to new team member onboarding requirements for clinical roles including Clinical Manager, Supervisor, RN, LP Social Worker, Chaplain, Bereavement Coordinator, Volunteer Coordinator, Thera and Aide. Requiring all newly hired clinical team members to complete this education and to complete the written exam covering content is an essent step to ensure understanding the requirement that all patier receive a patient-specific comprehensive assessment to includes the patient's need for physical, psychosocial, emotion and spiritual care, and accurating includes all areas of hospice related to the palliation and management of the patient's terminal illness and related conditions and in the prevention-compliance with this conformation of participation.  Completion date: April 8, 202 Responsible party: The Hosp Quality Manager  b. Team members on leave absence during the four-hour	all I N, pist, / to to to tal of nts hat r onal, ately care  fon of dition 2 ice	

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Event ID:

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AND PLAN OF CORRECTION IDENTIFI		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 151511	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY  COMPLETED  03/08/2022	
	PROVIDER OR SUPPLIE	R	950 N I	ADDRESS, CITY, STATE, ZIP COD MERIDIAN ST, SUITE 700 NAPOLIS, IN 46204		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION	
PREFIX TAG	•	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PREFIX TAG	Hospice Education Summit wischeduled for review of this material at the first bi-weekly Hospice Onboarding Session which will occur upon their ret Requiring all active team mem who missed the initial session complete the first available onboarding session of this material will ensure all team members have received this material, have been given the opportunity to ask questions, a have completed written evaluate to confirm their understanding the content. Ensuring all clinic team members have completed these requirements is an essesstep to increase education and understanding of the requirement that all patients receive a patient-specific comprehensive assessment that includes the patient's need for physical, psychosocial, emotional, and spiritual care, and accurately includes all areas of hospice of related to the palliation and management of the patient's terminal illness and related conditions and in the prevention of participation.  Completion date: April 8, 2022 Responsible party: The Hospi Quality Manager  c. Ten percent of monthly hospice active census will undersum will will will will will will will wil	urn. nbers s to  and ation of cal ed cential d nent re  care  on of dition 2 cce	
				detailed record review by hos	_	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES							FORM APPROVED OMB NO. 0938-039	
STATEME	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 151511	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY  COMPLETED  03/08/2022		
NAME OF	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD MERIDIAN ST, SUITE 700			
INDIANA	UNIVERSITY HEA	ALTH HOSPICE			IAPOLIS, IN 46204			
(X4) ID PREFIX 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 APPROPRI. DEFICIENCY)		(X5) COMPLETION DATE	
					quality audit RNs to confirm the each patient received a patient-specific comprehensive assessment that included the patient's need for physical, psychosocial, emotional, and spiritual care, and accurately included all areas of hospice related to the palliation and management of the patient's terminal illness and related conditions. Reviewing these records will allow for immediate coaching and remediation with team member determined to deficient in meeting the requirement and will allow for accountability measures to be taken should the deficiency reaction, and accountability measures for the members who fail to meet the requirements is an essential sto prevent recurrence of non-compliance with the condaudits will continue until 100% compliance is achieved for 3 consecutive months and will to continue at a regular cadence indefinitely to ensure sustained compliance with this condition participation.  Completion date for implementation of audit process.	care  te the any be cecur. uent esse step dition.		

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April 8, 2022

Quality Manager

Responsible Party: The Hospice

Hospice supervisors or

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DEPARTMENT	EPARTMENT OF HEALTH AND HUMAN SERVICES							
ENTERS FOR	NTERS FOR MEDICARE & MEDICAID SERVICES							
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION					NSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPLETED		
		151511	B. WING			03/08/2022		
NAME OF PROVIDER OR SUPPLIER INDIANA UNIVERSITY HEALTH HOSPICE				950 N N	ADDRESS, CITY, STATE, ZIP COD MERIDIAN ST, SUITE 700 APOLIS, IN 46204			
(X4) ID SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)		
PREFIX	(EACH DEFICIEN	FICIENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	TE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	

PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
			designees will complete one shared visit per week with rotating members of their regional clinical team. The supervisor or designee will review the patient record in advance of the visit, will observe the visit, and will observe visit documentation. The supervisor or designee will complete the "Hospice Comprehensive Assessment, Care Plan, and Visit Review" tracer document available electronically in the agency's network. The supervisor or designee observing patients in the field combined with record review will allow the supervisor or designee to take immediate action if a team member is determined to be deficient in ensuring that all patients receive appropriate services which could result in the agency not providing quality health care. Actions taken will include immediate coaching, remediation, and accountability measures should the deficiencies be observed. The supervisor or designee completing shared visits and documentation review is an essential step to prevent non-compliance with the condition. Shared visits and document review will continue until 100% compliance is achieved for 3 consecutive months and will then continue at a regular cadence indefinitely to ensure sustained compliance with this condition of participation.	
ORM CMS-2567(02	-99) Previous Versions Obsolete Event ID:	LIR112 Facility	ID: 005128 If continuation sheet Pa	age 17 of 108

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	T OF HEALTH AND HU R MEDICARE & MEDIC						RM APPROVED 1B NO. 0938-039	
	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 151511	A. BU	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 03/08/2022	
	PROVIDER OR SUPPLIE		•	950 N I	ADDRESS, CITY, STATE, ZIP COD MERIDIAN ST, SUITE 700 JAPOLIS, IN 46204	•		
(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 APPROPR DEFICIENCY)	IATE	(X5) COMPLETION DATE	
					Completion date for implementation of the audit process: April 8, 2022 Responsible party: The Hosp Quality Manager	oice		
					Plan of correction requirements: It clearly states the specific rof the corrective actions for edeficiency. (2) It sets reasons completion dates for all deficiencies prior to the termination date unless an extension is requested and approved. (3) It describes how your plan/action will prevent recurrence. And (4), it describes who will be the person(s) responsible for implementing monitoring the plan for future compliance with the regulation response to each deficiency the CMS-2567 is required.	each able  w bes J and e ons. A		
L 0521 Bldg. 00	writing a patient-s assessment that for hospice care a patient's need for emotional, and sp	PF PATIENT It conduct and document in Expecific comprehensive identifies the patient's need and services, and the physical, psychosocial, piritual care. This des all areas of hospice						

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related conditions.

management of the terminal illness and

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		151511	B. W	ING		03/08/	2022
				CERTE SEE	ADDRESS CITY OF THE STATE OF		
NAME OF F	PROVIDER OR SUPPLIER	1			ADDRESS, CITY, STATE, ZIP COD		
					MERIDIAN ST, SUITE 700		
INDIANA	UNIVERSITY HEA	LTH HOSPICE		INDIAN	APOLIS, IN 46204		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	DDOVIDED'S DI AN OF CODDECTION		(X5)
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TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					COMPREHENSIVE		
					ASSESSMENT OF PATIENT		
					CFR(s): 418.54		
					The hospice must conduct and	d	
					document in writing a		
					patient-specific comprehensiv	e l	
					assessment that identifies the		
					patient's need for		
					hospice care and services, an	d l	
					the patient's need for physical		
					psychosocial, emotional, and	,	
					spiritual care. This assessmer	nt	
					includes all areas of hospice of		
					related to the palliation and		
					management of the terminal		
					illness and related conditions.		
					This STANDARD is not met a	s	
					evidenced by: Based on recor	d	
					review and interview, the ager		
					failed to ensure all patients	,	
					received a		
					patient specific comprehensive	e	
					assessment which accurately		
					reflected the patient's current		
					health status and accurately		
					included the patient's need for		
					physical, psychosocial, emotic		
					and spiritual care; and include		
					areas of hospice care related		
					the palliation and managemer		
					the terminal illness and related		
					conditions for 2 (Patients #8,	12)	
					of 16 active records reviewed.		
					Plan of Correction		
					(1) Specific nature of the		
					corrective actions including		
					completion dates, description		

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of how each action will prevent

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPI	ETED
		151511	B. W			03/08	
		1		_		20,00	
NAME OF F	PROVIDER OR SUPPLIEF	3	STREET ADDRESS, CITY, STATE, ZIP COD				
1 1 1 1 1 1	no vident on borreie.			950 N N	MERIDIAN ST, SUITE 700		
INDIANA	UNIVERSITY HEA	ALTH HOSPICE		INDIAN	IAPOLIS, IN 46204		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					recurrence, and responsible	_	
					party	_	
					<del></del>		
					a. A special edition of the		
					communication tool "Hospice		
					Huddle Hot Topics" which		
					contained the Hospice 2/15/20	122	
					Federal Survey results was	122	
					verbally reviewed with Hospic	^	
					team members and an email of	.о <b>р</b> у	
					was also provided to team		
					members for independent rev		
					Included in the results summa	-	
					was detail concerning the failu		
					the agency to ensure all patie	nts	
					received a patient specific		
					comprehensive assessment w		
					accurately reflected the patier	ıt's	
					health status and accurately		
					included the patient's need for	r	
					physical, psychosocial, emotion	onal,	
					and spiritual care; and include	ed all	
					areas of hospice care related		
					palliation and management of		
					terminal illness and related		
					conditions for two patients. To	eam	
					member awareness of survey		
					results is a required step to		
					prevent recurrence of the		
					deficiencies identified during t	he	
					survey.		
					Completion date: March 18,		
					2022.		
						••	
					Responsible party: The Hospi	ce	
					Administrator		
					<del>-</del>		
					b. To ensure all hospice		
					patients receive a patient-spe		
			1		comprehensive assessment the	nat	I

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includes the patient's need for

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CENTERS FOR MEDICARE & MEDICAID SERVICES					OMB NO. 0938-039	
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		COMPLETED	
		151511	B. WING	<del></del>	03/08/2022	
			<del></del> =		l	
NAME OF F	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD		
				MERIDIAN ST, SUITE 700		
INDIANA	UNIVERSITY HEA	LTH HOSPICE	INDIAN	NAPOLIS, IN 46204		
(X4) ID	SIIMMARV	STATEMENT OF DEFICIENCIE	ID		(X5)	
PREFIX			PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		
		CY MUST BE PRECEDED BY FULL		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG		DATE	
				physical, psychosocial, and		
				spiritual care that accurately		
				includes all areas of hospice of	are	
				related to the palliation and		
				management of the patient's		
				terminal illness and related		
				conditions, the hospice		
				administrator and the hospice		
				infection preventionist comple	ted a	
				Comprehensive Assessment a		
				Care Planning Risk Assessme		
				The primary objective of the ri		
				assessment was to identify the		
				areas of greatest risk for		
				deficiency in the agencies abil	ity	
				to recognize and deliver care	-	
				services to ensure patients rec		
				appropriate services. Compon	ents	
				of the risk assessment were		
				ranked in probability, risk, and		
				preparedness categories with		
				combined scores of 9 and high	ner	
				determined to be deficient.		
				Identifying the areas of greate	st	
				risk for deficiency in the agend	cy's	
				ability to recognize and deliver	r	
				needed care and services to e	every	
				patient is required to prioritize		
				mitigation efforts and meet ea	ch	
				hospice patients identified nee		
				through comprehensive		
				assessment and care planning	a	
				and to prevent recurrence of the		
				agency's failure to meet this		
				condition.		
				Completion date: March 18, 2	1022	
				Responsible party: The Hosp		
				1		
				Administrator and The Hospic	e	
			İ	Infection Preventionist		

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f i		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 151511	(X2) MULTIPLE CO A. BUILDING B. WING	(X3) DATE SURVEY  COMPLETED  03/08/2022			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 950 N MERIDIAN ST, SUITE 700 INDIANAPOLIS, IN 46204				
(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		
				c. Education was develope for the following areas identific the comprehensive assessme and care planning risk assessment tool: Pediatric Assessment and Care Planning Bereavement Risk, Language Barrier, General Safety, Home Safety, Abuse/Neglect/Exploitation, Fooxygen Safety, and Medication Management. While developing education on these topics the agency's state and national hospice organizations were consulted and a comprehensing review of available literature woundertaken by the hospice administrator. Education material will be delivat four-hour hospice education summits for clinical employees the hospice including Clinical Managers, Supervisors, RN's, LPN's, Social Workers, Chaplains, Therapists, Bereavement Coordinators, Volunteer Coordinators, and Aides. Education will be interactive with relevant exam provided for each topic. Team members will be given the opportunity to ask question throughout the education presentation. Team members be given a written exam cover	ed ed in nt  ng, e Fire alls, en ng  ve vas erial ncy vered n s of		

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each topic presented to confirm

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NAME OF PROVIDER OR SUPPLIER  INDIANA UNIVERSITY HEALTH HOSPICE  (NA) ID SUMMARY STATEMENT OF DETICIENCIE (EACH DETICIENCY MUST BE PRECEDED BY FULL TAG  TAG  REGULATORY OR ISC IDENTIFYING INFORMATION  REGULATORY OR ISC IDENTIFYING INFORMATI	STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	` ′		ONSTRUCTION	(X3) DATE S	
NAME OF PROVIDER OR SUPPLIER  INDIANA UNIVERSITY HEALTH HOSPICE  (X4) ID  PRIFIX TAG  REGILATORY OR LSC IDENTIFYING INFORMATION  IDENTIFY TAG  INDIANAPOLIS, IN 46204  INDIANA	AND PLAN	OF CORRECTION				00		
INDIANA UNIVERSITY HEALTH HOSPICE  (X4) ID  PREFIX TAG    SUMMARY STATEMENT OF DEFICIENCY   CAS   ID   REGULATORY OR LSC IDENTIFYING INFORMATION			151511	B. W	ING		03/08/	2022
INDIANA UNIVERSITY HEALTH HOSPICE  (X4) ID PREFIX (EACH DEFICIENCY MIST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION  TAG REGULATORY OR LSC IDENTIFYING INFORMATION  Understanding of the material. Developing and delivering interactive, in-person education based on the agency is identified high-risk areas is required to prevent recurrent failure of the agency to ensure all patients received a patient specific comprehensive assessment which accurately included the patient's current health status and accurately included the patient's need for physical, psychosocial, emotional, and spiritual care; and included all areas of hospic care related to the palliation and management of the terminal illness and related conditions. Completion date: April 8, 2022 Responsible party: The Hospice Administrator  (2) Monitoring and Sustainability  - a. All education content developed for the Hospice Education Summit and based on areas of risk identified in the Comprehensive Assessment to added to new team member onboarding requirements for all clinical roles including Clinical Managers, Supervisors, RNYs, LPN's, Social Workers,	NAME OF P	DOMINED OF CLINDLES		-	STREET A	ADDRESS, CITY, STATE, ZIP COD		
CX4) ID   PREFIX   CACH DEFICIENCY MUST BE PRECEDED BY FULL   TAG   REGULATORY OR LSC IDENTIFYING INFORMATION   TAG   REGULATORY OR LSC IDENTIFY	NAME OF P	NO VIDER OR SUPPLIER	s					
PRETIX TAG  REQULATORY OR LSC IDENTIFYING INFORMATION    PRETIX TAG    PRETIX TAG   REQULATORY OR LSC IDENTIFYING INFORMATION	INDIANA	UNIVERSITY HEA	LTH HOSPICE		INDIAN	APOLIS, IN 46204		
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high-risk areas is required to prevent recurrent failure of the agency to ensure all patients received a patient specific comprehensive assessment which accurately reflected the patient's current health status and accurately included the patient's need for physical, psychosocial, emotional, and spiritual care; and included all areas of hospice care related to the palliation and management of the terminal illness and related conditions. Completion date: April 8, 2022 Responsible party: The Hospice Administrator  (2) Monitoring and Sustainability  a. All education content developed for the Hospice Education Summit and based on areas of risk identified in the Comprehensive Assessment and Care Plan Risk Assessment is added to new team member onboarding requirements for all clinical roles including Clinical Managers, Supervisors, RN's, LPN's, Social Workers,						-		
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Sustainability  a. All education content developed for the Hospice Education Summit and based on areas of risk identified in the Comprehensive Assessment and Care Plan Risk Assessment is added to new team member onboarding requirements for all clinical roles including Clinical Managers, Supervisors, RN's, LPN's, Social Workers,								
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developed for the Hospice Education Summit and based on areas of risk identified in the Comprehensive Assessment and Care Plan Risk Assessment is added to new team member onboarding requirements for all clinical roles including Clinical Managers, Supervisors, RN's, LPN's, Social Workers,						Sustainability		
developed for the Hospice Education Summit and based on areas of risk identified in the Comprehensive Assessment and Care Plan Risk Assessment is added to new team member onboarding requirements for all clinical roles including Clinical Managers, Supervisors, RN's, LPN's, Social Workers,						- ΔII adjucation content		
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Care Plan Risk Assessment is added to new team member onboarding requirements for all clinical roles including Clinical Managers, Supervisors, RN's, LPN's, Social Workers,								
added to new team member onboarding requirements for all clinical roles including Clinical Managers, Supervisors, RN's, LPN's, Social Workers,						Comprehensive Assessment a	and	
onboarding requirements for all clinical roles including Clinical Managers, Supervisors, RN's, LPN's, Social Workers,						Care Plan Risk Assessment is	;	
clinical roles including Clinical Managers, Supervisors, RN's, LPN's, Social Workers,								
Managers, Supervisors, RN's, LPN's, Social Workers,								
LPN's, Social Workers,						_		
Chapiains, Therapists, Bereavement Coordinators,						Chaplains, Therapists,		
Volunteer Coordinators, and								

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LIR112

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	OF CORRECTION	IDENTIFICATION NUMBER  151511	A. BUILDING B. WING	00	COMPLETED 03/08/2022
	ROVIDER OR SUPPLIER UNIVERSITY HEA		950 N I	ADDRESS, CITY, STATE, ZIP COD MERIDIAN ST, SUITE 700 IAPOLIS, IN 46204	
(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
				Aides. Requiring all newly hire clinical team members to complete this education and to complete the written exam covering content is an essenti step to ensure understanding the requirement that all patien receive a patient-specific comprehensive assessment the includes the patient's need for physical, psychosocial, emotion and spiritual care, and accuratincludes all areas of hospice or related to the palliation and management of the patient's terminal illness and related conditions and in the prevention non-compliance with this condition.  Completion date: April 8, 202 Responsible party: The Hospical Quality Manager  b. Team members on leave absence during the Hospice Education Summit will be scheduled for review of this material at the first bi-weekly Hospice Onboarding Session occur upon their return to work Requiring all active team mem who missed the initial session complete the first available onboarding session of this material will ensure all team members have received this material, have been given the opportunity to ask questions, a have completed written evaluate to confirm their understanding	al of ts nat onal, tely care on of to k. hbers s to

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NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 151511		JILDING	ONSTRUCTION 00	(X3) DATE COMPI 03/08	
PROVIDER OR SUPPLIER		•	950 N N	ADDRESS, CITY, STATE, ZIP COD MERIDIAN ST, SUITE 700 IAPOLIS, IN 46204		
SUMMARY (EACH DEFICIEN				PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIL DEFICIENCY)  the content. Ensuring all clinic team members have complet these steps is an essential strincrease education and understanding of the requirent that all patients receive a patient-specific comprehensive assessment that includes the patient's need for physical, psychosocial, emotional, and spiritual care, and accurately includes all areas of hospice related to the palliation and management of the patient's terminal illness and related conditions and in the preventinon-compliance with this condition.  Completion date: April 8, 202 Responsible party: The Hospital party in the preventinon of the patient's terminal illness and related conditions.	cal ed ep to nent ve care ion of	(X5) COMPLETION DATE
				Responsible party: The Hosp Quality Manager  c. Ten percent of monthly hospice census will undergo detailed record review by hos quality audit RN's to confirm the each patient received a patient-specific comprehensive assessment that included the patient's need for physical, psychosocial, emotional, and spiritual care, and accurately included all areas of hospice related to the palliation and management of the patient's	epice that ve	

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terminal illness and related conditions. Reviewing these records will allow for immediate coaching and remediation with any team member determined to be

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STATEMEN	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 151511	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY  COMPLETED  03/08/2022
	ROVIDER OR SUPPLIER		950 N I	ADDRESS, CITY, STATE, ZIP COD MERIDIAN ST, SUITE 700 NAPOLIS, IN 46204	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
TAG	REGULATORY OR	LISC IDENTIFYING INFORMATION	TAG	deficient in meeting the requirement and will allow for accountability measures to be taken should the deficiency re Auditing records with subseque coaching, remediation and accountability is an essential sto prevent recurrence of noncompliance with the stand Audits will continue until 100% compliance is achieved for 3 consecutive months and will the continue at a regular cadence indefinitely to ensure sustaine compliance with this standard Completion date for implementation of audit proce April 8, 2022 Responsible Party: The Hospin Quality Manager  d. Hospice Supervisors or designees will complete 1 shad visit per week with rotating members of their regional clinate team. The supervisor or designee will observe visit documentation. The supervisor designee will complete the "Hospice Comprehensive Assessment, Care Plan, and Neview" tracer document avail electronically in the agency's network. The supervisor or designee observing patients in	eccur. Juent Step  ard.  And And And And And And And And And An
				field combined with record rev	

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will allow the supervisor or designee to take immediate action

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 151511	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 03/08/2022
	PROVIDER OR SUPPLIE		950 N I	ADDRESS, CITY, STATE, ZIP COD MERIDIAN ST, SUITE 700 IAPOLIS, IN 46204	
(X4) ID PREFIX 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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				if a team member is determined be deficient in ensuring that a patients received a patient specomprehensive assessment waccurately reflected the patient current health status and accurately included the patient need for physical, psychosociemotional, and spiritual care; included all areas of hospice or related to the palliation and management of the terminal illness and related conditions. Actions taken will include immediate coaching, remediate and accountability measures should the deficiency recur. To supervisor or designee complishared visits and documentating review is a required step to pronocompliance with this standard visits and document rewill continue until 100% compliance is achieved for 3 consecutive months and will the continue at a regular cadence indefinitely to ensure sustained completion date for implementation of the audit process: April 8, 2022 Responsible party: The Hospi Quality Manager	ed to II ecific //hich it's it's al, and care  tion, The eting ion event dard. eview hen d
				Plan of correction requirements: It clearly states the specific na	ature

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of the corrective actions for each

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	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 151511	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 03/08/2022
	ROVIDER OR SUPPLIER UNIVERSITY HEA		950 N	ADDRESS, CITY, STATE, ZIP COD MERIDIAN ST, SUITE 700 NAPOLIS, IN 46204	
(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 APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
L 0524 Bldg. 00	identify the physic emotional, and sp terminal illness that order to promote t	ve assessment must al, psychosocial, iritual needs related to the at must be addressed in he hospice patient's rt, and dignity throughout		deficiency. (2) It sets reasonal completion dates for all deficiencies prior to the termination date unless an extension is requested and approved. (3) It describes how your plan/action will prevent recurrence. And (4), it describes who will be the person(s) responsible for implementing monitoring the plan for future compliance with the regulation response to each deficiency of the CMS-2567 is required.	w pes and ns. A
	and dying process		L 0524	L524 CONTENT OF COMPREHENSIVE ASSESSMENT CFR(s): 418.8 The comprehensive assessment identify the physical, psychosocial, emotional, and spiritual needs related to the terminal illness that must be addressed in order to promot hospice patient's well-being, comfort, and dignity throughouthe dying process.  This STANDARD is not met a evidenced by: Based on reco	e the ut

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	T OF DEFICIENCIES DF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 151511	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	COMP	E SURVEY LETED 3/2022
	ROVIDER OR SUPPLIE UNIVERSITY HEA		950 N I	ADDRESS, CITY, STATE, ZIP COI MERIDIAN ST, SUITE 700 NAPOLIS, IN 46204		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APP DEFICIENCY)	CTION JLD BE ROPRIATE	(X5) COMPLETION DATE
				review and interview, the failed to ensure all patier received an accurate and age-appropriate compress assessment that identifies physical, psychosocial, eand spiritual needs related to the patient's teillness, comfort, and digrithroughout the dying pro (Patients 8 and 12) of 2 a pediatric records reviewed total sample of 16 active.  Plan of Correction  (1) Specific nature of accorrective actions inclused actions inclused action will recurrence, and responsible party  - a. A special edition of a communication tool "Host Hot Topics" which contained the Hospice 2. Federal Survey results we verbally reviewed with Hot team members; an email was also provided to team members for independer Included in the results so was detail concerning the the agency to ensure all received an accurate and age-appropriate compress assessment that identifies physical, emotional, and needs related to the patieterminal illness, comfort,	ants ad anensive ad the amotional, arminal aity acess for 2 active ad in a arecords  a	

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	T OF DEFICIENCIES DF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 151511	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 03/08/2022
	ROVIDER OR SUPPLIEI		950 N	ADDRESS, CITY, STATE, ZIP COD MERIDIAN ST, SUITE 700 NAPOLIS, IN 46204	
(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 CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRI DEFICIENCY)	DBE COMPLETION DATE
				dignity throughout the dying process for two pediatric presents are quire prevent recurrence of the deficiencies identified during survey.  Completion date: March 1 Responsible party: The Hong Administrator  - b. To ensure all hospic patients receive an accurate age-appropriate compreher assessment that identifies physical, psychosocial, en and spiritual needs related patient's terminal illness the Hospice Administrator and Hospice Infection Prevent completed a Comprehens Assessment and Care Plan Risk Assessment to identified frisk for failure to provide with needed care and send Components of assessment care planning were ranked probability, risk, and preparategories with combined of 9 and higher determined deficient. Pediatric care with identified as a high-risk are based on the risk assessmaligns with survey findings Identifying the areas of grisk for deficiency in the agability to identify the physical psychosocial, emotional, as spiritual needs related to the terminal illness of all paties.	patients. It of It distep to Ing the It distep to Ing the It distep to

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	Г OF HEALTH AND HU R MEDICARE & MEDIC					RM APPROVED B NO. 0938-039
STATEME	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 151511	(X2) MULTIPLE A. BUILDING B. WING	construction <u>00</u>	(X3) DATE S COMPL 03/08/	SURVEY ETED
NAME OF	PROVIDER OR SUPPLIEF	<b>.</b>		T ADDRESS, CITY, STATE, ZIP COD	•	
INDIANA	UNIVERSITY HEA	LTH HOSPICE		I MERIDIAN ST, SUITE 700 NAPOLIS, IN 46204		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE  ICY MUST BE PRECEDED BY FULL  DUSC DEPUTE VINC DISCOMMATION	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	E RIATE	(X5) COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	ages is required in order to precurrence of the agency's fato meet this condition of participation and ensure all patients receive an accurate age-appropriate comprehens assessment that identifies the physical, psychosocial, emote and spiritual needs related to patient's terminal illness, corrand dignity throughout the dyprocess.  Completion date: March 18, Responsible party: The Hosp Administrator and the Hospid Infection Preventionist  c. Education was developed for the following areas identified the Comprehensive Assessment Care Planning Risk Assessment tool: Pediatric Assessment and Care Planning Bereavement Risk, Languag Barrier, General Safety, Honsafety, Abuse/Neglect/Exploitation, Oxygen Safety, and Medicat Management. While developed education on these topics the agency's state and national hospice organizations were consulted and a comprehensive review of available literature undertaken by the Hospice Administrator. Education material contents and the process of the second contents and a comprehensive of available literature undertaken by the Hospice Administrator. Education material contents are second contents and comprehensive of available literature undertaken by the Hospice Administrator. Education material contents are second contents and comprehensive of available literature undertaken by the Hospice Administrator. Education material contents are second contents and contents are second contents.	ailure  and sive le tional, o the mfort, lying  2022 bice ce  ped fied in ment  ing, le ne Fire  Falls, cion bing e sive was	DATE

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was selected based on relevancy and timeliness. Education material will be delivered at the four-hour Hospice Education

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 151511	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY  COMPLETED  03/08/2022
	PROVIDER OR SUPPLIER UNIVERSITY HEA		950 N I	ADDRESS, CITY, STATE, ZIP COD MERIDIAN ST, SUITE 700 IAPOLIS, IN 46204	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC 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	REGULATORT OF	A LOC IDENTIFY THAT INFORMATION	IAU	Summit for clinical employees the hospice including Clinical Managers, Supervisors, RNs, LPNs, Social Workers, Chapla Therapists, Bereavement Coordinators, Volunteer Coordinators, and Aides. Education will be interactive w relevant examples provided for each topic. Team members who be given the opportunity to asl questions throughout the education presentation. Team members will be given a written exam covering each topic presented to confirm understanding of the material. Developing and delivering interactive, in-person education based on the agency's identifier isk areas is required to prevent recurrent failure to ensure all patients receive an accurate a age-appropriate comprehensing assessment that identifies the physical, psychosocial, emotion and spiritual needs related to the patient's terminal illness, comfiand dignity throughout the dying process.  Completion date: April 8, 2022 Responsible party: The Hospic Administrator	of  ith r rill c n ed nt nd ve onal, che fort, ng
				Sustainability - a. All education content	

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES

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ENTERS FOR	MEDICARE & MEDIC	AID SERVICES				OM	B NO. 0938-039
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	LTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	ETED
		151511	B. WI	NG		03/08/	2022
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD MERIDIAN ST, SUITE 700		
INDIANA	UNIVERSITY HEA	LTH HOSPICE		INDIAN	APOLIS, IN 46204		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
DDEEDA	(EACH DEFICIEN	CV MUCT DE DRECEDED DV EUL I	Ι,	DDEELV	(EACH CORRECTIVE ACTION SHOULD BE		COMPLETION

INDIANA	UNIVERSITY HEALTH HOSPICE	INDIAN	IAPOLIS, IN 46204	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
			Education Summit and based on	
			areas of risk identified in the	
			Comprehensive Assessment and	
			Care Plan Risk Assessment is	
			added to new team member	
			onboarding required training for all	
			clinical roles including Clinical	
			Manager, Supervisor, RN, LPN,	
			Social Worker, Chaplain,	
			Bereavement Coordinator,	
			Volunteer Coordinator, Therapist,	
			and Aide. Requiring all newly hired	
			clinical team members to	
			complete this education and to	
			complete the written exam	
			covering content is an essential	
			step to ensure understanding of	
			the requirement that all patients	
			receive an accurate,	
			age-appropriate, comprehensive	
			assessment that identifies the	
			physical, psychosocial, emotional,	
			and spiritual needs related to the	
			patient's terminal illness and to	
			prevent recurrence of	
			non-compliance with this condition	
			of participation.	
			Completion date: April 8, 2022	
			Responsible party: The Hospice	
			Quality Manager	
			<b>b.</b> Team members on leave of	
			absence during the Hospice	
			Education Summit will be	
			scheduled for review of this	
			material at the first bi-weekly	
			Hospice Onboarding Session to	
			occur upon their return to work.	
			Requiring all active team members	
			who missed the initial sessions to	
			Wite Illiaged the little acceptance to	

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Event ID: LIR112 Facility ID: 005128

If continuation sheet Page 33 of 108

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 03/30/2022 FORM APPROVED OMB NO. 0938-039

CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES				OM	IB NO. 0938-039
STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER 151511		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>				
		B. WING			03/08	/2022	
				STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIER	8			MERIDIAN ST, SUITE 700		
INDIANA	UNIVERSITY HEA	LTH HOSPICE		1	NAPOLIS, IN 46204		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION		TAC	TAG	DEFICIENCY		DATE
					complete the first available		
					onboarding session of this		
					material will ensure all team		
					members have received this		
					material, have been given the		
					opportunity to ask questions, a	and	
					have completed written evalua	ation	
					to confirm their understanding	of	
					the content. Ensuring all clinic	al	
					team members have complete	ed	
					these steps is an essential ste	p to	
					increase education and		
					understanding of the requirem	ent	
					that all patients receive an		
					accurate age-appropriate		
					comprehensive assessment the	nat	
					identifies the physical,		
					psychosocial, emotional, and		
					spiritual needs related to the		
					patient's terminal illness and to	0	
					prevent recurrence of		
					non-compliance with this		
					requirement.		
					Completion date: April 8, 2022	2	
					Responsible party: The Hospi	ce	
					Quality Manager		
					c. All pediatric records will		
					undergo detailed record reviev	w by	
					hospice quality audit RNs to		
					confirm that each patient rece	ived	
					an accurate age-appropriate		
					comprehensive assessment the	nat	
					identifies the physical,		
					psychosocial, emotional, and		
					spiritual needs related to the		
					patient's terminal illness.		
					Reviewing these records will a	allow	

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Event ID:

LIR112

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for immediate coaching and remediation with any team

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 03/30/2022 FORM APPROVED

CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES				OM	IB NO. 0938-039	
STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER 151511		IDENTIFICATION NUMBER	A. Bl	A. BUILDING <u>00</u>			COMPLETED	
		B. WING			03/08	/2022		
				CTDEET	ADDRESS, CITY, STATE, ZIP COD			
NAME OF I	PROVIDER OR SUPPLIEF	₹			MERIDIAN ST, SUITE 700			
INDIANA	UNIVERSITY HEA	LTH HOSPICE			NAPOLIS, IN 46204			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID			(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PROVIDER'S PLAN OF CORRECTION PREFIX  (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIATE OF THE APPROPRIATE O		TE	COMPLETION		
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	DEFICIENCY)	NIE.	DATE	
					member determined to be def	icient		
					in meeting the requirement ar			
					will allow for accountability			
					measures to be taken should	the		
					deficiency recur. Auditing of			
					records with subsequent			
					coaching, remediation, and			
					accountability measures for te	eam		
					members who fail to meet the			
					requirements is an essential s			
					to prevent recurrence of	•		
					non-compliance with the stand	dard.		
					Audits will continue until 100%			
					compliance is achieved for thr	ee		
					consecutive months and will the			
					continue at a regular cadence			
					indefinitely to ensure sustaine			
					compliance with this standard			
					Completion date for			
					implementation of audit proce	ss:		
					April 8, 2022			
					Responsible Party: The Hosp	ice		
					Quality Manager			
					d. Hospice Supervisors or			
					designees will complete a sha			
					visit within the first week of ne	wiy		
					admitted pediatric hospice	ho		
					patients coming on service. The	ile		
					Supervisors or designees will	rio		
					complete the "Hospice Pediat	HC		
					Shared Visit and Document			
					Review" tracer available			
					electronically in the agency's			
					network. The Supervisor or	_		
					designee observing care in the			
					field combined with record rev	riew		
					will allow the supervisor or			

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designee to take immediate action if a team member is determined to

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 151511		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 03/08/2022	
	ROVIDER OR SUPPLIER		950 N	ADDRESS, CITY, STATE, ZIP COD MERIDIAN ST, SUITE 700 NAPOLIS, IN 46204	
(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
				be deficient in ensuring that the patient received an age-appropriate comprehensis assessment that identifies all required components and need Actions taken will include immediate coaching, remediate and accountability measures should the deficiencies be observed. The supervisor or designee completing shared wand documentation review is a essential step to prevent non-compliance with the stand Shared visits and document rewill continue until 100% compliance is achieved for 3 consecutive months and will to continue at a regular cadence indefinitely to ensure sustained completion date for implementation of the audit process: April 8, 2022 Responsible party: The Hospit Quality Manager	ve eds. tion, visits an dard. eview hen
				Plan of correction requirements: It clearly states the specific na of the corrective actions for ea deficiency. (2) It sets reasona completion dates for all deficiencies prior to the termination date unless an extension is requested and approved. (3) It describes how your plan/action will prevent recurrence. And (4), it describ	ach ble

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		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  00			(X3) DATE SURVEY COMPLETED	
		151511		B. WING 03/08/2022			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 950 N MERIDIAN ST, SUITE 700 INDIANAPOLIS, IN 46204				
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE  CY MUST BE PRECEDED BY FULL  LISC IDENTIFYING INFORMATION		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION
PREFIX TAG	418.56(b) PLAN OF CARE All hospice care a patients and their individualized writt by the hospice inte collaboration with any), the patient o primary caregiver	and services furnished to families must follow an ten plan of care established erdisciplinary group in the attending physician (if r representative, and the in accordance with the any of them so desire.	L 03	TAG	who will be the person(s) responsible for implementing a monitoring the plan for future compliance with the regulation response to each deficiency o the CMS-2567 is required.  L543 Plan OF CARE CFR(s): 418.56 (b) All hospice care and services furnished to patients and their families must follow an individualized written plan of c established by the hospice interdisciplinary gi in collaboration with the attence	and ns. A n	COMPLETION DATE  04/08/2022
					physician (if any), the patient of representative, and the primar caregiver in accordance with t patient's needs if any of them desire.	ry he	
					This STANDARD is not met as evidenced by: Based on recor review and interview, the ager failed to ensure all hospice ca and services furnished to patients their families followed an	d ncy re	

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Event ID:

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 151511		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 03/08/2022	
	ROVIDER OR SUPPLIE		950 N I	ADDRESS, CITY, STATE, ZIP COD MERIDIAN ST, SUITE 700 IAPOLIS, IN 46204	
(X4) ID PREFIX 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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				individualized written plan of contestablished by the hospice interdisciplinary group in collaboration with the attending physician (if any), the patient of representative, and the primar caregiver in accordance with the patient's needs as they desire 1 (Patient 8) of 2 pediatric patients.	g or ry he , for
				Plan of Correction  (1) Specific nature of the corrective actions including completion dates, description of how each action will prevene recurrence, and responsible party	<u>n</u> ent
				a. A special edition of the communication tool "Hospice Huddle Hot Topics" which contained the Hospice 2/15/20 Federal Survey results was verbally reviewed with Hospice team members; an email copy was also provided to team	e /
				members for independent revi Included in the results summa was detail concerning the failu the agency to ensure all hospi care and services furnished to patients and their families follo an individualized written plan of care established by the hospic interdisciplinary group in collaboration with the attendin physician (if any), the patient of representative, and the primar caregiver in accordance with the	g g g g g g

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PRINTED: 03/30/2022 FORM APPROVED OMB NO. 0938-039

		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 00  B. WING		00	COMPLETED	
		151511	B. W	ING		03/08/	2022
NAME OF P	PROVIDER OR SUPPLIEI				ADDRESS, CITY, STATE, ZIP COD		
			950 N MERIDIAN ST, SUITE 700				
INDIANA	UNIVERSITY HEA	ALTH HOSPICE		INDIAN	APOLIS, IN 46204		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	NCY MUST BE PRECEDED BY FULL		PREFIX  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	ATE.	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY)	•	DATE
					patient's needs as they desire	e TOr	
					one patient reviewed during	ness	
					survey. Team member aware of survey results is a required		
					to prevent recurrence of the	sieh	
					deficiencies identified during t	he	
					survey.		
					Completion date: March 18, 2	022.	
					Responsible party: The Hospi		
					Administrator		
					_		
					b. Education was develope		
					Pediatric Assessment and Ca	re	
					Planning. While developing		
					education on these topics the		
					agency's state and national		
					hospice organizations were		
					consulted and a comprehensi		
					review of available literature v	/aS	
					undertaken by the Hospice Administrator. Education mat	orial	
					was selected based on releva		
					and timeliness. Education	y	
					material will be delivered at		
					four-hour Hospice Education		
					Summits for clinical employee	s of	
					the hospice including Clinical		
					Managers, Supervisors, RN's	,	
					LPN's, Social Workers,		
					Chaplains, Therapists,		
					Bereavement Coordinators,		
					Volunteer Coordinators, and		
					Aides. Education will be in-pe	rson	
					and interactive with relevant		
					examples provided for each to	-	
					Team members will be given	uie	
					opportunity to ask questions throughout the education		
					presentation. Team members	: will	
					be given a written exam cover		
			1		I so given a whiteir chain cover	y	l

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 151511	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 03/08/2022		
	PROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZIP COD 950 N MERIDIAN ST, SUITE 700 INDIANAPOLIS, IN 46204				
(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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
				each topic presented to confir their understanding of the man Developing and delivering interactive, in-person education based on the agency's failure ensure all hospice care and services furnished to patients their families follows an individualized written plan of cis a required step to prevent recurrence of the agency's fail to meet the requirement.  Completion date: April 8, 2022 Responsible party: The Hospin Administrator  (2) Monitoring and Sustainability  - a. All education content developed for the Hospice Education Summit is added to new team member onboarding training requirements for all cl roles including Clinical Manag Supervisors, RN's, LPN's, Soworkers, Chaplains, Therapis Bereavement Coordinators, Volunteer Coordinators, Volunteer Coordinators, and Aides. Requiring all newly hir clinical team members to complete this education and to complete the written exam covering content is an essentistep to ensure understanding	m terial.  on to and care lure 2 ce  g inical eers, cial ets, ed o		

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the requirement that all hospice

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STATEMENT OF DEFICIENCIES X1		X1) PROVIDER/SUPPLIER/CLIA	X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u> COMPLE			ETED	
		151511	B. WING 03/08/2022			/2022	
		<u> </u>	<u> </u>	CTDEET /	ADDRESS CITY STATE 7IB COD		
NAME OF P	PROVIDER OR SUPPLIER	8	STREET ADDRESS, CITY, STATE, ZIP COD  950 N MERIDIAN ST, SUITE 700				
INIDIANA	UNIVERSITY HEA	I TH HOSPICE					
INDIANA	ONIVERSIT HEA	LITTIOGFICE	_	INDIAN	APOLIS, IN 46204		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	TE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION	ļ	TAG	DEFICIENCY)		DATE
					care and services furnished to		
					patients and their families mus		
					follow an individualized writter	-	
					of care established by the hos	pice	
					interdisciplinary group in		
					collaboration with the attendin	-	
					physician (if any), the patient o		
					representative, and the primar	-	
					caregiver in accordance with t		
					patient's needs if any of them		
					desire and will prevent failure	ເປ	
					meet this requirement.	)	
					Completion date: April 8, 2022 Responsible party: The Hospi		
					Quality Manager	U <del>C</del>	
					Guanty Manayer		
					- b. Team members on leave	e of	
					absence during the four-hour	= -	
					Hospice Education Summit wi	ll be	
					scheduled for review of this		
					material at the first bi-weekly		
					Hospice Onboarding Session	to	
					occur upon their return. Requ	iring	
					all active team members who		
					missed the initial sessions to		
					complete the first available		
					onboarding session of this		
					material will ensure all team		
					members have received this		
					material, have been given the		
					opportunity to ask questions, a		
					have completed written evalua		
					to confirm their understanding		
					the content. Ensuring all clinic		
					team members have complete	ea	
					these steps is essential to		
					increasing education and	4	
					understanding of the requirem		
					that all hospice care and servi	ces	

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If continuation sheet

furnished to patients and their

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CENTERS FOR MEDICARE & MEDICAID SERVICES					OMB NO. 0938-039	
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED	
		151511	B. WING		03/08/2022	
NAME OF P	ROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP COD		
				MERIDIAN ST, SUITE 700		
INDIANA UNIVERSITY HEALTH HOSPICE		INDIA	NAPOLIS, IN 46204			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		(X5)	
PREFIX		ICY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE	
1110	REGUENTURE OF	REDU IDENTIFICAÇÃO DE COMPANIO	1110	families must follow an	5.112	
					noro	
				individualized written plan of o	are.	
				This plan of care must be		
				established by the hospice		
				interdisciplinary group in		
				collaboration with the attending	g	
				physician (if any), the patient	or	
				representative, and the prima	ry	
				caregiver in accordance with t	the	
				patient's needs if any of them	so	
				desire and will prevent recurre	ence	
				of failure to meet this requiren		
				for all patients.		
				Completion date: April 8, 2022	,	
				Responsible party: The Hospi		
				Quality Manager		
				Quality Manager		
				c. Ten percent of monthly		
				hospice census will undergo		
				detailed record review by hos	pice	
				quality audit RNs to confirm th		
				all hospice care and services		
				furnished to patients and their		
				families must follow an		
				individualized written plan of c	eare	
				established by the hospice	, ai c	
				•		
				interdisciplinary group in		
				collaboration with the attending	-	
				physician (if any), the patient		
				representative, and the prima	•	
				caregiver in accordance with t		
				patient's needs if any of them		
				desire. Reviewing these recor		
				will allow for immediate coach	ing	
				and remediation with any tear	n	
				member determined to be def		
				in meeting the requirement ar	nd	
				will allow for accountability		

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If continuation sheet

measures to be taken should the deficiency recur. Auditing records

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STATEMENT OF DEFICIENCIES X1) PROVID		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED	
		151511	B. WING 03/08/2022			
			STREET	ADDRESS, CITY, STATE, ZIP COD	1	
NAME OF F	PROVIDER OR SUPPLIEF	₹		MERIDIAN ST, SUITE 700		
INDIANA	UNIVERSITY HEA	ALTH HOSPICE	INDIAN	IAPOLIS, IN 46204		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
				with subsequent coaching,		
				remediation, and accountability	-	
				measures for team members		
				fail to meet these requirement	S IS	
				an essential step to prevent		
				recurrence of noncompliance.		
				Audits will continue until 100%		
				compliance is achieved for the consecutive months and will the		
			continue at a regular cadence indefinitely to ensure sustaine			
				compliance with this standard		
				Completion date for	•	
				implementation of audit proce	ee.	
				April 8, 2022	J	
				Responsible Party: The Hosp	ice	
				Quality Manager		
				d Hoopigo supervisors se		
				d. Hospice supervisors or		
				designees will complete one	ating	
				shared visit per week with rota members of their regional clin	-	
				team. The supervisor or design		
				will review the patient record i	- I	
				advance of the visit, will obser		
				the visit, and will observe visit		
				documentation. The supervisor		
				designee will complete the	·· -·	
				"Hospice Comprehensive		
				Assessment, Care Plan, and	√isit	
				Review" tracer document avail		
				electronically in the agency's		
				network. The supervisor or		
				designee observing patients in	n the	
				field combined with record rev		
				will allow the supervisor or		
				designee to take immediate a	ction	
				if a team member is determine	ed to	
				be deficient in ensuring that a		

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If continuation sheet

hospice care and services

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 00 COMPLE				
		151511	B. WING 03/08/2022				
NAME OF P	PROVIDER OR SUPPLIER		_		ADDRESS, CITY, STATE, ZIP COD		
			950 N MERIDIAN ST, SUITE 700				
INDIANA	UNIVERSITY HEA	LTH HOSPICE		INDIAN	IAPOLIS, IN 46204		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY)		DATE
					furnished to patients and their families follows an individualiz		
					written plan of care establishe		
					the hospice interdisciplinary gr	-	
					in collaboration with the attend	-	
					physician (if any), the patient of	-	
					representative, and the primar	-	
					caregiver in accordance with t		
					patient's needs if any of them		
					desire. Actions taken will inclu		
					immediate coaching, remediate	ion,	
					and accountability measures should the deficiency recur. T	'he	
					supervisor or designee comple		
					shared visits and documentati	-	
					review is a required step to pro		
					non-compliance with this		
					requirement. Shared visits an	d	
					document review will continue		
					100% compliance is achieved		
					three consecutive months and		
					then continue at a regular cad indefinitely to ensure sustained		
					compliance with this condition		
					participation.	J.	
					Completion date for		
					implementation of the audit		
					process: April 8, 2022		
					Responsible party: Hospice		
					Quality Manager		
					Plan of correction		
					requirements:		
					It clearly states the specific na	ture	
					of the corrective actions for ea		
					deficiency. (2) It sets reasonal	ole	
					completion dates for all		
					deficiencies prior to the		
					termination date unless an		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 151511		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 00 COMPLETED B. WING 03/08/2022				
	PROVIDER OR SUPPLIE		950 N	STREET ADDRESS, CITY, STATE, ZIP COD 950 N MERIDIAN ST, SUITE 700 INDIANAPOLIS, IN 46204		
(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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
	418.56(b) PLAN OF CARE The hospice mus and the primary of education and tra hospice as appro	t ensure that each patient care giver(s) receive lining provided by the priate to their receives and services		extension is requested and approved. (3) It describes how your plan/action will prevent recurrence. And (4), it describes who will be the person(s) responsible for implementing monitoring the plan for future compliance with the regulation response to each deficiency of the CMS-2567 is required.  L544 PLAN OF CARE CFR(s. 418.56(b)  The hospice must ensure that each patient and the primary giver(s) receive education and training provided by the hospi appropriate to their responsib for the care and services identing the plan of care.  This STANDARD is not met a evidenced by: Based on recoil	DATE  DATE  DATE  DATE  DATE  DATE  DATE  DATE	
				review and interview, the age failed to ensure that all patien their families, and/or representative received education and training related the specific and age-appropriate needs for 1 (Patient #8) of 2	ts, es	

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Event ID:

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3)			(3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u> COMPLETED				
		151511	B. WING 03/08/2022			2	
				STREET	ADDRESS CITY STATE 710 COD		
NAME OF F	PROVIDER OR SUPPLIER	8	STREET ADDRESS, CITY, STATE, ZIP COD  950 N MERIDIAN ST, SUITE 700				
ΙΝΟΙΔΝΔ	UNIVERSITY HEA	I TH HOSPICE			APOLIS, IN 46204		
אוואורוטואור	ONVERONTHEA			וואטואוו	5215, 114 70207		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE COM	<b>IPLETION</b>
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	1	TAG	DEFICIENCY)		DATE
					active pediatric patients.		
					Plan of Correction		
					(1) Specific nature of the		
					corrective actions including		
					completion dates, descriptio		
					of how each action will preve	ent_	
					recurrence, and responsible		
					party		
					a. A special edition of the		
					communication tool "Hospice		
					Huddle Hot Topics" which		
					contained the Hospice 2/15/20	122	
					Federal Survey results was		
					verbally reviewed with Hospic		
					team members; an email copy		
					was also provided to team		
					members for independent revi		
					Included in the results summa	-	
					was detail concerning the failu	re of	
					the agency to ensure that all		
					patients, their families, and/or	_4:	
					representatives received educ	ation	
					and training related to their		
					specific age-appropriate need	s tor	
					one patient reviewed. Team		
					member awareness of survey		
					results is a required step to		
					prevent recurrence of the		
					deficiencies identified during the	ie	
			1		Survey.		
			1		Completion date: March 18, 20		
					Responsible party: The Hospi	je	
					Administrator		
					-		
					h Toors manufacture (		
					b. Team member education	'	
			1		was developed concerning		
					pediatric comprehensive		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 151511		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY  COMPLETED  03/08/2022			
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 950 N MERIDIAN ST, SUITE 700 INDIANAPOLIS, IN 46204				
(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		
				assessment, care planning ar caregiver education needs. We developing education on these topics the agency's state and national hospice organizations were consulted and a comprehensive review of availiterature was undertaken by thospice administrator. Team member education material we selected based on relevancy stimeliness. Team member education will be delivered at four-hour Hospice Education Summit for clinical employees the hospice including Clinical Managers, Supervisors, RN's LPN's, Social Workers, Chaplains, Therapists, Bereavement Coordinators, Volunteer Coordinators, Volunteer Coordinators, and Aides. Education will be in-pe and interactive with relevant examples provided for each to Team members will be given opportunity to ask questions throughout the education presentation. Team members be given a written exam cover each topic presented to confir understanding of the material. Developing and delivering interactive, in-person education based on the agency's failure meet patient and caregiver education needs is essential to prevent recurrence of non-compliance with this requirement. Completion date: April 8, 2022.	Inhile de solution de la composition della compo		

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STATEMENT OF DEFICIENCIES X1) PROV		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u> COM			COMPL	ETED
		151511	B. W			03/08	
		1		_		20,00	
NAME OF F	PROVIDER OR SUPPLIEF	8	STREET ADDRESS, CITY, STATE, ZIP COD				
					MERIDIAN ST, SUITE 700		
INDIANA	UNIVERSITY HEA	ALTH HOSPICE		INDIAN	IAPOLIS, IN 46204		
(X4) ID	SUMMARY	MARY STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	ļ	TAG	DEFICIENCY)		DATE
					Responsible party: The Hospi	ce	
					Administrator.		
					(2) <u>Monitoring and</u>		
					<u>Sustainability</u>		
					a. Indiana University Heal		
					Riley Hospital for Children pro		
					the agency with patient and fa	-	
					education materials which will		
					used by hospice team member		
					to educate patients and familie		
					concerning identified needs of		
					pediatric hospice patients. Thi		
					material is age appropriate an		
					developed by Indiana Univers	-	
					Health Riley Hospital for Child	lren	
					and is essential to prevent		
					recurrence of failure to ensure		
					all patients, their families, and		
					representative's receive educa		
					and training related to the spe		
					and age-appropriate needs fo	r	
					pediatric patients.		
					Completion date: March 23, 2		
					Responsible party: The Hospi	ce	
					Quality Manager		
					<b>b.</b> All education content		
					developed for the Hospice		
					Education Summit and based	on	
					areas of-risk identified in the	OH	
					Comprehensive Assessment	and	
					Care Plan Risk Assessment is		
					added to new team member	,	
					onboarding requirements for a	all	
					clinical roles including, Clinica		
					Managers, Supervisors, RN, L Social Worker, Chaplain,	-i⁻IN,	
					•		
	I		1		Therapists, Bereavement		1

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Coordinator, Volunteer

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u>		COMPL	ETED
		151511	B. WI	NG		03/08	/2022
				_			
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD		
					MERIDIAN ST, SUITE 700		
INDIANA	UNIVERSITY HEA	ALTH HOSPICE		INDIAN	IAPOLIS, IN 46204		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					Coordinators, and Aides.		
					Requiring all newly hired clinic	cal	
					team members to complete th	is	
					education and to complete the	)	
					written exam covering content		
					an essential step to ensure		
					understanding of the requirem	ent	
					that all patients receive an		
					accurate, age-appropriate,		
					comprehensive assessment the	nat	
					identifies the physical,		
					psychosocial, emotional, and		
					spiritual needs related to the		
					patient's terminal illness and to	0	
					prevent recurrence of		
					non-compliance with this		
					requirement.		
					Completion date: April 8, 2022		
					Responsible party: The Hospi	ce	
					Quality Manager		
					-		
					<b>c.</b> Team members on leav	e of	
					absence during the four-hour		
					Hospice Education Summit wi	ll be	
					scheduled for review of this		
					material at the first bi-weekly		
					Hospice Onboarding Session		
					occur upon their return. Requ	ııring	
					all active team members who		
					missed the initial sessions to		
					complete the first available		
					onboarding session of this		
					material will ensure all team		
					members have received this		
					material, have been given the		
					opportunity to ask questions, a		
					have completed written evalua		
					to confirm their understanding		
					the content. Ensuring all clinic		
1	1				team members have complete	ed	I

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 151511	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY  COMPLETED  03/08/2022
	ROVIDER OR SUPPLIE UNIVERSITY HEA		950 N I	ADDRESS, CITY, STATE, ZIP COD MERIDIAN ST, SUITE 700 JAPOLIS, IN 46204	
(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)	(X5) COMPLETION DATE
				these steps is essential to increase education and understanding of the requirem that all patients receive an accurate, age-appropriate, comprehensive assessment the identifies the physical, psychosocial, emotional, and spiritual needs related to the patient's terminal illness and to prevent recurrence of non-compliance with this requirement.  Completion date: April 8, 2022 Responsible party: The Hospid Quality Manager  d. All pediatric records will undergo detailed record review hospice quality audit RNs to confirm that each patient recei an accurate, age-appropriate, comprehensive assessment the identifies the physical, psychosocial, emotional, and spiritual needs related to the patient's terminal illness and education was provided. Reviet these records will allow for immediate coaching and remediation with any team member determined to be defined in meeting the requirement and will allow for accountability measures to be taken should the deficiency recur. Auditing recovith subsequent coaching, remediation and accountability measures for team members with the patient of the patient	ent nat  2 2 2 3 3 4 5 5 6 7 7 8 7 8 8 7 8 8 8 8 8 8 8 8 8 8 8 8

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 151511	(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 03/08/2022
	PROVIDER OR SUPPLIER UNIVERSITY HEA		950 N	ADDRESS, CITY, STATE, ZIP COD MERIDIAN ST, SUITE 700 NAPOLIS, IN 46204	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
				an essential step to prevent recurrence of noncompliance Audits will continue until 100% compliance is achieved for the consecutive months and will the continue at a regular cadence indefinitely to ensure sustained compliance with this standard Completion date for implementation of audit process. April 8, 2022  Responsible Party: The Host Quality Manager  e. Hospice supervisor or designee will complete a share visit within the first week of neadmitted pediatric hospice parts coming on service. The superior designee will complete the "Hospice Pediatric Shared Visiand Document Review" trace available electronically in the agency's network. The Superior designee observing care in field combined with record rewill allow the supervisor or designee to take immediate as if a team member is determined be deficient in ensuring that the patient received an age-appropriate comprehensional assessment that identifies all required components and near including education and training Actions taken will include immediate coaching, remediate and accountability measures should deficiencies be observed.	ree hen e ed ed ed ewly tient evisor est r rvisor et the view ed to ne ed t

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 151511		(X2) MULTIPLE CONSTRUCTION   X3) DATE SURVEY			
	PROVIDER OR SUPPLIEF A UNIVERSITY HEA		950 N N	ADDRESS, CITY, STATE, ZIP COD MERIDIAN ST, SUITE 700 IAPOLIS, IN 46204	
(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)  completing shared visits and	BIII B
				document review is an essent step to prevent noncompliance with this standard. Shared vision and document review will contuntil 100% compliance is achifor three consecutive months will then continue at a regular cadence indefinitely to ensure sustained compliance with this standard.  Completion date for implementation of the audit process: April 8, 2022  Responsible party: The Hospi Quality Manager	e its tinue eved and
				Plan of correction requirements: It clearly states the specific na of the corrective actions for ea deficiency. (2) It sets reasonal completion dates for all deficiencies prior to the termination date unless an extension is requested and approved. (3) It describes how your plan/action will prevent recurrence. And (4), it describ who will be the person(s) responsible for implementing monitoring the plan for future compliance with the regulation response to each deficiency of the CMS-2567 is required.	es and
L 0545	418.56(c) CONTENT OF PL	AN OF CARE			

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The hospice must develop an individualized

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	OF CORRECTION	IDENTIFICATION NUMBER  151511	A. BUILDING B. WING	00	COMPLETED 03/08/2022
	PROVIDER OR SUPPLIER UNIVERSITY HEA		950 N	ADDRESS, CITY, STATE, ZIP COD MERIDIAN ST, SUITE 700 NAPOLIS, IN 46204	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	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
	of care must reflect and interventions I identified in the init updated comprehe plan of care must necessary for the	e for each patient. The plan of patient and family goals based on the problems tial, comprehensive, and ensive assessments. The include all services palliation and management ess and related conditions, wing:	L 0545	L545 Plan OF CARE CFR(s): 418.56 (c) The hospice must develop an individualized written plan of of for each patient. The plan of of must reflect patient and family goals and interventions based the problems identified in the initial, comprehensive, and updated comprehensive assessments. The plan of car must include all services necessary for the palliation ar management of the terminal illness and related conditions, including the following:  This STANDARD is not met a evidenced by: Based on recorreview and interview, the Interdisciplinary Team failed the ensure a plan of care included services being provided by an outside home health provider the delineation of duties betwithe hospice and home health agency in 2 (Patients 1 and 12 record reviewed patients receiving services from home health or attendant care	care care of on  e and  s and o d and een 0) of

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PRINTED: 03/30/2022 FORM APPROVED OMB NO. 0938-039

í í	ONSTRUCTION  00	(X3) DATE SURVEY  COMPLETED  03/08/2022
950 N I	MERIDIAN ST, SUITE 700	
Y FULL PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
	of how each action will prevere recurrence, and responsible party  - a. A special edition of the communication tool "Hospice Huddle Hot Topics" which contained the Hospice 2/15/20 Federal Survey results was verbally reviewed with Hospice team members; an email copy was also provided to team members for independent revilncluded in the results summar was detail concerning the Interdisciplinary Group's failure ensure a plan of care included services being provided by an outside home health provider a delineation of duties between thospice and home health for the patient records reviewed. Team member awareness of survey results is a required step to prevent recurrence of the deficiencies identified during the survey.  Completion date: March 18, 20 Responsible party: The Hospice Administrator	ent.  222 ew. ry e to and the wo m
	A. BUILDING B. WING  STREET 950 N I INDIAN  CIE Y FULL  PREFIX	STREET ADDRESS, CITY, STATE, ZIP COD 950 N MERIDIAN ST, SUITE 700 INDIANAPOLIS, IN 46204  THE PREFIX TAG MATION  Plan of Correction (1) Specific nature of the corrective actions including completion dates, description of how each action will preve recurrence, and responsible party  a. A special edition of the communication tool "Hospice Huddle Hot Topics" which contained the Hospice 2/15/20 Federal Survey results was verbally reviewed with Hospice team members; an email copy was also provided to team members for independent revilincluded in the results summa was detail concerning the Interdisciplinary Group's failure ensure a plan of care included services being provided by an outside home health provider a delineation of duttes between hospice and home health for the patient records reviewed. Teal member awareness of survey results is a required step to prevent recurrence of the deficiencies identified during the survey.  Completion date: March 18, 20 Responsible party: The Hospic Administrator  B. A care plan was added to the completion date and the special concerning the laterature.  B. A care plan was added to the completion date and the special concerning the laterature.

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DA		(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	a. building <u>00</u>		00	COMPL	ETED
		151511	B. W	ING		03/08/	2022
NAME OF F	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD		
					MERIDIAN ST, SUITE 700		
INDIANA	UNIVERSITY HEA	ALTH HOSPICE		INDIAN	APOLIS, IN 46204		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	'E	DATE
					documentation of outside prov	rider	
					contact information and for		
					delineation of care and service	es	
					that will be provided by the ou		
					provider. Education on access		
					and use of the care coordination		
					care plan will be delivered at the		
					four-hour Hospice Education	-	
					Summit for clinical employees	of	
					the hospice including Clinical		
					Managers, Supervisors, RN's,		
					LPN's, Social Workers,		
					Chaplains, Therapists,		
					Bereavement Coordinators,		
					Volunteer Coordinators, and		
					Aides. Education will be in-per	son.	
					interactive, and team member		
					be given the opportunity to asl		
					questions. Creating this care		
					is an essential step to prevent		
					non-compliance with the		
					requirement that the hospice p	olan	
					of care must include all service		
					including those provided by	•	
					outside agencies, that are		
					necessary for the palliation an	d	
			1		management of the terminal		
					illness and related conditions.		
					Completion date: April 8, 2022	2	
					Responsible party: The Hospid		
					Administrator		
					c. The Hospice		
					Interdisciplinary Note template	.	
					was updated to include aligne		
					information from the shared		
					services section of the hospice	e	
					electronic health record. Tear		
					members reporting out at IDG	and	
					documenting IDG notes in the		

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES			OMB NO. 0938-039
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED
		151511	B. WING		03/08/2022
			<u> </u>		
NAME OF F	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD	
			950 N I	MERIDIAN ST, SUITE 700	
INDIANA	UNIVERSITY HEA	LTH HOSPICE	INDIAN	IAPOLIS, IN 46204	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	1	(X5)
PREFIX			PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
	·	CY MUST BE PRECEDED BY FULL		CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG		DATE
				record will use the updated no	
				template to ensure delineation	of
				services between an outside	
				provider and hospice are	
				documented in the patient's re	cord
				and monitored by the IDG.	
				Education material will be	
				delivered at four-hour Hospice	
				Summit for clinical employees	
				the hospice including Clinical	
				Managers, Supervisors, RN's,	
				LPN's, Social Workers,	
				Chaplains, Therapists,	
				Bereavement Coordinators,	
				Volunteer Coordinators, and	
				Aides. Education will be	
				in-person, interactive, and tea	m
				members will be given the	
				opportunity to ask questions.	
				Updating the IDG note templar	te is
				an essential step to prevent	
				non-compliance with the	
				requirement that the hospice p	olan
				of care must include all service	es,
				including those provided by	
				outside agencies, that are	
				necessary for the palliation an	d
				management of the terminal	
				illness and related conditions.	
				Completion date: April 8, 2022	,
				Responsible party: The Hospid	
				Administrator	
				Administrator	
				(2) Monitoring and	
				(2) Monitoring and	
				<u>Sustainability</u>	
				[ - <u>, , , , , , , , , , , , , , , , , , </u>	
				a. All education content	
				developed for the Hospice	
				Education Summit is added to	

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new team member onboarding

If continuation sheet

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 151511	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 03/08/2022
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD	
INDIANA	UNIVERSITY HEA	LTH HOSPICE		MERIDIAN ST, SUITE 700 NAPOLIS, IN 46204	
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
	•			CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
PREFIX TAG	•	CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	es cial ts, eam ice the der are ed as will g of ce e of ll be to
				material will ensure all team members have received this	

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If continuation sheet

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CENTERS FOR	R MEDICARE & MEDIC	CAID SERVICES			OMB NO. 0938-039
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE (	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED
		151511	B. WING	<u> </u>	03/08/2022
NAME OF F	PROVIDER OR SUPPLIE	R		T ADDRESS, CITY, STATE, ZIP COD	
01 1	no viden on borrein.		950 N	MERIDIAN ST, SUITE 700	
INDIANA	UNIVERSITY HEA	ALTH HOSPICE	INDIA	NAPOLIS, IN 46204	
(X4) ID	SUMMADV	STATEMENT OF DEFICIENCIE	ID		(X5)
				PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	(A3)
PREFIX		NCY MUST BE PRECEDED BY FULL	PREFIX	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG		DATE
				material, have been given the	
				opportunity to ask questions,	
				have completed written evalu	ation
				to confirm their understanding	g of
				the content. Ensuring all clinic	cal
				team members have complet	ed
				these steps is essential to	
				increase education and	
				understanding of the requiren	nent
				that when a hospice patient is	
				receiving care by an outside h	
				health provider the delineation	
				duties between hospice and t	
				· ·	
				outside provider must be	
				documented in the electronic	1-
				checklist in the patient's healt	
				record. This documentation m	
				be included in the patient's ID	oG
				discussions and IDG note	
				documentation will prevent fa	ilure
				to meet this requirement throu	ugh
				early awareness and	
				understanding of expectations	s.
				Completion date: April 8, 202	2
				Responsible party: The Hosp	ice
				Quality Manager	
				c. Ten percent of monthly	
				hospice census will undergo	
				detailed record review by hos	nice
				quality audit RNs to confirm the	•
				all hospice patients who have	
				and services furnished to pati	
				and their families by an outside	ie
				agency have an updated and	
				accurate care plan, and upda	
				IDG notes which each clearly	
				identify the delineation of serv	/ices

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between hospice and the outside home health agency. Reviewing

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 151511	A. BUILDING <u>00</u> COM		(X3) DATE SURVEY  COMPLETED  03/08/2022
	PROVIDER OR SUPPLIEF		950 N I	ADDRESS, CITY, STATE, ZIP COD MERIDIAN ST, SUITE 700 JAPOLIS, IN 46204	
(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)	(X5) COMPLETION DATE
IAU	REGULATORY OF	CESC IDENTIF THYS EXPONENTION		these records will allow for immediate coaching and remediation with any team member determined to be def in meeting the requirement and will allow for accountability measures to be taken should deficiency recur. Auditing recuith subsequent coaching, remediation, and accountability measures for team members of fail to meet the requirements it essential step to prevent recurrence of noncompliance the standard. Audits will continuatil 100% compliance is achifor three consecutive months will then continue at a regular cadence indefinitely to ensure sustained compliance with thisstandard.  Completion date for implementation of audit proce April 8, 2022 Responsible Party: The Hosp Quality Manager  d. Hospice Supervisors or designees will complete one shared visit per week with rota members of their regional clin team. The supervisor or designee will complete the "Hospice Comprehensive Assessment, Care Plan, and Nanet and Care Plan, and Nanet Plan, a	icient id the ords ty who s an with nue eved and ss: oice ating ical gnee n rve

FORM CMS-2567(02-99) Previous Versions Obsolete

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.8

Review" tracer document available

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES

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STATEMEN	T MEDICARE & MEDIC IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 151511	A. BUILDING <u>00</u> B. WING		(X3) DATE SURVEY COMPLETED 03/08/2022	
	PROVIDER OR SUPPLIEF		950 N I	ADDRESS, CITY, STATE, ZIP COD MERIDIAN ST, SUITE 700 IAPOLIS, IN 46204		
INDIANA (X4) ID PREFIX TAG	SUMMARY (EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	INDIAN  ID  PREFIX  TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)  electronically in the agency's network. The Supervisor or designee observing patients in field combined with record revivill allow the supervisor or designee to take immediate a if a team member is determined be deficient in ensuring the placare includes all services necessary for the patient's ne including the delineation of services provided by an outsid home health provider. Actions taken will include immediate coaching, remediation, and accountability measures shout the deficiency recur. The supervisor or designee complishared visit and document revising a required step to prevent noncompliance with this stand Shared visits and document we continue until 100% compliance achieved for three consecutives.	n the view ction ed to an of eds de s	
				months and will then continue regular cadence indefinitely to ensure sustained compliance the standard. Completion date for implementation of the audit process: April 8, 2022 Responsible party: The Hospi Quality Manager  Plan of correction requirements: It clearly states the specific na of the corrective actions for each	e at a  o  with  cce	

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deficiency. (2) It sets reasonable

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DAT			(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>			COMPLETED	
		151511	B. WING 03/08/2022				/2022
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 950 N MERIDIAN ST, SUITE 700 INDIANAPOLIS, IN 46204				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DECLIDED IN AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	IE	DATE
L 0548 Bldg. 00	necessary for the of the terminal illn including the followal (3) Measurable out	must include all services palliation and management ess and related conditions,	L 0:	548	completion dates for all deficiencies prior to the termination date unless an extension is requested and approved. (3) It describes how your plan/action will prevent recurrence. And (4), it describe who will be the person(s) responsible for implementing a monitoring the plan for future compliance with the regulation response to each deficiency of the CMS-2567 is required.  L548 CONTENT OF THE PLA OF CARE CFR(s): 418.56 (c)() The plan of care must include services necessary for the palliation and management of terminal illness and related conditions, including the following:] (3) Measurable outcomes anticipated from implementing and coordinating the plan of care.  This STANDARD is not met as evidenced by: Based on recontexity and interview, the agentable of the polaries of called to ensure all plans of care failed to ensure all plans of care failed to ensure all plans of care.	es and ns. A n 3) all the ated s d ncy	04/08/2022

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included measurable outcomes

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 151511		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 03/08/2022		
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
INDIANA	UNIVERSITY HEA	LTH HOSPICE	950 N MERIDIAN ST, SUITE 700 INDIANAPOLIS, IN 46204				
(X4) ID		STATEMENT OF DEFICIENCIE	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		,	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	anticipated from implementing coordinating the plan of care for (Patient #8) of 2 pediatric paties in a sample of 16 active clinical records.  Plan of Correction  (1) Specific nature of the corrective actions including completion dates, description of how each action will prevent the communication tool "Hospice Huddle Hot Topics" which contained the Hospice 2/15/20. Federal Survey results was verbally reviewed with Hospice team members; an email copy was also provided to team members for independent revillation included in the results summar was detail concerning the failuate agency to ensure all plans care included measurable outcomes anticipated from implementing and coordinating plan of care for one (Patient 8 two pediatric patients in a sam of 16 active clinical records. To member awareness of survey results is a required step to prevent recurrence of the deficiencies identified during the survey.  Completion date: March 18, 20 Responsible party: The Hospice in a sam of 18 active deficiencies identified during the survey.	or 1 ents ents ent  n ent  222 e v ew. ry ure of of eam he	DATE
			1		Administrator		

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	OF HEALTH AND HUN R MEDICARE & MEDIC						RM APPROVED B NO. 0938-039
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 151511			(X2) MULTIPLE CONSTRUCTION       (X3) DATE SUF         A. BUILDING       00       COMPLETI         B. WING       03/08/20			SURVEY ETED	
	PROVIDER OR SUPPLIER			950 N N	ADDRESS, CITY, STATE, ZIP COD MERIDIAN ST, SUITE 700 IAPOLIS, IN 46204		
(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)	TE	(X5) COMPLETION DATE
					b. Education was develope Pediatric Assessment and Car Planning. While developing education on these topics the agency's state and national hospice organizations were consulted and a comprehensive review of available literature woundertaken by the Hospice Administrator. Education material will be delivered at the four-hour Hospice Education summit for clinical employees the hospice including Clinical Managers, Supervisors, RN's, LPN's, Social Workers, Chaplains, Therapists, Bereavement Coordinators, Volunteer Coordinators, volunteer Coordinators, and Aides. Education will be in-per and interactive with relevant examples provided for each to Team members will be given to opportunity to ask questions throughout the education presentation. Team members be given a written exam cover each topic presented to confirm their understanding of the material power on the agency's failure in the state of the presented to confirm their understanding of the material power on the agency's failure in the presented to the presente	re /e ras erial ncy e of will ing m erial. n	

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ensure all plans of care included measurable outcomes anticipated

coordinating the plan of care is a required step to prevent recurrence

from implementing and

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	T OF DEFICIENCIES DF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 151511	(X2) MULTIPLE C A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 03/08/2022			
	ROVIDER OR SUPPLIEI		STREET ADDRESS, CITY, STATE, ZIP COD 950 N MERIDIAN ST, SUITE 700 INDIANAPOLIS, IN 46204					
(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 APPROPRI. DEFICIENCY)	5.112			
				of the agency's failure to mee requirement. Completion date: April 8, 202 Responsible party: The Hosp Administrator	2			
				(2) <u>Monitoring and</u> <u>Sustainability</u>				
				a. All education content developed for the Hospice Education Summit is added to new team member onboardin requirements for all clinical rounding Clinical Managers, Supervisors, RNs, LPNs, Soc Worker, Chaplain, Bereaveme Coordinator, Therapists, Volu Coordinators, and Aides. Requiring all newly hired cliniteam members to complete the education and to complete the written exam covering content an essential step to ensure understanding of the requirement that all plans of care must income measurable outcomes anticip from implementing and coordinating each patient's placer and will prevent failure to meet this requirement. Completion date: April 8, 202 Responsible party: The Hosp	g les les lial lent nteer cal nis le t is nent lude lude ated an of o			
				b. Team members on leav absence during the four-hour Hospice Education Summit w scheduled for review of this material at the first bi-weekly				

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	T OF HEALTH AND HU R MEDICARE & MEDIC						RM APPROVED IB NO. 0938-039
STATEMEN	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 151511	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 03/08/2022	
	PROVIDER OR SUPPLIER			950 N N	ADDRESS, CITY, STATE, ZIP COD MERIDIAN ST, SUITE 700 IAPOLIS, IN 46204		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  Hospice Onboarding Session to				(X5) COMPLETION DATE
					occur upon their return. Requall active team members who missed the initial sessions to complete the first available onboarding session of this material will ensure all team members have received this material, have been given the opportunity to ask questions, have completed written evaluate to confirm their understanding the content. Ensuring all clinic team members have complete these steps is an essential steincrease education and understanding of the requirem that plans of care must includ measurable outcomes anticip from implementing and coordinating each patient's placare and will prevent recurring failure to meet this requirement. Completion date: April 8, 2023. Responsible party: The Hospi Quality Manager  c. Ten percent of the mon hospice active census will undetailed record review by hos quality audit RN's to confirm thall plans of care include	and ation g of cal ed ep to nent e ated an of g nt. 2 ice thly dergo pice	
					measurable outcomes anticip from implementing and coordinating each patient's pla		

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If continuation sheet

care. Reviewing these records will allow for immediate coaching and remediation with any team

member determined to be deficient in meeting the requirement and

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	Γ OF HEALTH AND HU R MEDICARE & MEDIC				FORM APPROVED OMB NO. 0938-039	
STATEMEN	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 151511			(X3) DATE SURVEY COMPLETED 03/08/2022	
	PROVIDER OR SUPPLIE		950 N	ADDRESS, CITY, STATE, ZIP COD MERIDIAN ST, SUITE 700 NAPOLIS, IN 46204	-	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE  NOY 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)	(X5) COMPLETION DATE	
				will allow for accountability measures to be taken should deficiency recur. Auditing recompliance with subsequent coaching, remediation and accountability measures for team members fail to meet these requirement an essential step to prevent recurrence of noncompliance. Audits will continue until 100% compliance is achieved for the consecutive months and will the continue at a regular cadence indefinitely to ensure sustaine compliance with this standard Completion date for implementation of audit proce April 8, 2022  Responsible Party: The Hosp Quality Manager  d. Hospice Supervisors or designees will complete one shared visit per week with rotal members of their regional clin team. The supervisor or designing the visit, and will observe visit documentation. The supervisidesignee will complete the "Hospice Comprehensive Assessment Care Plan and Vance of Care Plan and Vance of Care Plan and Vance with care Plan and Vance of Care Plan and Vance Plan and Vance of Care Plan and	ords  y who ts is fee hen st d . ss: oice  ating ical gnee n rve for or or	

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If continuation sheet

Review" tracer document available electronically in the agency's network. The Supervisor or designee observing patients in the field combined with record review will allow the supervisor or

designee to take immediate action

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PARTMENT OF HEALTH AND HUMAN SERVICES							
TERS FOR MEDICARE & MEDICAID SERVICES							
STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY				
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 00	COMPLETED				

	OF DEFICIENCIES F CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 151511	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	COMP	SURVEY LETED 5/2022
	OVIDER OR SUPPLIE		950 N	ADDRESS, CITY, STATE, ZIP CO MERIDIAN ST, SUITE 700 JAPOLIS, IN 46204		
(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 CORRI (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	ECTION DULD BE PROPRIATE	(X5) COMPLETION DATE
				if a team member is det be deficient in ensuring plans of care include me outcomes anticipated from implementing and coord each patient's plan of care actions taken will includ immediate coaching, remand accountability means should the deficiency resupervisor or designed shared visits and docum review is a required stepnoncompliance with this requirement. Shared visits document review will conform to a compliance is active consecutive month then continue at a regul indefinitely to ensure sucompliance with this state Completion date for implementation of the approcess: April 8, 2022 Responsible party: The Quality Manager	that all easurable om dinating are. le mediation, sures cur. The completing nentation p to prevent sits and ontinue until nieved for hs and will ar cadence estained undard.	
				Plan of correction requirements: It clearly states the spec of the corrective actions deficiency. (2) It sets recompletion dates for all deficiencies prior to the termination date unless	s for each asonable	
				extension is requested approved. (3) It describe		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDIN	G <u>00</u>	COMPLETED		
		151511	B. WING 03/08/2022				
	PROVIDER OR SUPPLIER		950	STREET ADDRESS, CITY, STATE, ZIP COD 950 N MERIDIAN ST, SUITE 700 INDIANAPOLIS, IN 46204			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	`	CY MUST BE PRECEDED BY FULL	PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)		E COMPLETION		
L 0549 Bldg. 00	418.56(c)(4) CONTENT OF PL [The plan of care necessary for the of the terminal illn including the follow	must include all services palliation and management ess and related conditions, wing:] atment necessary to meet	L 0549	your plan/action will prevent recurrence. And (4), it descr who will be the person(s) responsible for implementing monitoring the plan for future compliance with the regulati response to each deficiency the CMS-2567 is required.  L549 CONTENT OF THE PL OF CARE CFR(s): 418.56 (c) The plan of care must include services necessary for the palliation and management terminal illness and related conditions, including the following:] (4) If and treatment necessary to the needs of the patient.  This STANDARD is not met evidenced by: Based on recoview, the agency failed to implement drugs and treatment necessary to meet the need the patient for 1 (Patient #2) clinical records reviewed.  Plan of Correction (1) Specific nature of the corrective actions including the following including the corrective actions including the correction actions in the correction	g and e ons. A on 04/08/2022  LAN 04/08/2022  C)(4) de all of the Orugs meet as ord ent s of of 20		

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DEPARTMENT	EPARTMENT OF HEALTH AND HUMAN SERVICES							
CENTERS FOR	ENTERS FOR MEDICARE & MEDICAID SERVICES							
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 00			COMPLETED		
		151511	B. WING			03/08/2022		
NAME OF PROVIDER OR SUPPLIER INDIANA UNIVERSITY HEALTH HOSPICE				950 N N	ADDRESS, CITY, STATE, ZIP COD MERIDIAN ST, SUITE 700 APOLIS, IN 46204			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR	1	COMPLETION	

INDIANA UNIVERSITY HEALTH HOSPICE			INDIANAPOLIS, IN 46204				
(X4) ID SUMMARY STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	ON (X5)			
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION			
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION	TAG		DATE			
			completion dates, description				
			of how each action will prevent				
			recurrence, and responsible				
			party				
			a. A special edition of the				
			•				
			communication tool "Hospice				
			Huddle Hot Topics" which contained the Hospice 2/15/2022				
			Federal Survey results was verbally reviewed with Hospice				
			team members; an email copy				
			was also provided to team				
			members for independent review.				
			Included in the results summary				
			was detail concerning the failure of				
			the agency implement drugs and				
			treatment necessary to meet the				
			needs of the patient for one record				
			reviewed. Team member				
			awareness of survey results is a				
			required step to prevent recurrence				
			of the deficiencies identified during				
			the survey.				
			Completion date: March 18, 2022.				
			Responsible party: The Hospice				
			Administrator				
			b. Education was developed for				
			Medication Reconciliation and				
			Medication Management. While				
			developing education on these				
			topics the agency's state and				
			national hospice organizations				
			were consulted and a				
			comprehensive review of available				
			literature was undertaken by the				
			hospice administrator. Education				
			material was selected based on				
			relevancy and timeliness.				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLI		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPLETED	
		151511	B. WING 03/08/2022			2022	
				STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIE	R			MERIDIAN ST, SUITE 700		
INDIANA	UNIVERSITY HEA	ALTH HOSPICE			IAPOLIS, IN 46204		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					Education material will be		
					delivered at a four-hour Hospi	ce	
					Education Summit for clinical		
					employees of the hospice that	are	
					responsible for medication		
					management. Education will b	e	
					in-person and interactive with		
					relevant examples provided fo		
					each topic. Team members w		
					be given the opportunity to asl	k	
					questions throughout the		
					education presentation. RN's		
					LPN's will be given a written e		
					covering medication reconcilia		
					and medication management		
					confirm their understanding of		
					material. Developing and deliv	-	
					interactive, in-person education		
					based on the agency's failure	10	
					implement the drugs and treatment necessary to meet a	,	
					patient's needs is a required s		
					to prevent recurrence of the	ich	
					agency's failure to meet the		
					requirement.		
					Completion date: April 8, 2022	<u>.</u>	
					Responsible party: The Hospid		
					Administrator.		
					(2) Monitoring and		
					<u>Sustainability</u>		
					<b>a.</b> All education content		
					developed for the Hospice		
					Education Summit is added to		
					new team member onboarding	- 1	
					requirements for all clinical rol	es	
					responsible for medication		
					management. Requiring all ne		
					hired clinical team members to	)	

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY			
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		00	COMPLETED			
151511		151511	B. WING			03/08/2022			
NAME OF T	DROWNED OF CURRY IED		•	STREET A	ADDRESS, CITY, STATE, ZIP COD				
NAME OF F	PROVIDER OR SUPPLIER			950 N MERIDIAN ST, SUITE 700					
INDIANA UNIVERSITY HEALTH HOSPICE				INDIANAPOLIS, IN 46204					
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)		
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE (	COMPLETION		
TAG	REGULATORY OR	REGULATORY OR LSC IDENTIFYING INFORMATION TAG		DEFICIENCY		DATE			
					complete this education and				
					complete the written exam				
					covering medication reconcilia				
					and medication management is an essential step to confirm				
					understanding of the requirem	ent			
					that team members must ensu	I			
					patient needs related to drugs	I			
					treatments are met and will	and			
					prevent recurring failure to me	et			
					this requirement.				
					Completion date: April 8, 2022	<u> </u>			
					Responsible party: The Hospid	I			
					Quality Manager				
					-				
					<b>b.</b> Team members with clin	ical			
					roles responsible for medication	on			
					management who were on a le	I			
					of absence during the four- ho	I			
					Hospice Education Summit wi	ll be			
					scheduled for review of this				
					material at the first bi-weekly	.			
					Hospice Onboarding Session				
					occur upon their return. Requ	iring			
					all active team members who				
					missed the initial sessions to				
					complete the first available onboarding session of this				
					material will ensure all team				
					members have received this				
					material, have been given the				
					opportunity to ask questions, a	I			
					have completed written evalua	I			
					to confirm their understanding				
					the content. Ensuring that tear				
					members with clinical roles				
					responsible for medication				
					management have completed	this			
					education is an essential step				
					increase understanding that				

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	r í		LE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING		00	COMPLETED 03/08/2022			
151511			B. WING 03/08			03/08/	2022		
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD				
				950 N MERIDIAN ST, SUITE 700					
INDIANA UNIVERSITY HEALTH HOSPICE			INDIANAPOLIS, IN 46204						
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)		
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL  PEGLIL ATORY OR LSC IDENTIFYING INFORMATION			PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION		
IAU	REGULATORY OR LSC IDENTIFYING INFORMATION		+	TAG	patient's needs must be met		DATE		
					related to drugs and treatmen	ts			
					and will prevent recurrence of				
					failure to meet this requirement.				
					Completion date: April 8, 2022	)			
			Responsible party: The						
					Quality Manager				
					c. Ten percent of monthly				
				hospice census will undergo					
				detailed record review by hos	oice				
				quality audit RNs to confirm th					
					no indication of failure to ensu				
					patient needs related to drugs	and			
					treatments are identified.	-11			
					Reviewing these records will for immediate coaching and	allOW			
					remediation with any team				
					member determined to be def	icient			
					in meeting the requirement an				
					will allow for accountability				
					measures to be taken should				
					deficiency recur. Auditing reco	ords			
					with subsequent coaching,	h./			
					remediation, and accountabilit measures for team members	-			
					fail to meet these requirement				
					an essential step to prevent				
					recurrence of noncompliance.				
					Audits will continue until 100%				
					compliance is achieved for thr				
					consecutive months and will the				
					continue at a regular cadence indefinitely to ensure sustaine				
					compliance with this standard				
					Completion date for	•			
					implementation of audit proce	ss:			
					April 8, 2022				
					Responsible Party: The Hosp	ice			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 151511		(X2) MULTIPLE CO A. BUILDING B. WING	(X3) DATE SURVEY  COMPLETED  03/08/2022		
	PROVIDER OR SUPPLIER UNIVERSITY HEA		950 N I	ADDRESS, CITY, STATE, ZIP COD MERIDIAN ST, SUITE 700 IAPOLIS, IN 46204	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL DUSC IDENTIFYING INFORMATION	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	Quality Manager  d. Hospice Supervisors or designees will complete one shared visit per week with rota members of their regional clin team. The supervisor or designees the visit including medication reconciliation, and will observe visit documentation. Supervisit documentation. Supervisit designee will complete the "Hospice Comprehensive Assessment, Care Plan, and Review" tracer document avail electronically in the agency's network. The Supervisor or designee observing patients in field combined with record reviewll allow the supervisor or designee to take immediate arif a team member is determined be deficient in ensuring that patient needs related to drugs treatments are implemented. Actions taken will include immediate coaching, remediate and accountability measures should the deficiency recur. To supervisor or designee compleshared visits and documentation review is an essential step to prevent noncompliance with the requirement. Shared visits and document review will continued three consecutive months and then continue at a regular cade the same and then continue at a regular cade the same and the continue at a regular cade the same and the continue at a regular cade the same and the continue at a regular cade the same and the continue at a regular cade the same and the continue at a regular cade the same and the continue at a regular cade the same and the continue at a regular cade the same and the continue at a regular cade the same and the continue at a regular cade the same and the continue at a regular cade the same and the continue at a regular cade the same and the continue at a regular cade the same and the continue at a regular cade the same and the continue at a regular cade the same and the continue at a regular cade the same and the continue at a regular cade the cad	ical gnee n rve e sor or  Visit ilable n the view ction ed to s and tion, The eting ion his d e until for d will

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indefinitely to ensure sustained

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 151511		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 03/08/2022	
	PROVIDER OR SUPPLIE		950 N	ADDRESS, CITY, STATE, ZIP COD MERIDIAN ST, SUITE 700 NAPOLIS, IN 46204	
(X4) ID PREFIX 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 APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
				compliance with this standard. Completion date for implementation of the audit process: April 8, 2022 Responsible party: The Hospic Quality Manager	
				Plan of correction requirements: It clearly states the specific nar of the corrective actions for ea deficiency. (2) It sets reasonal completion dates for all deficiencies prior to the termination date unless an extension is requested and approved. (3) It describes how your plan/action will prevent recurrence. And (4), it describe who will be the person(s) responsible for implementing a monitoring the plan for future compliance with the regulation response to each deficiency of the CMS-2567 is required.	ch ble es and s. A
L 0550 Bldg. 00	necessary for the of the terminal illr including the follo (5) Medical suppl	must include all services palliation and management ness and related conditions,			
		·	L 0550	L550 CONTENT OF THE PLAN OF CARE CFR(s): 418.56 (c)(s) [The plan of care must include services necessary for the palliation and management of	all

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	T OF DEFICIENCIES  OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 151511	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 03/08/2022		
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 950 N MERIDIAN ST, SUITE 700 INDIANAPOLIS, IN 46204				
(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 APPROPRI DEFICIENCY)	(X5) COMPLETION DATE		
				terminal illness and related conditions, including the following:] (5) Medical supplies and applian necessary to meet the needs the patient.			
				This STANDARD is not met a evidenced by: Based on recoreview, observation, and interthe agency failed to include a durable medical equipment (I and medical supplies necess to meet the patient's needs in plan of care (POC) in 7 (Patie 2, 5, 6, 7, 10, 14, and 16) of 2 clinical records reviewed.	rd rview, ill DME) ary the ents #		
				Plan of Correction  (1) Specific nature of the corrective actions including completion dates, description of how each action will preverecurrence, and responsible party  - a. A special edition of the communication tool "Hospice Huddle Hot Topics" which contained the Hospice 2/15/2 Federal Survey results was verbally reviewed with Hospice team members; an email cope was also provided to team members for independent revincluded in the results summary was detail concerning the fail the agency to include all durations.	on rent 2022 Dee yy view.		

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CENTERS FOR MEDICARE & MEDICAID SERVICES OMB N						B NO. 0938-039	
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 151511	A. BU B. W	JILDING ING	00	COMPLETED 03/08/2022	
		131311	D. W.	_	-	03/00/	
NAME OF I	NAME OF PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD MERIDIAN ST, SUITE 700		
INDIANA	UNIVERSITY HEA	LTH HOSPICE			APOLIS, IN 46204		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
IAU	REGULATORY OR	A LSC IDENTIFY ING INFORMATION		IAU	medical supplies necessary to meet the patient's need in the Plan of Care (POC) for seven patients reviewed. Team mem awareness of survey results is required step to prevent recurr of the deficiencies identified do the survey.  Completion date: March 18, 20 Responsible party: The Hospid Administrator  - b. Education concerning the requirement that all durable medical equipment (DME) and medical supplies necessary to meet the patient's needs must documented in the general clir portion of the electronic health record in order for this informat to populate to the plan of care be provided at a four-hour Hose Education Summit for clinical employees of the hospice including Clinical Managers, Supervisors, RN's, and LPN's, Social Workers, Chaplains, Therapists, Bereavement Coordinators, Volunteer Coordinators, and Aides. Teamembers will be given the opportunity to ask questions throughout the education presentation. Delivering interactive, in-person education based on the agency's failure document durable medical	aber a a rence suring 022. ce e d d d d d d d d d d d d d d d d d	DATE

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equipment and supplies on the plan of care is required to prevent recurrence of this deficiency.

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY  A BUILDING 00 COMPLETED					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER  151511	A. BUILDING 00 COMPLETED  B. WING 03/08/2022				
		131311	D. W			03/06/	2022
NAME OF F	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD MERIDIAN ST, SUITE 700		
INDIANA	UNIVERSITY HEA	LTH HOSPICE			APOLIS, IN 46204		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL  LISC IDENTIFYING INFORMATION		PREFIX TAG	Completion date: April 8, 2022 Responsible party: The Hospid Administrator  (2) Monitoring and Sustainability  - a. All education content developed for the Hospice Education Summit is added to new team member onboarding requirements for all clinical rol including Clinical Managers, Supervisors, RNs, LPNs, Soci Workers, Chaplains, Bereaver Coordinators, Therapists, Volunteer Coordinators, and Aides. Requiring all newly hint team members to complete th education is an essential step confirm awareness of the requirement that all durable medical equipment and suppli must be documented in gener clinical in order to populate to the plan of care. This will ensure team member awareness of the location this  documentation and will preven recurring failure to meet this standard. Completion date: April 8, 2022 Responsible party: The Hosp Quality Manager  b. Team members on a lead of absence during the four-hosp	ges al ment ed is to es al of ation et gice	DATE

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		A. BUILDING <u>00</u> B. WING		COMPLETED	
		151511	B. W	ING	03/08/2022		
NAME OF P	PROVIDER OR SUPPLIER		•		ADDRESS, CITY, STATE, ZIP COD		
INDIANA	UNIVERSITY HEA	LTH HOSPICE	950 N MERIDIAN ST, SUITE 700 INDIANAPOLIS, IN 46204				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE	
					Hospice Education Summit wi	ll be	
					scheduled for review of this		
					material at the first bi-weekly	to	
					Hospice Onboarding Session		
					occur upon their return. Requall active team members who	""'9	
					missed the initial sessions to		
					complete the first available		
					onboarding session of this		
					material will ensure all team		
					members have received this		
					material and have been given	the	
					opportunity to ask questions.		
					Ensuring that all clinical team		
					members are aware that		
					documentation of durable med	dical	
					equipment and supplies is		
					required and are made aware	of	
					the appropriate location within	the	
					hospice electronic health reco		
					document will prevent recurring	g	
					failure to meet this standard.		
					Completion date: April 8, 2022		
					Responsible party: The Hospi	ce	
					Quality Manager		
					c. Ten percent of monthly		
					hospice census will undergo		
					detailed record review by hosp	pice	
					quality audit RN's to confirm the		
					all durable medical equipment		
					supplies mentioned in the pati	ent	
					record is documented in the		
					general clinical section of the		
					electronic health record. Revie	ewing	
					these records will allow for		
					immediate coaching and		
					remediation with any team		
					member determined to be defi		
					in meeting the requirement an	d	

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	T OF DEFICIENCIES DF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 151511	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	COMP	E SURVEY PLETED 3/2022
	ROVIDER OR SUPPLIEI UNIVERSITY HEA		950 N I	ADDRESS, CITY, STATE, ZIP C MERIDIAN ST, SUITE 70 JAPOLIS, IN 46204		
(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 COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	RECTION HOULD BE APPROPRIATE	(X5) COMPLETION DATE
				will allow for accountable measures should the drecur. Auditing records subsequent coaching, remediation, and accommeasures for team me fail to meet the require essential step to preve recurrence of noncompathis standard. Audits wountil 100% compliance for three consecutive nowill then continue at a cadence indefinitely to sustained compliance standard.  Completion date for implementation of audit April 8, 2022  Responsible Party: The Quality Manager  d. Hospice Supervised designees will complete shared visit per week womembers of their region team. Supervisor or dereview the patient reconsidered and supplied to the patient, and will equipment and supplied to the patient, and will visit documentation after to ensure equipment and are correctly document plan of care. Supervised esignee will complete "Hospice Comprehens Assessment, Care Plan Review" tracer documents.	deficiency s with  untability embers who ement is an ent pliance with vill continue e is achieved months and regular ensure with this  it process:  ne Hospice  sors or te one with rotating onal clinical esignee will ord in beerve the able medical es provided observe ter the visit and supplies ted on the sor or e the sive n, and Visit	

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	OF CORRECTION	IDENTIFICATION NUMBER  151511	A. BUILDING B. WING	00 00	COMPLETED 03/08/2022
	ROVIDER OR SUPPLIER		950 N N	ADDRESS, CITY, STATE, ZIP COD MERIDIAN ST, SUITE 700 IAPOLIS, IN 46204	
(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
				electronically in the agency's network. The Supervisor or designee observing patients in field combined with record rev will allow the supervisor or designee to take immediate aci if a team member is determine be deficient in ensuring that durable medical equipment an supplies are documented on the plan of care. Actions taken wi include immediate coaching, remediation, and accountability measures should the deficient recur. The supervisor or design completing shared visits and document review is a required to prevent noncompliance with standard. Shared visits and document review will continue 100% compliance is achieved three consecutive months and then continue at a regular cad indefinity to ensure sustained compliance with this standard. Completion date for implementation of the audit process: April 8, 2022 Responsible party: The Hospic Quality Manager Plan of correction requirements:  It clearly states the specific natof the corrective actions for eat deficiency. (2) It sets reasonal completion dates for all deficiencies prior to the termination date unless an extension is requested and approved. (3) It describes how	ction ed to ad he II y cy nee step in this until for will ence ce ture ach ole

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CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES			OMB NO. 0938-039	
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED	
		151511	B. WING		03/08/2022	
	PROVIDER OR SUPPLIER UNIVERSITY HEA		950 N I	ADDRESS, CITY, STATE, ZIP COD MERIDIAN ST, SUITE 700 JAPOLIS, IN 46204	(X5)	
PREFIX TAG	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION DATE	
				your plan/action will prevent recurrence. And (4), it describe who will be the person(s) responsible for implementing a monitoring the plan for future compliance with the regulation response to each deficiency of the CMS-2567 is required.	and ns. A	
L 0553	418.56(d)					
	REVIEW OF THE	PLAN OF CARE				
Bldg. 00	comprehensive as	ne patient's updated ssessment and must note ess toward outcomes and				
			L 0553	L553 REVIEW OF THE PLAN CARE CFR(s): 418.56 (c)(5)	<b>OF</b> 04/08/2022	
				A revised plan of care must include information from the patient's updated comprehens assessment and must note the patient's progress toward outcomes and goals specified the plan of care.	e	
				This STANDARD is not met as evidenced by: Based on recor review and interview, the ager failed to ensure the Interdisciplinary Team updated plan of care when there were changes in a patient's diet, medications, and failed to ens goals were updated, measural and pertinent/specific to the patient's ongoing care needs in (Patients #5 and 7) of 14 activing review of the patients #5 and 7) of 14 activing review of the patients #5 and 7) of 14 activing review of the patients #5 and 7) of 14 activing review of the patients #5 and 7) of 14 activing review of the patients #5 and 7) of 14 activing review of the patients #5 and 7) of 14 activing review of the patients #5 and 7) of 14 activing review of the patients #5 and 7) of 14 activing review of the patients #5 and 7) of 14 activing review of the patients #5 and 7) of 14 activing review of the patients #5 and 7) of 14 activing review of the patients #5 and 7) of 14 activing review of the patients #5 and 7) of 14 activing review of the patients #5 and 7) of 14 activing review of the patients #5 and 7) of 14 activing review of the patients #5 and 7) of 14 activing review of the patients #5 and 7) of 14 activing review of the patients #5 and 7) of 14 activing review of the patients #5 and 7) of 14 activing review of the patients #5 and 7) of 14 activing review of the patients #5 and 7) of 14 activing review of the patients #5 and 7) of 14 activing review of the patients #5 and 7) of 14 activing review of the patients #5 and 7) of 14 activing review of the patients #5 and 7) of 14 activing review of the patients #5 and 7) of 14 activing review of the patients #5 and 7) of 14 activing review of the patients #5 and 7) of 14 activing review of the patients #5 and 7) of 14 activing review of the patients #5 and 7) of 14 activing review of the patients #5 and 7) of 14 activing review of the patients #5 and 7) of 14 activing review of the patients #5 activity for	d the ure ble,	

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records reviewed in a sample of

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER				COMPLETED	
		151511	B. WI	NG		03/08/2022	
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
ΙΝΟΙΔΝΙΛ	UNIVERSITY HEA	I TH HOSPICE	950 N MERIDIAN ST, SUITE 700 INDIANAPOLIS, IN 46204				
	T				I OLIO, IIN 70204		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)	
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION	PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		TE COMPLETION DATE		
1710	ingention on			0	20.	DATE	
					Plan of Correction		
					(1) Specific nature of the		
					corrective actions including	•	
					completion dates, descriptio	l l	
					of how each action will prever recurrence, and responsible		
					party	•	
					a. A special edition of the		
					communication tool "Hospice		
					Huddle Hot Topics" which		
					contained the Hospice 2/15/20	)22	
					Federal Survey results was verbally reviewed with Hospical		
					team members; an email copy		
					was also provided to team		
					members for independent revi	ew.	
					Included in the results summa	ry	
					was detail concerning the failu	ire of	
					the agency to ensure the		
					Interdisciplinary Group (IDG)		
					updated the plan of care wher there were changes in a patiel		
					diet and medications. IDG also		
					failed to ensure goals were		
					updated, measurable, and		
					pertinent/specific to the patien	t's	
					ongoing care needs for two		
					patients reviewed. Team mem		
					awareness of survey results is		
					required step to prevent recurs of the deficiencies identified de		
					the survey.		
					Completion date: March 18, 20	022.	
					Responsible party: The Hospi		
					Administrator		
					- Education concerning th		

### DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTERS FOR	MEDICARE & MEDIC	AID SERVICES				OM	IB NO. 0938-039
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETED	
		151511	B. W	NG		03/08	/2022
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER				MERIDIAN ST, SUITE 700		
INDIANA	UNIVERSITY HEA	LTH HOSPICE			IAPOLIS, IN 46204		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					requirement of IDG to ensure	that	
					each patient's documented die		
					and medications are accurate		
					updated and to ensure that pa	itient	
					goals are measurable and		
					pertinent/specific to the patien	t's	
					ongoing care needs will be		
					delivered at the Hospice Educ		
					Summit for clinical employees	of	
					the hospice including Clinical		
					Managers, Supervisors, RN's,	and	
					LPN's, Social Workers,		
					Chaplains, Therapists,		
					Bereavement Coordinators,		
					Volunteer Coordinators, and		
					Aides. Education will be in-per	rson	
					and interactive with relevant		
					examples provided for each to	-	
					Team members will be given t	ne	
					opportunity to ask questions		
					throughout the education		
					presentation. Providing in-pe		
					education with a display of rela		
					examples will increase awarer	iess	
					and understanding of this requirement and in turn prevent	nt	
					recurrence of this deficiency.	i it	
					Completion date: April 8, 2022	)	
					Responsible party: The Hospid		
					Administrator	00	
					Autilitionaloi		
					(2) Monitoring and		
					Sustainability		
					<b>a.</b> All education content		
					developed for the Hospice		
					Education Summit is added to	)	

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new team member onboarding requirements for all clinical roles including Clinical Manages,

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 03/08/2022			
	PROVIDER OR SUPPLIER UNIVERSITY HEA		STREET ADDRESS, CITY, STATE, ZIP COD 950 N MERIDIAN ST, SUITE 700 INDIANAPOLIS, IN 46204				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
				Supervisors, RN, LPN, Social Worker, Chaplain, Bereavener Coordinator, Therapists, Volu Coordinator, and Aides. Requall newly hired team members complete this education is an essential step to confirm awareness of the requirement patient's diet and medications must be accurate and updated and that patient goals  must be updated, measurable and pertinent to the patient's ongoing care needs. Increasing awareness through education subsequently prevent recurring failure to meet this standard. Completion date: April 8, 2022 Responsible party: The Hospic Quality Manager  b. Team members on a least of absence during the fourbusted of absence during the fourbusted dieter and the first bi-weekly Hospice Onboarding Session occur upon their return. Requall active team members who missed the initial sessions to complete the first available onboarding session of this material will ensure all team members have received this material and have been given opportunity to ask questions. Ensuring that all clinical team members are aware that each patient's diet and medications.	ent inteer iring is to it that it did it is a second iring is great in the inteer iring is to it is a second iring		

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPLETED	
		151511	B. W	NG		03/08/2022	
				CTDEET A	ADDRESS CITY STATE ZID COD		
NAME OF F	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD		
INDIANA	I INII\/EDQITV LIEA	I TH HOSDICE	950 N MERIDIAN ST, SUITE 700				
INDIANA UNIVERSITY HEALTH HOSPICE			INDIANAPOLIS, IN 46204				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					must be accurate and updated	t	
					and that patient goals must be	:	
					updated, measurable, and		
					pertinent to the patient's ongo	ing	
					care needs will raise awarene	SS	
					and understanding of these		
					requirements and subsequent	ly	
					prevent recurrence of this		
					deficiency.		
					Completion date: April 8, 2022		
					Responsible party: The Hospid	ce	
					Quality Manager		
					T		
					c. Ten percent of monthly		
					hospice census will undergo		
					detailed record review by hosp		
					quality audit RN's to confirm the	iai	
					each patient's diet and medications are updated and	that	
					patient goals are also updated		
					measurable, and pertinent to t		
					patient's ongoing care needs.	i i C	
					Reviewing these records will a	llow	
					for immediate coaching and		
					remediation with any team		
					member determined to be defi	cient	
					in meeting the requirement an		
					will allow for accountability	-	
					measures should the deficience	CV	
					recur. Auditing records with	,	
					subsequent coaching,		
					remediation, and accountabilit	V	
					measures for team members \	•	
					fail to meet the requirement is	an	
					essential step to prevent		
					recurrence of noncompliance	with	
					this standard. Audits will conti		
					until 100% compliance is achie	eved	
					for three consecutive months		

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will then continue at a regular

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETED	
		151511	B. WING 03/08/2022			2022	
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	₹			MERIDIAN ST, SUITE 700		
ΙΝΠΙΔΝΙΔ	UNIVERSITY HEA	II TH HOSPICE			APOLIS, IN 46204		
INDIVITY CHAPTER THE ACTION TO L			INDIAN				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					cadence indefinitely to ensure		
					sustained compliance with this	5	
					standard.		
					Completion date for		
					implementation of audit proce	SS:	
					April 8, 2022		
					Responsible Party: The Hosp	ice	
					Quality Manager		
					d. Hospice Supervisors or		
					designees will complete one		
					shared visit per week with rota	ating	
					members of their regional clin	ical	
					team. The supervisor or desig	nee	
					will review the patient record i	n	
					advance of the visit, will obser	ve	
					the visit, and will observe visit		
					documentation after the visit.		
					Supervisor or designee will		
					complete the "Hospice		
					Comprehensive Assessment,		
					Plan, and Visit Review" tracer		
					document available electronic	ally	
					in the agencies network. The		
			1		supervisor or designee observ	•	
					patients in the field combined	with	
					record review will allow the		
					supervisor or designee to take	<del>)</del>	
					immediate action if a team		
					member is determined to be	nt.	
					deficient in documenting curre		
					Actions taken will include	· <b>.</b>	
					immediate coaching, remedia	tion	
			1			uon,	
					and accountability measures should the deficiency recur. The should the deficiency recur.	he	
					_		
					supervisor or designee compless shared visits and document re	-	
			1		is a required step to prevent	VICW	
						lard	
	I		1		noncompliance with this stand	ıaıu.	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES					FOI	FORM APPROVED	
CENTERS FOR	R MEDICARE & MEDIC	CAID SERVICES				OM	IB NO. 0938-039
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>			COMPLETED	
		151511	B. WI	NG		03/08/2022	
	PROVIDER OR SUPPLIE		•	950 N I	ADDRESS, CITY, STATE, ZIP COD MERIDIAN ST, SUITE 700 JAPOLIS, IN 46204		
(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 APPROPRIA DEFICIENCY)	ESS, CITY, STATE, ZIP COD IDIAN ST, SUITE 700 DLIS, IN 46204  PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE ROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  ared visits and document review I continue until 100% impliance is achieved for three insecutive months and will then intinue at a regular cadence efinitely to ensure sustained impliance with this standard. Impletion date for oblementation of the audit incress: April 8, 2022 is sponsible party: Hospice ality Manager in of correction indicess: April 8, 2022 is ponsible party: Hospice ality Manager in of corrective actions for each ficiency. (2) It sets reasonable in intinuition date unless an intension is requested and coroved. (3) It describes how car plan/action will prevent interest. And (4), it describes in will be the person(s) is ponsible for implementing and intitoring the plan for future impliance with the regulations. A sponse to each deficiency on	COMPLETION
L 0558	418.56(e)(5)				will continue until 100% compliance is achieved for the consecutive months and will to continue at a regular cadence indefinitely to ensure sustained compliance with this standard Completion date for implementation of the audit process: April 8, 2022 Responsible party: Hospice Quality Manager Plan of correction requirements:  It clearly states the specific near of the corrective actions for each deficiency. (2) It sets reasonal completion dates for all deficiencies prior to the termination date unless an extension is requested and approved. (3) It describes how your plan/action will prevent recurrence. And (4), it describes who will be the person(s) responsible for implementing monitoring the plan for future	ree hen e d l.  ature ach ble v  es and ns. A	

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Bldg. 00

COORDINATION OF SERVICES

(5) Provide for an ongoing sharing of

and procedures, to-]

[The hospice must develop and maintain a system of communication and integration, in accordance with the hospice's own policies

information with other non-hospice healthcare providers furnishing services unrelated to the

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	OF CORRECTION	IDENTIFICATION NUMBER  151511	A. BUILDING 00 CO		COMPL	COMPLETED 03/08/2022	
	PROVIDER OR SUPPLIER UNIVERSITY HEA		950 N MERIDIAN ST, SUITE 700 INDIANAPOLIS, IN 46204				
(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)	ΤE	(X5) COMPLETION DATE
	terminal illness and	d related conditions.	L OS	558	L558 COORDINATION OF SERVICES CFR(s): 418.56(e). The hospice must develop and maintain a system of communication and integration accordance with the hospice's own policies and procedures, to-] (5) Provide for ongoing sharing of information other non-hospice healthcare providers furnishing services unrelated to the terminal illness and related conditions.  This STANDARD is not met as evidenced by: Based on reconserview and interview, the Interdisciplinary Team failed to ensure all collaboration with outside hom health providers was documer in 2 (Patients #1 and 10) of 3 records reviewed of patients we received services from home health and attendant care providers, in a sample of 20.  Plan of Correction  (1) Specific nature of the corrective actions including completion dates, description of how each action will prevene recurrence, and responsible party  - a. A special edition of the communication tool "Hospice Huddle Hot Topics" which contained the Hospice 2/15/20	n, in r an with s d d red d ho	04/08/2022

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SUR			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPLETED	
		151511	B. WI	NG		03/08/2022	
				STREET .	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	₹			MERIDIAN ST, SUITE 700		
INDIANA	UNIVERSITY HEA	LTH HOSPICE		INDIAN	IAPOLIS, IN 46204		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID PROVIDER'S PLAN OF CORRECTION		PROVIDER'S PLAN OF CORRECTION	(.	X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL	PREFIX		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		LETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DA	TE
					Federal Survey results was		
					verbally reviewed with Hospico team members; an email copy		
					was also provided to team		
					members for independent revi	ew	
					Included in the results summa		
					was detail concerning the	´	
					Interdisciplinary Group's (IDG)		
					failure to ensure all collaborati		
					with outside home health prov	iders	
					was documented for two recor	ds	
					reviewed. Team member		
					awareness of survey results is		
					required step to prevent recuri		
					of the deficiencies identified d	uring	
					the survey.	222	
					Completion date: March 18, 20 Responsible party: The Hospid		
					Administrator		
					/ tarrimotrator		
					b. A care coordination		
					template was created for use i	n	
					the hospice electronic health		
					record clinical notes that allow		
					documentation of outside prov		
					care coordination. Education of	on	
					access and use of the clinical		
					note care coordination templa		
					will be delivered at the four-ho		
					Hospice Education Summit for clinical employees of the hosp		
					including Clinical Managers,		
					Supervisors, RN's, LPN's, Soc	<sub>cial</sub>	
					Workers, Chaplains, Therapis		
					Bereavement Coordinators,	<i>'</i>	
					Volunteer Coordinators, and		
					Aides. Education will be in-per	son,	
					interactive and team members		
					be given the opportunity to asl	(	
					questions. Creating this temple	ate	

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### DEPARTMENT OF HEALTH AND HUMAN SERVICES CEN

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NTERS FOR MEDICARE & MEDICA	OMB NO. 0938-039		
STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>	COMPLETED
	151511	B. WING	03/08/2022
		CERTIFIE ADDRESS CITY OF THE ZID COD	

STREET ADDRESS, CITY, STATE, ZIP COD 950 N MERIDIAN ST. SUITE 700 NAME OF PROVIDER OR SUPPLIER

INDIANA	UNIVERSITY HEALTH HOSPICE	950 N MERIDIAN ST, SUITE 700 INDIANAPOLIS, IN 46204		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
IAG	REGULATORY OR LSC IDENTIFYING INFORMATION	IAG	is an essential step to prevent non-compliance with the requirement to document all collaboration with outside home health providers. Completion date: April 8, 2022 Responsible party: The Hospice Administrator & The Quality & Education Manager  - (2) Monitoring and Sustainability - a. All education content developed for the Hospice Education Summit is added to new team member onboarding requirements for all clinical roles including, Clinical Managers, Supervisors, RNs, LPNs, Social Worker, Chaplain, Bereavement Coordinator, Therapists, Volunteer Coordinators, and Aides. Ensuring new clinical team members are aware of the requirement that collaboration with an outside home care provider must be documented using the care coordination template in clinical notes of the patient's electronic health record will prevent failure to meet this requirement through early awareness and understanding of expectations. Completion date: April 8, 2022 Responsible party: The Hospice Quality Manager	DATE

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	T OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTITUTE OF CORRECTION IDENTIFICATION NUMBER A. BUILDING OB. WING		onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 03/08/2022			
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 950 N MERIDIAN ST, SUITE 700 INDIANAPOLIS, IN 46204				
(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		
				b. Team members on leav absence during the four-hour Hospice Education Summit w scheduled for review of this material at the first bi-weekly Hospice Onboarding Session occur upon their return. Requall active team members who missed the initial sessions to complete the first available onboarding session of this material will ensure all team members have received this material, and that they have be given the opportunity to ask questions about it. Ensuring a clinical team members have completed these steps essent to increase education and understanding of the requirem that all collaboration with outs home care providers must be documented in clinical notes a will prevent failure to meet this requirement.  Completion date: April 8, 2023 Responsible party: The Hospi Quality Manager  c. Ten percent of monthly hospice census will undergo detailed record review by hos quality audit RNs to confirm thall hospice patients who have and services furnished by an outside home care provider may have care coordination clearly documented using the care coordination clinical note template. Reviewing these recordination clinical note template. Reviewing these recordination than a survival to the survival template.	e of Ill be to to tiring  een all tial tial tient tide and tis 2 cce pice totat care totat care totat		

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	Γ OF HEALTH AND HU						RM APPROVED
	R MEDICARE & MEDIC	-					B NO. 0938-039
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETED	
		151511	B. W	ING		03/08/	/2022
NAME OF I	PROVIDER OR SUPPLIE	?	•	STREET.	ADDRESS, CITY, STATE, ZIP COD		
				950 N I	MERIDIAN ST, SUITE 700		
INDIANA	UNIVERSITY HEA	ALTH HOSPICE		INDIAN	IAPOLIS, IN 46204		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					will allow for immediate coachi	ing	
					and remediation with any team	ı	
					member determined to be defi	cient	
					in meeting the requirement an	d	
					will allow for accountability		
					measures to be taken should t		
					deficiency recur. Auditing reco	rds	
					with subsequent coaching,		
					remediation, and accountabilit	-	
					measures for team members v		
					fail to meet the requirements is	s an	
					essential step to prevent		
					recurrence of non-compliance		
					the standard. Audits will continuate the standard. Audits will continuate the standard the standard the standard the standard.		
					for three consecutive months a		
					will then continue at a regular	and	
					cadence indefinitely to ensure		
					sustained compliance with the		
					standard.		
					Completion date for		
					implementation of audit proces	ss:	
					April 8, 2022		
					Responsible Party: The Hosp	ice	
					Quality Manager		
					d Haaniaa Cumamiir		
					d. Hospice Supervisors or		
					designees will complete one	tina	
					shared visit per week with rota	_	
					members of their regional clini		
					team. The supervisor or designation will review the patient record in		
					advance of the visit, will obser		
	I		ı		advance of the visit, will obser	٧ <del>٠</del>	I

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Event ID:

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If continuation sheet

the visit, and will observe visit documentation. Supervisor or designee will complete the "Hospice Comprehensive

Assessment, Care Plan, and Visit Review" tracer document available electronically in the agency's

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### DEPARTMENT OF HEALTH AND HUMAN SERVICES

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 B. WING		(X3) DATE SURVEY COMPLETED 03/08/2022				
	ROVIDER OR SUPPLIEF UNIVERSITY HEA		STREET ADDRESS, CITY, STATE, ZIP COD 950 N MERIDIAN ST, SUITE 700 INDIANAPOLIS, IN 46204				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	(X5) COMPLETION DATE			
TAU	REGULATORY OF	CESC IDENTIFY ING INFORMATION	IAG	network. The supervisor or designee observing patients in field combined with record rev will allow the supervisor or designee to take immediate aci if a team member is determined be deficient in ensuring that calcoordination with outside home care providers is documented the health record. Actions take will include immediate coaching remediation, and accountability measures should the deficient recur. The supervisor or design completing shared visit and document review is a required to prevent noncompliance with standard. Shared visits and document review will continue 100% compliance is achieved three consecutive months and then continue at a regular cad indefinitely to ensure sustained completion date for implementation of the audit process: April 8, 2022 Responsible party: The Hospic Quality Manager	n the riew ction ed to care e in en ng, cy cy nee I step in this until for I will ence d		
				Plan of correction requirements: It clearly states the specific na of the corrective actions for ea deficiency. (2) It sets reasonal completion dates for all deficiencies prior to the termination date unless an	nch		

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extension is requested and

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	T OF DEFICIENCIES DF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 151511	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 03/08/2022	
	ROVIDER OR SUPPLIE UNIVERSITY HEA		950	EET ADDRESS, CITY, STATE, ZIP COD N MERIDIAN ST, SUITE 700 IANAPOLIS, IN 46204		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	CROSS-REFERENCED TO THE APPROPRI	(X5) COMPLETION DATE	
				approved. (3) It describes how your plan/action will prevent recurrence. And (4), it describes who will be the person(s) responsible for implementing monitoring the plan for future compliance with the regulation response to each deficiency of the CMS-2567 is required.	and ns. A	
L 0559						
Bldg. 00			L 0559	L559 QUALITY ASSESSMEN PERFORMANCE IMPROVENCE CFR(s): 418.58 (c)(5)  This CONDITION is not met a evidenced by: Based on recoreview and interview, the age failed to ensure governing be oversight to ensure the hospi maintained an effective QAPI (Quality Improvement and Performance Improvement) program to document improvin Hospice performance for 1 Hospice provider.	MENT  as rd ncy dy ce	
				systemic problem resulted in agency's inability to ensure patients received appropriate services which could result in the agency not providing quality health care, resulting in non-compliance w 42 CFR 418.58 Condition of Participation: Quality	t thus	

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	EMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION  LAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00  B. WING			(X3) DATE SURVEY  COMPLETED  03/08/2022	
	ROVIDER OR SUPPLIEF UNIVERSITY HEA		950 N I	ADDRESS, CITY, STATE, ZIP COD MERIDIAN ST, SUITE 700 JAPOLIS, IN 46204	
INDIANA  (X4) ID  PREFIX  TAG	SUMMARY (EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)  Improvement.  Plan of Correction (1) Specific nature of the corrective actions including completion dates, description of how each action will preverecurrence, and responsible party  - a. The Hospice Administration participated in meetings to discuss Hospice QAPI governi body oversight. A final meeting 3/22/2022 was also held with the IU Health (IUH) Senior Vice President, General Counsel, V President, Chief Compliance Officer, Executive Director, Accreditation, Director, Quality and Safety and Executive Director Home Health/Hospice to affirm	n
				plan for increased frequency of hospice QAPI reporting. b. Hospice Administrator with ensure QAPI information from monthly Hospice QAPI meeting is provided to System Health Solutions Quality, Safety, Accreditation and Risk (SHS QSAR) Committee. The SHS QSAR Committee will then property to the Hospice governity body, the Indiana University He (IUH) Board of Director's committee on Quality and Patic Safety, twice yearly beginning April 28, 2022. The Hospice	gs ovide ng ealth

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policy "Quality Assessment and

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 151511		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 03/08/2022	
	ROVIDER OR SUPPLIE		950 N I	ADDRESS, CITY, STATE, ZIP COD MERIDIAN ST, SUITE 700 IAPOLIS, IN 46204	
(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 APPROPRIA DEFICIENCY)  Performance and Improvement	DATE
				Performance and Improvement (QAPI)" will be revised to reflet these changes prior to the Apt Board Committee meeting.  c. Hospice QAPI plan was enhanced to include the followinformation (revised plan attached):  1) Scope of Services  2) Definition of Quality and Safety Framework  3) Definition of High-Risk Patients for Risk Assessment  4) Specifies QAPI meeting frequency and attendees  5) Definition of how inform will be cascaded to front line to members  6) Overview of Data Collect  7) Adverse data trends will result in action planning utilizite Lean principles and methodol  8) Hospice QAPI Committed in conjunction with SHS QSAI Committee, will determine what in conjunction with SHS QSAI Committee, will determine what in conjunction with SHS QSAI Committee, will determine what in conjunction with SHS QSAI Committee, will determine what in conjunction with SHS QSAI Committee, will determine what in conjunction with SHS QSAI Committee, will determine what in conjunction with SHS QSAI Committee, will determine what in conjunction with SHS QSAI Committee, will determine what in conjunction with SHS QSAI Committee, will determine what in conjunction with SHS QSAI Committee, will determine what in conjunction with SHS QSAI Committee, will determine what in conjunction with SHS QSAI Committee, will determine what in conjunction with SHS QSAI Committee, will determine what in conjunction with SHS QSAI Committee, will determine what in conjunction with SHS QSAI Committee, will determine what in conjunction with SHS QSAI Committee, will determine what in conjunction with SHS QSAI Committee, will determine what in conjunction with SHS QSAI Committee, will determine what in conjunction with SHS QSAI Committee, will determine what in conjunction with SHS QSAI Committee, will determine what in conjunction with SHS QSAI Committee, will determine what in conjunction with SHS QSAI Committee, will determine what in conjunction with SHS QSAI Committee, will determine what in conjunction will be responsible for problem of the pro	ect ril s sving  s sation ream ction I ng ogy ee, R en m n f rs will the vill be f

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 151511		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 03/08/2022	
	PROVIDER OR SUPPLIE		STREET 950 N I INDIAN		
(X4) ID PREFIX 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 APPROPRIA' DEFICIENCY)  2022	(X5) COMPLETION DATE
				e. Responsible party: Hosp Administrator  (2) Monitoring and Sustainability	pice
				a. The revised QAPI plan of be shared at the Hospice QAPI meeting on 4/8/2022. Completion date: April 8, 2022 Responsible party: The Hospi Quality Manager b. Attendees and invitees unable to attend the April 8th meeting will be educated on the revised plan by the Quality and Education Manager no later the April 30th. c. The revised QAPI plan at Hospice QAPI meeting minute will be shared at the SHS QSA Committee meeting in April 20 Completion date: April 30, 202 Responsible party: Hospice Quality and Education Manager full QAPI plan will not copy passinto this response field. QAPI plan sent via email to IDOH or 3/24/2022	el 2 cce ne d an and s AR 22 22

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 151511		A. BUILDING <u>00</u> COMP		(X3) DATE COMPL 03/08/	ETED		
	PROVIDER OR SUPPLIEF		950 N MERIDIAN ST, SUITE 700 INDIANAPOLIS, IN 46204				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION		ID PROVIDER'S PLAN OF CORRECTION  PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		TE	(X5) COMPLETION DATE
L 0778	418.112(e)(1)(i) COORDINATION [The designated in member is respon (i) Providing overa	OF SERVICES nterdisciplinary group sible for:] all coordination of the e SNF/NF or ICF/MR	L 07		L778 CCOORDINATION OF		04/08/2022
					SERVICES CFR(s): 418.112 ((i)  [The designated interdisciplinal group member is responsible to the corrective actions including completion dates, description of the corrective action will prevene active and interview. The patient of the patient o	ary for:] on of IF or or with wed yed y	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPLI	
		151511	B. W	ING		03/08/	2022
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 950 N MERIDIAN ST, SUITE 700 INDIANAPOLIS, IN 46204				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	1	ID	NEOVIDERIC N. AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE .	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					communication tool "Hospice Huddle Hot Topics" which contained the Hospice 2/15/20 Federal Survey results was verbally reviewed with Hospice team members; an email copy was also provided to team members for independent revillation in the results summa was detail concerning the failute agency to ensure documentation of coordination care activities for two hospice patients who received care in skilled nursing facilities. Team member awareness of survey results is a required step to prevent recurrence of the deficiencies identified during the survey.  Completion date: March 18, 20 Responsible party: The Hospic Administrator	e / ew. ry ire of i of	
					b. A care coordination template was created for use the hospice electronic health record clinical notes that allow documentation of skilled nursi facility coordination of care. Education on access and use the clinical note care coordina template will be delivered at the four-hour Hospice Education Summit for clinical employees the hospice including Clinical Managers, Supervisors, RN's, LPN's, Social Workers, Chaplains, Therapists,	rs for ng of tion ne of	

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 151511		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY  COMPLETED  03/08/2022		
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 950 N MERIDIAN ST, SUITE 700 INDIANAPOLIS, IN 46204			
(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	
AAG	ALGOLATORY ON			Bereavement Coordinators, Volunteer Coordinators, and Aides. Education will be in-pe interactive and team members be given the opportunity to as questions. Creating this templ is an essential step to prevent non-compliance with the requirement to document coordination of care activities each patient's skilled nursing facility. Completion date: April 8, 2022 Responsible party: The Hospi Administrator & The Quality & Education Manager  (2) Monitoring and Sustainability  - a. All education content developed for the Hospice Education Summit is added to new team member onboarding requirements for all clinical ro including Clinical Managers, Supervisors, RN, LPN, Social Worker, Chaplain, Bereaveme Coordinator, Therapists, Volu Coordinator, and Aides. Ensu new clinical team members an aware of the requirement that coordination of care activities each patient's skilled nursing facility must be documented u the clinical note care coordinatemplate is an essential step to confirm understanding of the requirement. Early education awareness of expectations wi	rson, s will k ate : with 2 ce ent nteer uring e with using tion o and	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 00 COMPLETED 03/08/2022				
		151511	B. WING 03/08/2022				
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
INIDIANIA	UNIVERSITY HEA		950 N MERIDIAN ST, SUITE 700				
INDIANA	ONIVERSIT HEA	LIIIIOOFICE		INDIAN	IAPOLIS, IN 46204		
(X4) ID		STATEMENT OF DEFICIENCIE	ID PROVIDER'S PLAN OF CORRECTION			(X5)	
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	prevent recurrence of failure to		DATE
					meet this standard.	,	
					Completion date: April 8, 2022	2	
					Responsible party: The Hospi		
					Quality Manager		
					<del>.</del>		
				<b>b.</b> Team members on a lea			
				of absence during the four- ho Hospice Education Summit wi			
				scheduled for review of this	ii DC		
					material at the first bi-weekly		
				Hospice Onboarding Session	to		
				occur upon their return. Requ	iring		
				all active team members who			
					missed the initial sessions to		
					complete the first available		
					onboarding session of this material will ensure all team		
					members have received this		
					material and have been given	the	
					opportunity to ask questions.		
					Ensuring all clinical team		
					members have completed the		
					requirements is an essential s	tep	
					to increase awareness and		
					understanding of the requirem	ent	
					that collaboration with skilled nursing facility must be		
					documented for patients who		
					receive care in a skilled nursir	ıg	
					facility and will prevent recurre	-	
					of failure to meet this		
					requirement.		
					Completion date: April 8, 2022		
					Responsible party: The Hospi	ce	
					Quality Manager		
					c. Ten percent of monthly		
					hospice census will undergo		
					detailed record review by host	oice	

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CENTERS FOR	MEDICARE & MEDIC.				OMB NO. 0936-039	
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2		(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED	
		151511	B. WING	<del></del>	03/08/2022	
l			D. WING		03/00/2022	
N. 1	POLUBER OF SUPER		STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER		950 N	MERIDIAN ST, SUITE 700		
INDIANA	UNIVERSITY HEA	LTH HOSPICE		NAPOLIS, IN 46204		
			1			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
				quality audit RN's to confirm the	nat	
				collaboration with the skilled		
				nursing facility is documented	for	
				those patients who receive ca		
				1	16 111	
				a skilled nursing facility.	-11	
				Reviewing these records will	allow	
				for immediate coaching and		
				remediation with any team		
				member determined to be def		
				in meeting the requirement an	d	
			will allow for accountability			
			measures to be taken should	the		
				deficiency recur. Auditing reco	ords	
				with subsequent coaching,		
				remediation, and accountabilit	v	
				measures for team members	•	
				fail to meet the requirement is		
				1	an	
				essential step to prevent	:41-	
				recurrence of non-compliance		
				the standard. Audits will conti		
				until 100% compliance is achi		
				for three consecutive months	and	
				will then continue at a regular		
				cadence indefinitely to ensure		
				sustained compliance with this	3	
				standard.		
				Completion date for		
				implementation of audit proces	ss:	
				April 8, 2022		
				Responsible Party: The Hosp	ice	
				Quality Manager.		
				Quality Mallager.		
				d Haaniaa Curamiisaaa		
				d. Hospice Supervisors or		
				designees will complete one		
				shared visit per week with rota	<u> </u>	
				members of their regional clin		
				team. Supervisor or designee	will	
				review the patient record in		

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advance of visit, will observe the visit, and will observe visit

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 151511		IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION       (X3) DATE SURVEY         A. BUILDING       00       COMPLETED         B. WING       03/08/2022			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 950 N MERIDIAN ST, SUITE 700 INDIANAPOLIS, IN 46204			
(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	
	ALGOLINION ON			documentation. Supervisor or designee will complete the "Hospice Comprehensive Assessment, Care Plan, and Neview" tracer document availelectronically in the agency's network. The supervisor or designee observing patients in field combined with record review will allow the supervisor or designee to take immediate actif a team member is determined be deficient in documenting collaboration with the skilled nursing facility. Actions taken include immediate coaching, remediation, and accountability measures should the deficient recur. The supervisor or design completing shared visit and document review is a required to prevent noncompliance with standard. Shared visits and document review will continue 100% compliance is achieved three consecutive months and then continue at a regular cad indefinitely to ensure sustained compliance with this standard. Completion date for implementation of the audit process: April 8, 2022 Responsible party: The Hospic Quality Manager  Plan of correction requirements: It clearly states the specific na	/isit lable  In the liew letion led to let	
				of the corrective actions for ea	ich	

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deficiency. (2) It sets reasonable

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PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  PREFIX TAG (CASE-REFERENCE) TO THE APPROPRIATE DATE  COMPLETION OF LSC IDENTIFYING INFORMATION  Completion dates for all deficiencies prior to the termination date unless an extension is requested and approved. (3) It describes how your plan/action will prevent recurrence. And (4), it describes who will be the person(s) responsible for implementing and monitoring the plan for future compliance with the regulations. A response to each deficiency on the CMS-2567 is required.  L 0782 418.112(f)  ORIENTATION AND TRAINING OF STAFF Hospice staff, in coordination with SNF/NF or ICF/IID facility staff, must assure orientation of such staff furnishing care to hospice patients in the hospice philosophy, including	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 151511		(X2) MULTIPLE A. BUILDING B. WING	construction 00	(X3) DATE SURVEY  COMPLETED  03/08/2022	
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)    PREFIX TAG   PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION   PREFIX TAG   COMPLET GROSS-REFERENCED TO THE APPROPRIATE DATE				950 N	N MERIDIAN ST, SUITE 700	
completion dates for all deficiencies prior to the termination date unless an extension is requested and approved. (3) It describes how your plan/action will prevent recurrence. And (4), it describes who will be the person(s) responsible for implementing and monitoring the plan for future compliance with the regulations. A response to each deficiency on the CMS-2567 is required.  L 0782	PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	(X5) COMPLETION DATE
hospice policies and procedures regarding methods of comfort, pain control, symptom management, as well as principles about death and dying, individual responses to death, patient rights, appropriate forms, and record keeping requirements.  L 0782  L782 ORIENTATION AND TRAINING OF STAFF CFR(s): 418.112 (f) Hospice staff, in coordination with SNF/NF or ICF/IID facility staff, must assure orientation of such staff furnishing care to hospice patients in the hospice philosophy, including hospice policies and procedures regarding methods of comfort, pain control, symptom management, as well as	L 0782	418.112(f) ORIENTATION A Hospice staff, in of such staff furning patients in the hospice policies a methods of comformanagement, as death and dying, death, patient rig	and procedures regarding ort, pain control, symptom well as principles about individual responses to hts, appropriate forms, and		completion dates for all deficiencies prior to the termination date unless an extension is requested and approved. (3) It describes how your plan/action will prevent recurrence. And (4), it describes who will be the person(s) responsible for implementing monitoring the plan for future compliance with the regulation response to each deficiency of the CMS-2567 is required.  L782 ORIENTATION AND TRAINING OF STAFF CFR(statistical and the complete staff, in coordination SNF/NF or ICF/IID facility statistical and staff furnishing care to hospic patients in the hospice philosophy, including hospice policies and procedures regarmethods of comfort, pain contents in the hospice policies and procedures regarmethods of comfort, pain contents in the hospice policies and procedures regarmethods of comfort, pain contents in the hospice policies and procedures regarmethods of comfort, pain contents in the hospice policies and procedures regarmethods of comfort, pain contents in the hospice policies and procedures regarmethods of comfort, pain contents in the hospice policies and procedures regarmethods of comfort, pain contents in the hospice policies and procedures regarmethods of comfort, pain contents in the hospice policies and procedures regarmethods of comfort, pain contents in the hospice policies and procedures regarmethods of comfort, pain contents in the hospice policies and procedures regarmethods of comfort, pain contents in the hospice policies and procedures regarmethods of comfort, pain contents in the hospice policies and procedures regarmethods of comfort, pain contents in the hospice pain the pain and the procedure regarmethods of comfort, pain contents in the hospice pain the pain and the procedure regarmethods of comfort, pain contents in the pain and the procedure regarmethods of comfort, pain contents in the pain and the procedure regarmethods of comfort and the procedure regarmeth	w bes and sins. A on O4/30/2022  i):  i with aff, ich ce ender a control,

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER  151511		A. BUILDING B. WING	00	COMPLETED 03/08/2022	
	ROVIDER OR SUPPLIER		950 N I	ADDRESS, CITY, STATE, ZIP COD MERIDIAN ST, SUITE 700 IAPOLIS, IN 46204	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				patient rights, appropriate form and record keeping requirements. This STANDARD is not met an evidenced by: Based on recording review, and interview the ager failed to ensure it had provide documented orientation and training of Skilled Nursing Facilities (SNF) staff who were furnishing care to hospice patients in this hospice's philosophy, this hospice's policies, and proceding regarding comfort in pain conting symptom management, princing about death and dying and the individuals' responses to death and patient rights in 19 of 21 skilled nursing facilities (SNFs who were contracted to provide services to hospice patients.  Plan of Correction  (1) Specific nature of the corrective actions including completion dates, description of how each action will prevened the party  - a. A special edition of the communication tool "Hospice Huddle Hot Topics" which contained the Hospice 2/15/20 Federal Survey results was verbally reviewed with Hospic team members and an email of was also provided to team members for independent reviewed included in the results summare included in t	ents. s rd ncy d and e s dures erol, ples e h, s) de

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			JRVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u>			COMPLETED	
		151511	B. WING 03/			03/08/2	022	
	PROVIDER OR SUPPLIED			950 N I	ADDRESS, CITY, STATE, ZIP COD MERIDIAN ST, SUITE 700 IAPOLIS, IN 46204			
(VA) ID	CIDALADY	OT A TEMPAT OF DEFICIENCIE	I		1	1	(7/5)	
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		(X5) COMPLETION	
PREFIX TAG	· ·	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE	
					was detail concerning the failu	ire of		
					provided and documented	اما		
					orientation and training of Skil			
					Nursing Facilities (SNF) staff v			
					were furnishing care to hospic patients in this hospice's	C		
					philosophy, this hospice's			
					policies, and procedures regar	rdina		
					comfort in pain control, sympto	~		
				management, principles about				
				death and dying and the				
				individuals' responses to deatl	n,			
					and patient rights for 19 faciliti	es.		
					Team member awareness of			
					survey results is a required ste	ep to		
					prevent recurrence of the			
					deficiencies identified during the	he		
					survey.			
					Completion date: March 18,			
					2022.			
					Responsible party: the hospic	е		
					administrator			
					b. The Administrator or			
					designee of all skilled nursing			
					facilities which are currently			
					providing care to hospice agei	ncy		
					patients will be contacted to			
					schedule orientation and traini	-		
					for facility staff who provide ca			
					hospice patients. Orientation			
					training will include this hospic	e's		
					philosophy, this hospice's			
					policies, and procedures regar			
					comfort in pain control, sympto			
					management, principles about	[		
					death and dying and the			
					individuals' responses to death			
I					and patient rights. Contacting			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 151511		(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY  COMPLETED  03/08/2022			
	ROVIDER OR SUPPLIE UNIVERSITY HEA		STREET ADDRESS, CITY, STATE, ZIP COD 950 N MERIDIAN ST, SUITE 700 INDIANAPOLIS, IN 46204				
(X4) ID PREFIX TAG	(EACH DEFICIEN	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 APPR DEFICIENCY)	TION D BE OPRIATE	(X5) COMPLETION DATE	
				each facility's administrate designee to review this requirement and to sched facility staff education will that facility leadership understands this requirem assists the agency in dete the most beneficial time for education to be presented prevent recurrence of failument this standard.  Completion date: April 30 Responsible party: Hospi Director  (2) Monitoring and Sustainability  - a. The hospice agency enter into any new contract agreements with skilled not facilities until the Administ designee of the facility has contacted regarding the requirement that hospice provide orientation and trafacility team members who care for hospice patients with sust include this hospice's policies, and procedures remote that and dying and the individuals' responses to cand patient rights and that orientation must be sched prior to entering into the nicontract. Ensuring that e	uled ensure  nent and ermining or I and will ure to I, 2022 ce  y will not ct ursing trator or s been must aining to o will which s regarding mptom bout death, t this luled ew		

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	· · · · · · · · · · · · · · · · · · ·		00	COMPLETED	
151511			B. WING 03/08/2022			/2022	
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP COD		
			950 N MERIDIAN ST, SUITE 700				
INDIANA UNIVERSITY HEALTH HOSPICE			INDIANAPOLIS, IN 46204				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION		TAG		DEFICIENCY)		DATE
					_	d training is scheduled through	
				the facility administrator or designee, prior to entering into any			
			new contrac			-	
					new contracts will prevent recurrence of non-compliance	with	
					this standard.	iipiiaiice witti	
			Completion date: April 3			22	
					Responsible party: Hospice		
				Director			
					b. The hospice "Coordination	on of	
					Care" policy will be updated to		
				indicate that hospice orientation with skilled nursing facility staff will occur annually. Completion date: April 30, 2022 Responsible party: The Hospice Director			
					Plan of correction		
					requirements:		
					It clearly states the specific na	ture	
					of the corrective actions for ea	ch	
					deficiency. (2) It sets reasonal	ole	
					completion dates for all		
					deficiencies prior to the		
					termination date unless an		
					extension is requested and		
					approved. (3) It describes how	1	
					your plan/action will prevent		
					recurrence. And (4), it describe	<i>‡</i> 8	
					who will be the person(s)	and	
					responsible for implementing a monitoring the plan for future	ai iU	
					compliance with the regulation	ις Δ	
					response to each deficiency o		
					the CMS-2567 is required.	1.	
					and ome 2001 to required.		

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