STATEME	R MEDICARE & MEDIC NT OF DEFICIENCIES OF CORRECTION	CAID SERVICES X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 151587	(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION	(X3) DAT COM	MB NO. 0938-039 E SURVEY PLETED 9/2021
	PROVIDER OR SUPPLIE	R CE OF CENTRAL INDIANA LLC	1385 N	ADDRESS, CITY, STATE, ZIP CO N BALDWIN AVE DN, IN 46952	DD	
(X4) ID PREFIX TAG E 0000	(EACH DEFICIE)	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
Bldg. 00	0000dg. 00An Emergency Preparedness Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 418.113.Survey Dates: 10/22, 10/25, 10/26, 10/27, 10/28, 11/4, 11/5, 11/8, 11/9; 2021.Facility Number: 003966 Provider Number: 151587Census: 155At this Emergency Preparedness survey, Heart to Heart Hospice was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 418.113.0000		E 0000			
Bldg. 00			L 0000			

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

TITLE

(X6) DATE

PRINTED: 12/15/2021

Any defiencystatement 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.

Event ID:

PD1P11 Facility ID: 003966

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 151587	(x2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		(X3) DATE SURVEY COMPLETED 11/09/2021	
	PROVIDER OR SUPPLIE	R CE OF CENTRAL INDIANA LLC	1385 N	address, city, state, zip c I BALDWIN AVE DN, IN 46952	COD	
(X4) ID PREFIX		Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE	HOULD BE	(X5) COMPLETIO
TAG		R LSC IDENTIFYING INFORMATION pardy (IJ) was identified on	TAG	DEFICIENCY)		DATE
	substances. A cab onsite at the agence multiple medication substances, of both patients that had ex- found to be relabed CMS granted perm survey to be comp notified on 10/25/2 immediate jeopard 3:30 PM. The host received medication to ensure medication to ensure medication failed to ensure medication failed to ensure medication failed to ensure medication active Home Pation Active General Inp Active Continuous Active Assisted Lin Census: 10 Active Skilled Nut Census: 79 Active Respite Pation Unduplicated censs Heart to Heart Host compliance with the	ent Census: 66 patient (GIP) Census: 0 care (CC) Patient Census: 0 ving Facility (ALF) Patient rsing Facility (SNF) Patient ient Census: 0 us: 450 spice was found to be out of ne Conditions of Participation 42				
	supplies, and dura	gs and biologicals, medical ble medical equipment. mpleted 11/30/21 Area 2				
0509	418.52(b)(4)(ii)	RIGHTS/RESPECT FOR				

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 151587	(X2) MULTIPLE C A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 11/09/2021	
	PROVIDER OR SUPPLIE	R CE OF CENTRAL INDIANA LLC	1385 N	address, city, state, zip cod I BALDWIN AVE DN, IN 46952		
(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)	ATE	(X5) COMPLETION DATE
Bldg. 00	PROPRTY/PERS [The hospice must (ii) Immediately in violations involvir on behalf of the h take action to pre- violations while th verified. Investiga of all alleged viola accordance with Based on record re- failed to fully inve- the complaint was Findings include: 1. A document title Administrator," in- the responsibilities include, but not lin complaint manage A document titled Responsibilities," if family has the righ entitled to exercise and to this end may recommend chang behalf of himself of staff, to government of his or her choice to be assured the investigate all alleg 2. During a review complaint indicate Date of Event 6 Revocation Typ Patient had fall	SON st:] hvestigate all alleged ng anyone furnishing services hospice and immediately event further potential he alleged violation is being ations and/or documentation ations must be conducted in established procedures; wiew and interview, the hospice stigate each complaint to ensure not a systemic issue.	L 0509	The Executive Director will be responsible to help ensure to violations are immediately investigated on all alleged violations involving anyone furnishing services on behale the hospice and will immediately take action to prevent further potential violations while the alleged violation is being verified. Executive Director will help ensure that investigations are documentation of all alleged violations are conducted in accordance with established procedures to help ensure the this was not a systemic issue Education was provided by the Regional VP of Clinical Operations (RVPCO) to the Executive Director (ED) and Alternate Executive Director 12/08/2021 on the policy LD. "Responsibilities of the Administrator" to include but not limited to conflict and complaint management. Education was provided by the Chief Clinical Officer (CCLO)	hat If of Ind I hat e. the 5 it	12/22/202

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	ENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 151587	(X2) MULTIPLE C A. BUILDING B. WING	onstruction (x 00	3) DATE SURVEY COMPLETED 11/09/2021
	PROVIDER OR SUPPLIE	R CE OF CENTRAL INDIANA LLC	1385 N	ADDRESS, CITY, STATE, ZIP COD I BALDWIN AVE DN, IN 46952	
X4) ID PREFIX TAG	(EACH DEFICIE)	' STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<ul> <li>chose to seek aggr hospice POC [plan 6/16/21"</li> <li>3. During a review complaint dated 9/ complaint indicate</li> <li> Date of Event</li> <li> FSN [sic] nurse</li> <li> Type D [Con</li> <li> [Former Patient administrator on-c.</li> <li>[Registered Nurse</li> <li> Date Resolved</li> <li>4. During an interv when asked if all c a system wide app.</li> </ul>	essive treatment outside of the of care] Date Resolved v of the agency complaint log, a 25/21 was reviewed. The d "Date reported 9/26/21 9/25 & 9/26 [sic] Complaint called with medication concerns nmunication] Actions Taken Care Manager B] and all spoke with FSN [sic] and D] made PRN [as needed] visit		all staff on 11/27/2021 on Right and Responsibilities indicating every patient is entitled to exercise their right to present grievances or recommend change and to be assured that the agency will investigate all alleged violations. Education was provided to all staff on 12/9/2021 by the Regional VP of Clinical Operations (RVPCO) and the Area Clinical Manager (ACM) on policy RI.5 "Resolution of Patient Conflicts, Grievances or Complaints". The Agency will immediately investigate all complaints made by a patient, a patient's family or guardian, or a patient's health care provider. On 12/9/2021, ACM and RVPCO educated all nurses on Policy EC.5 "Occurrence/Incident Reporting" and TX. 21 "Reporting/Follow-U Medication Incidents". The Regional VP of Clinical Operations (RVPCO) or designee will audit 100% of all complaints or alleged violations for 3 months or unti 100%, compliance is met to ensure that an immediate investigation occurred with follow-up and with a resolution. Ongoing the Area Clinical Manager (ACM) or designee will audit the complaint log through the QAF process.	ts a of p of

	R MEDICARE & MEDI						MB NO. 0938-039	
	VT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 151587	î ź	JILDING	onstruction 00	СОМ	(X3) DATE SURVEY COMPLETED 11/09/2021	
	PROVIDER OR SUPPLIE	R CE OF CENTRAL INDIANA LLC		1385 N	ADDRESS, CITY, STATE, ZIP COD I BALDWIN AVE DN, IN 46952			
(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 CORRECTI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ON DBE DPRIATE	(X5) COMPLETION DATE	
					Trends identified during t audits will be reviewed in no less than quarterly an plan of correction and/or training will be updated a indicated to help ensure sustained improvement.	QAPI d the		
_ 0512 Bldg. 00	<ul> <li>(1) Receive effect symptom control conditions related Based on record reinterview, the hosp Registered Nurse (symptoms related for 2 of 30 (#2, 3)</li> <li>Findings include: <ol> <li>A document titl Responsibilities," family has the righmanagement and shospice for the conillness"</li> <li>A document titl indicated "The cidentify physical, pspiritual needs relate be addressed in or well-being, comford ying process 4</li> </ol> </li> </ul>	E PATIENT a right to the following: tive pain management and from the hospice for d to the terminal illness; view, observation, and bice failed to ensure the RN) effectively managed to the patient's terminal illness clinical records reviewed. ed "Patient Rights and indicated "Every patient and t to receive effective pain ymptom control from the additions related to the terminal ed "Patient Assessments," comprehensive assessment will osychosocial, emotional, and ted to terminal illness that will der to promote the patient's rt, and dignity throughout the A comprehensive pain on accepted clinical standards lude history of pain and its	L 05	512	The Executive Director w responsible to help ensu- the Rights and Responsil of the patients have been followed and that all patie have received effective p management and sympto control related to the terr illness. Education was provided Regional VP of Clinical Operations (RVPCO) and Area Clinical Manager (Ar on 11/22/2021 and 11/23/2 all nursing staff on "Patie Assessments" which incl that in the initial comprehensive assessm well as subsequent comprehensive assessm the assessment will inclu is not limited to a comple pain assessment under accepted standards of pr	re that bilities ents ain om ninal by the the CM) 2021 to ent luded ent, as ents, de but te	12/22/202	

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 151587	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 11/09/2021
	PROVIDER OR SUPPLIE	R CE OF CENTRAL INDIANA LLC	1385 N	ADDRESS, CITY, STATE, ZIP COD I BALDWIN AVE DN, IN 46952	
HEART (X4) ID PREFIX TAG	SUMMARY (EACH DEFICIEN REGULATORY O of pain frequence impact of pain f or treatment that pu strategies and factor symptoms associat " 3. The clinical recor- on 11/8/21 at 12:00 election date of 9/2 of cerebral atheroso- hardening of the w During a home visi Patient #2, Registe completing wound failed to assess the wound care. 4. The clinical recor- on 11/8/21 at 1:00 election date of 8/1 of cerebral atheroso- hardening of the w During a home visi Patient #3, Registe completing wound failed to assess the wound care. 5. During an interv when asked if an as	CE OF CENTRAL INDIANA LLC STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL <u>R LSC IDENTIFYING INFORMATION</u> cy timing duration factors such as activities, care, recipitate or exacerbate pain fors to reduce pain additional ed with painnausea pain ord of Patient #2 was reviewed D PM and indicated a hospice 23/21 with a primary diagnosis clerosis (thickening and alls of the arteries in the brain). it on 11/9/21 at 10:00 AM with red Nurse F was observed care. The Registered Nurse patient's pain before starting ord of Patient #3 was reviewed PM and indicated a hospice 14/21 with a primary diagnosis clerosis (thickening and alls of the arteries in the brain). it on 11/9/21 at 11:30 AM with red Nurse G was observed care. The Registered Nurse patient's pain before starting ord of Patient #3 was reviewed PM and indicated a hospice 14/21 with a primary diagnosis clerosis (thickening and alls of the arteries in the brain). it on 11/9/21 at 11:30 AM with red Nurse G was observed care. The Registered Nurse patient's pain before starting view on 11/9/21 at 2:00 PM, ssessment of pain take place starts, Administrator E,	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAL DEFICIENCY)         (RVPCO) and the Area Clinic: Manager (ACM) provided education to all nursing staff 11/22/2021 and 11/23/2021 or "Patient Rights and Responsibilities" indicating that all patients have the right to receive effective pain management and symptom control. POLICY REVIEW/HANDOUTS include PE.1 "Patient Assessments" TX.30 "Pain Management" TX.07 "Implementing Care an Treatment"; TX. 25 "Hospice Care In A Nursing Facility"; TX.5 "Orders For Care"; TX.1 "Medication List and Monitoring"; RI.1 IN "Patient Rights and Responsibilities. 10/27/2021, the Chief Clinical Officer (CCLO) provided education to all nursing staff "Patient Rights and Responsibilities" and policy RI.1 IN "Patient Rights and Responsibilities", indicating that all patients have the right to receive effective pain management and symptom control.         The Area Clinical Manager (ACM) or designee will audit 100% of all active patients' comprehensive assessments 3 months or until 100%, compliance is met to ensure	al DATE

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	R MEDICARE & MEDI		1		-	IB NO. 0938-039
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA		CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPI	
		151587	B. WING		11/09	/2021
NAME OF 1	PROVIDER OR SUPPLIE	R		TADDRESS, CITY, STATE, ZIP COD		
HEARI	TO HEART HOSPI	CE OF CENTRAL INDIANA LLC	MARIO	ON, IN 46952		
(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 APPROPRIA	ATE	COMPLETIO
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE
				wound treatment. Ongoing		
				Area Clinical Manager (ACM	) or	
				designee will audit 10% of		
				active patient records		
				comprehensive assessment	S	
				through the QAPI process.		
				Trends identified during the		
				audits will be reviewed in Q		
				no less than quarterly and the	ne	
				plan of correction and/or		
				training will be updated as indicated to ensure sustained	ام	
				improvement.	a	
_ 0522	418 54(2)					
_ 0022	418.54(a) INITIAL ASSESS	MENT				
Bldg. 00		stered nurse must complete				
0		nent within 48 hours after				
		spice care in accordance				
		omplete (unless the				
	-	, or representative requests				
		essment be completed in				
	less than 48 hour	s.)				
		view and interview, the	L 0522	The Executive Director will I	be	12/22/202
	Registered Nurse (	RN) failed to assess the		responsible to help ensure t	hat	
	patient's ongoing r	nedication use as part of the		the hospice registered nurse	e	
	-	essment for 2 of 30 (#2, 3)		will complete an initial		
	clinical records rev	riewed.		assessment within 48 hours		
				after the election of hospice		
	Findings include:			care unless the physician or		
	1. A document titled "Patient Assessments," indicated " The comprehensive assessment will			representative requests that		
				assessment be completed in		
				less than 48 hours, to includ		
		sychosocial, emotional, and		an assessment of the patien		
	-	ted to terminal illness that will		ongoing medication use as	part	
		ler to promote the patient's		of the comprehensive		
		t, and dignity throughout the		assessment. The Executive		
		urrent medical conditions,		Director will help ensure tha		
	medications and co	-morbid psychiatric diagnoses	1	all patients have the right to		1

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 151587	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 11/09/2021
	PROVIDER OR SUPPLIE	R CE OF CENTRAL INDIANA LLC	1385 N	address, city, state, zii I BALDWIN AVE NN, IN 46952	P COD
(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 C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY)	ORRECTION (X: N SHOULD BE IE APPROPRIATE DAT
	<ul> <li>or history"</li> <li>2. The clinical records on 11/8/21 at 1:00 election date of 9/2 of cerebral atheross hardening of the were bardening of the were bardening of the were bardening of the were bardening wound failed to assess the for any changes.</li> <li>3. The clinical records on 11/8/21 at 1:00 election date of 8/2 of cerebral atheross hardening of the were bardening wound failed to assess the for any changes.</li> <li>4. During an interverse when asked if an an looking at all mediated in the bardening of the were bardening wound failed to asked if an an looking at all mediated to a structure bardening wound failed to a structure bardening wound failed to asked if an an looking at all mediated to a structure bardening wound the structure bardening wound failed to a structure bardening wound failed to asked if an an looking at all mediated to a structure bardening wound the structure bardening wound failed to a structure bardening wound failed to asked if an an looking at all mediated to a structure bardening wound the structure bardening wound failed to a stru</li></ul>	ord of Patient #2 was reviewed PM and indicated a hospice 23/21 with a primary diagnosis clerosis (thickening and alls of the arteries in the brain). it on 11/9/21 at 10:00 AM with red Nurse F was observed care. The Registered Nurse patient's current medications ord of Patient #3 was reviewed PM and indicated a hospice 14/21 with a primary diagnosis clerosis (thickening and alls of the arteries in the brain). it on 11/9/21 at 11:30 AM with red Nurse G was observed care. The Registered Nurse patient's current medications the or 11/9/21 at 2:00 PM, ssessment should include cations to ensure accuracy of use, Administrator E, indicated		receive effective pair management and sy control. Education was prove Regional VP of Clini Operations (RVPCO Area Clinical Manage on 11/22/2021 and 1 all nursing staff on Assessments" which that in the initial ass will be completed we hours after the elect hospice care unless physician or represe request the assessment will that pain has been a and effective pain management and sy control are in place accordance with sta practice and under direction of the phy nurse practitioner. If REVIEW/HANDOUT PE.1 "Patient Assess TX.30 "Pain Manage TX.07" Implementin Treatment"; TX. 25 " Care In A Nursing F TX.5 "Orders For Ca "Medication List and Monitoring"; RI.1 IN Rights and Respons The Area Clinical Ma (ACM) or designee of 100% of all active pair	in ymptom vided by the ical b) and the ger (ACM) 1/23/2021 to "Patient th included sessment vithin 48 tion of s the entative ment to be n 48 hours. Il ensure assessed ymptom in andards of the sician or POLICY S included asments"; g Care and "Hospice facility"; are"; TX.17 d "Patient sibilities". anager will audit atients'

		CAID SERVICES				MB NO. 0938-039	
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 151587	A. BUILE B. WING	<u></u>	СОМ	(X3) DATE SURVEY COMPLETED 11/09/2021	
	PROVIDER OR SUPPLIE	R CE OF CENTRAL INDIANA LLC	1	treet address, city, state, zip c 385 N BALDWIN AVE //ARION, IN 46952	COD		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PRI	D PROVIDER'S PLAN OF COF EFIX (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	RECTION HOULD BE APPROPRIATE	(X5) COMPLETION DATE	
				to ensure a pain asse being completed on a and ongoing, specific to wound treatment. the Area Clinical Man (ACM) or designee wi 10% of active patient comprehensive asses through the QAPI pro Trends identified dur audits will be reviewe no less than quarterly plan of correction and training will be updat indicated to ensure s improvement. /p>	admission cally prior Ongoing ager III audit records assments cess. ing these ed in QAPI y and the d/or ed as		
L 0579 Bldg. 00	of practice to pre- infections and co- including the use Based on observat interview, the hosp employees follower policies and proce- for 2 of 3 home vis Findings include: 1. A policy titled " indicated "The A program will be ba Current federal, sta regulations The include Implem procedures imp	t follow accepted standards vent the transmission of mmunicable diseases, of standard precautions. on, record review, and bice failed to ensure all d agency infection control dures and standard precautions bit observations (#2, 3). Infection Control Program," Agency's infection control sed on the following criteria tte, and local laws and Infection Control Program will enting appropriate preventative lementing appropriate measures a Management will be	L 0579	The Executive Director responsible to help end the accepted standar practice to prevent the transmission of infector communicable diseas including the use stan precautions are follow Executive Director wite ensure that all staff por proper hand hygienent techniques in the pread and spread of infection communicable diseas The Area Clinical Mare (ACM) provided educt	nsure that ds of e tions and ses, ndard wed. The II help ractice vention on and ses. nager	12/22/202	

ENTERS FOR MEDICARE & MEDICAID SERVICES					OMB NO. 0938-039
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE (	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED
		151587	B. WING		11/09/2021
NAMEOEI	PROVIDER OR SUPPLII		STREET	T ADDRESS, CITY, STATE, ZIP COD	
NAME OF 1	PROVIDER OR SUPPLI	EK		N BALDWIN AVE	
HEART	TO HEART HOSP	ICE OF CENTRAL INDIANA LLC	MARI	ON, IN 46952	
(X4) ID	SUMMAR	Y STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTI	ON (X5)
PREFIX	(EACH DEFICIE	ENCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBE COMPLETION
TAG		OR LSC IDENTIFYING INFORMATION	TAG		DATE
	-	ordinating all activities related		staff on 11/17/2021 and	
	to the Infection Co	ontrol Program"		11/18/2021 on policies IC	
				"Hand Hygiene" and IC.1	2 Bag
		"Bag Technique," indicated "		Technique indicating the	
		ed on a clean, safe surface If		practice of proper hand	
	-	e, a barrier is to be placed		washing or use of hand	
	•	When the visit is completed,		sanitizer to include prope	
		nt is cleaned using alcohol,		infection control before a	-
	-	and/or antimicrobial soap and		after removing gloves an	d to
		ate, hands are washed, and		ensure a proper barrier is	used
		pplies are returned to the bag		for the bag technique dur	ing
	"			the patient visit. Hand	
				Hygiene competencies w	ith all
		"Hand Hygiene," indicated "		staff providing direct pati	ent
		f providing patient/client care		care were completed on	
		er hand hygiene techniques if		11/17/2021 and 11/18/202	1 to
		bly soiled, staff may use an		ensure that hand washing	g is
	alcohol-based han	d rub for routinely		occurring or the use of ha	and
		hands in all other clinical		sanitizer is used in accor	dance
		ed below Alternatively, staff		with infection control pol	icies
	may wash hands w	with an antimicrobial soap and		and procedures to includ	e,
	water in all clinica	al situations described below		when removing gloves or	
	Decontaminate ha	inds after contact with		providing wound care or	other
	patient's/client's in	ntact skin, even when gloves are		treatments. Competencie	es on
	worn Decontar	ninate hands after contact with		Bag Technique will be	
	-	pretions, mucous membranes,		completed for all staff	
		d wound dressings if hands are		providing direct patient c	are by
		Decontaminate hands if		12/17/2021.	
	-	ntaminated body sit to a clean		Monitoring will be comple	
		atient/client care		by a review of competence	cies
		nds after contact with inanimate		completed on all new hire	es for
		medical equipment] in the		3 months or until 100%,	
	immediate vicinity	y of the patient/client"		compliance has been me	t.
				Results will be reported t	o the
		"Cleaning and Management of		QAPI committee and repo	orted
	Supplies and Equi	ipment," indicated "Item		to the Governing Body	
	Nurse/HHA [hom	e health aide] Bag Notes		annually.	
	Prevent contamina	ation by not placing		Trends identified during t	hese
	contaminated sup	plies back inside bag		audits will be reviewed in	
		requency between each		no less than quarterly an	

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 151587	(X2) MULTIPLE ( A. BUILDING B. WING	construction <u>00</u>	(X3) DATE SURVEY COMPLETED 11/09/2021	
	PROVIDER OR SUPPLIE	R CE OF CENTRAL INDIANA LLC	1385 1	address, city, state, zip cod N BALDWIN AVE ON, IN 46952		
(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 B CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	E (X5) E COMPLETIO DATE	
	each use Pulse each use Therm	cissors Frequency After Dximeter Frequency after ometer" visit on 11/9/21 at 10:00 AM with		plan of correction and/or training will be updated as indicated to ensure sustain improvement.	ned	
	Nurse F was obser The Registered Nu touching multiple a same gauze, pullin without changing g hygiene, and touch	a date of 9/23/21), Registered wed completing wound care. rse (RN) was observed areas of the wound with the g glasses from their pocket gloves or completing hand ing their charting tablet after d then not cleaning the tablet.				
	Patient #3 (election Nurse G was obser The Registered Nu using proper bag to	risit on 11/9/21 at 11:30 AM with a date of 8/14/21), Registered ved completing wound care. rse (RN) was observed not echnique, not using proper and touching multiple areas of e same gauze.				
	when asked if all n	iew on 11/9/21 at 2:00 PM, urses and aides should follow es on infection control, ndicated "Yes."				
0580	418.60(b)(1) CONTROL					
Bldg. 00	agency-wide prog identification, pre investigation of ir diseases that- (1) Is an integral	t maintain a coordinated gram for the surveillance, vention, control, and fectious and communicable part of the hospice's quality performance improvement				
	Based on observation interview, the hosp	on, record review, and ice failed to ensure COVID recautions were followed for 3	L 0580	The Executive Director will responsible to maintain a coordinated agency-wide	be 12/22/202	

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 151587	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 11/09/2021
	PROVIDER OR SUPPLIE	R CE OF CENTRAL INDIANA LLC	1385 N	ADDRESS, CITY, STATE, ZIP COD I BALDWIN AVE DN, IN 46952	
(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 APPROPRI DEFICIENCY)	(X5) COMPLETI DATE
	of 3 patient home Findings Include: 1. A policy titled " indicated " The <i>A</i> program will be ba Current federal, str regulations The include Implem procedures imp to control infection responsible for coo to the Infection Co 2. A policy titled Addendum Infecti indicated " The <i>A</i> current informatio provided by local, related to any infe- epidemic The <i>A</i> patients/client and of the infection Manager/Supervis patients/clients and factors as well as s disease as defined available" 3. During a home Patient #2 (election Nurse F was obser The Registered Nu screening patient f already having phy 4. During a home	visit observations (#2, 3, 4). Infection Control Program," Agency's infection control ased on the following criteria ate, and local laws and Enfection Control Program will enting appropriate preventative lementing appropriate measures n Management will be ordinating all activities related ontrol Program" "Infection Control Program ous Disease Pandemic," Agency will stay abreast of n and practice guidelines state, and federal agencies ctious outbreak, pandemic, or Agency will identify staff will signs and symptoms well as those considered at risk		program for the surveillance identification, prevention, control and investigation of infections and communicab diseases, and that this is ar integral part of the hospice' quality assessment and performance improvement program. The Executive Director will ensure COVID infection control precaution are followed and that screenings by all discipline will be complete prior to entering the patients home/room. The Regional VP of Clinical Operations (RVPCO) and th Area Clinical Manager (ACI educated all staff on 12/08/2 on policies IC.02 "Infection Control Program" and IC.2a "Infection Control Program Addendum Infectious Disea Pandemic" indicating screening for COVID sympt of patients/care givers occu prior to entering the patient home/room. The Regional V of Clinical Operations (RVP) and the Area Clinical Manager (ACM) educated all staff on 12/09/2021 on Policy IC.13 "Infectious Disease Pandemic/Coronavirus". The Area Clinical Manager (ACM) or designee will audi 100% of patient records for months to ensure all staff providing direct patient care	e, lle s s s s s e M) 2021 se oms rs s /P CO) jer

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 151587	(X2) MULTIPLE ( A. BUILDING B. WING	construction 00	(X3) DATE SURVEY COMPLETED 11/09/2021
	PROVIDER OR SUPPLIE	R CE OF CENTRAL INDIANA LLC	1385	i address, city, state, zip cod N BALDWIN AVE ON, IN 46952	
(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
	Nurse G was obser The Registered Nu screening patient f already having phy 5. During a home v with Patient #4 (el Nurse Aide H was care. The Certified screening patient f already having phy 6. During an interv when asked if all s for COVID sympto	ved completing wound care. rse (RN) was observed or COVID symptoms after rsical contact with the patient. risit on 10/18/21 at 10:00 AM ection date of 8/14/21), Certified observed completing wound Nurse Aide was observed or COVID symptoms after rsical contact with the patient. iew on 11/9/21 at 2:00 PM, taff needed to screen patients oms before they have physical Administrator E, confirmed		will complete screening prior to entering the patients home/room and before providing care until 100%, compliance is met. Ongoing the Area Clinical Manager (ACM) or designee will audit 10% of active patient records comprehensive assessments through the QAPI process. ACM/designee will do an on-sight field visit with care staff for demonstration of understanding of screening prior to patient visit to be completed by 12/30/2021. If a employee demonstrates lack of understanding, re-educati- will occur and another field visit will be performed until compliance is met. Trends identified during thes audits will be reviewed in QA no less than quarterly and th plan of correction and/or training will be updated as indicated to ensure sustained	r an c, on se vPl ie
L 0686					
Bldg. 00	interview, the hosp received medication failed to ensure med (L693); failed to en- disposed of proper discrepancies for c	view, observation, and ice failed to ensure patients ns from a pharmacy (L691); dications were labeled correctly nsure medications were ly (L694); and failed to ensure ontrolled drugs were igated by the pharmacist and	L 0686	The Executive Director (ED) be responsible to help ensur this condition is met by ensuring patients receive medications from a pharmac labeled correctly and dispose of properly. The Executive Director (ED) will be responsible to ensure if any	e y,

	NT OF DEFICIENCIES	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 151587	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION <u>00</u>	(X3) DATE SURVEY COMPLETED 11/09/2021
	PROVIDER OR SUPPLIE	R CE OF CENTRAL INDIANA LLC	STREET ADDRESS, CITY, STATE, Z 1385 N BALDWIN AVE MARION, IN 46952		OD
(X4) ID PREFIX TAG	(EACH DEFICIE	' STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S) CROSS-REFERENCED TO THE A DEFICIENCY)	RECTION (X5) HOULD BE PPROPRIATE COMPLETI DATE
	administrator (L70 The cumulative ef resulted in the hos hospice care was p Condition of Partic	00). fect of these systemic problems pice's inability to ensure safe provided as required by the cipation 42 CFR 418.106 Drugs edical supplies, and durable		discrepancies are four regarding controlled investigation will occu- immediately by the ph and the administrator Effective immediately 10/22/2021, Agency w store any medication patient or deceased p the Agency's office, o those medications in accordance with polic procedures and as ap the Department of Ag Disability Services, St Federal Guidelines. A nurses will adhere to policy & procedures a accordance to policy procedures, scope of state and federal regu Agency Executive Dir was placed on Admin suspension on 10/22/ Governing Body appor Alternate ED. 10/25/20 attempted to send 100 out to employee healt for urine drug screen to COVID and staffing the laboratory, the clii only able to accommon staff. It was shared wi To Heart Hospice lead staffing levels at the clii not be able to comple of tests needed. Discu-	nd drugs, an ur harmacist / / ill not stock for atient at ther than cy and oproved by ing and tate & gency company and in & practice, llations. ector (ED) istrative 2021 & binted 021 site 0% of staff th clinic tests. Due issues at nic was boate 8 ith Heart dership clinic er nic would te 100% ussed

	T OF DEFICIENCIES DF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 151587	(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION	COM	) DATE SURVEY COMPLETED 11/09/2021	
	ROVIDER OR SUPPLIE	R CE OF CENTRAL INDIANA LLC	1385 N	ADDRESS, CITY, STATE, ZIP ( N BALDWIN AVE DN, IN 46952	COD		
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				Surveyor. Hospice we direction under the e- circumstances due to go out and purchase kits at least 7 panel. Leadership complied recommendation and purchased enough O- kits to screen staff. C 10/26/2021, most staff to come into the office provide urine sample urine drug screens we completed by 10/29/2 staff who had positiv were sent over to the laboratory for an add test. Staff provided h the laboratory a copy prescription medicati affecting the test. All cleared. One staff (HI member walked off th based on the urine du results not following with additional labora testing. All staff test i were compiled. On 10 Leadership conducte inspections as well to any prescription medicati afice (CLO) and C Compliance officer (C provided in person et to all staff on 10/27/20 policies TX.19 "Medic	xtreme o COVID to OTC drug I with d DTC drug Dn ff were able ce to a. 100% vere 2021. The re results dospice and v of any ions were HA) he job rug screen through atory results 0/26/2021, de car poking for dications esults 0/26/2021, ed car poking for dications esults 0/26/2021, ed car poking for dications esults or f Clinical chief CCO) ducation 0/21 on		

	T OF DEFICIENCIES OF CORRECTION	x1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 151587	(X2) MULTIPLI A. BUILDING B. WING	e construction G <u>00</u>	COMI	(x3) DATE SURVEY COMPLETED 11/09/2021	
	ROVIDER OR SUPPLIE	R CE OF CENTRAL INDIANA LLC	STREET ADDRESS, CITY, STATE, Z 1385 N BALDWIN AVE MARION, IN 46952		COD		
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				Disposal", TX.18 "Me Possession and Transportation", Form-Medication Transportation Log, H "Grievance/Complain Resolution", HR.21 "Professional Practice "Standard of Conduct" "Standard of Practice "Abuse, Neglect and Exploitation", PE.05 " Care and Safety"; RL. "Patient Rights and Responsibilities"; TX "Medication Administ EC.07 "Hazardous Materials/Waste", IC.0 "Disposal of Needles Sharps"; LD.16 "Com Program"; Form-Com Pledge (Resigned by "Code of Conduct" "Compliance & Ethics Program"; "Heart to H Employee Guidelines Article 23. Nurses, Arti Indiana State Nurses A Program, Article 4 Adv Nursing & Prescriptive for Advanced Practice Nu Advanced Practice Nu Article 2 Standards for Competent Practice Re Licensed Practice Nu 3 Nurse-Midwives, Titl Indiana State Board of Central Indiana Plan o Correction/Conditions	IR.17 t e" HR.27 t", TX.01 ", TX.03 (Patient 1 IN .16 tration", 07 and upliance all staff), s Heart ". IC 25-30 icle 7 Assistance vanced Authority Nursing, suthority for rsing, the egistered & rsing, Article e 848 Nursing, f		

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 151587	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION <u>00</u>	(X3) DATE SURVEY COMPLETED 11/09/2021
	ROVIDER OR SUPPLIE	<sup>R</sup> CE OF CENTRAL INDIANA LLC	1385 N	ADDRESS, CITY, STATE, ZIP COD I BALDWIN AVE DN, IN 46952	
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				Participation/Indiana Hospic Regulations. All nurses we emailed with read receipt th content of the education of 10/27/2021, as well as receipt a paper copy of all the mater referenced. All nurses sign off on the receipt of the material provided & received and a copy of the receipt we placed in the employee file under section II. Those not present came into the offic and received their one on of training from the Area Clinic Manager (ACM), Area Executive Director (AED) of Regional VP of Clinical Operations (RVPCO). Train was completed by 11/12/20 On 11/2/2021, ACM provide education to Nursing Team HCHB death note and discharge summary and ho complete documentation of medication destruction dur the death visit. It was ident during the training the RN8 death visit was different from the SN88 death visit, which lead to discrepancy of information provided on medication destruction. Bo assessments were updated VP EMR Operations 11/3/20 Staff were made aware they would need to complete an update to their devices in of to receive the updated deat visit note. Form Transport	e re ne no ved erial ed aas e d aas e one ical r hing 21. ed on pow to f f ring iffied 8 bom f th th t by )21. / v v d aas

	NT OF DEFICIENCIES OF CORRECTION	x1) provider/supplier/clia identification number 151587	A. B	IULTIPLE C UILDING /ING	ONSTRUCTION 00	CON	te survey 19leted 09/2021
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- 0691 Bldg. 00	418.106(c) DISPENSING OF BIOLOGICALS The hospice mus (1) Obtain drugs community or ins stock drugs and f (2) The hospice t directly in its own (i) Have a written promotes dispens (ii) Maintain curre	F DRUGS AND t and biologicals from titutional pharmacists or biologicals itself. hat provides inpatient care			Log was updated 11/ 11/4/2021, ACM proveducation to all Nurse the changes made to Transportation Log, all provided copies of updated form and ed how to properly com 10/28/2021 both Patie Managers (PCM) resipositions effective immediately. Alterna Care Manager (PCM) appointed at that tim Executive Director's employment was tern on 11/11/2021 after of of the internal investigation Executive Director (B Patient Care Manage were reported to the Attorney General in accordance with the State Board of Nursi	ided sing staff of o the they were of the ducated on oplete. On ent Care igned their ate Patient was ne. The (ED) minated completion tigation. a complete n, the ED) and two ers (PCM) State Indiana	DAIE

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	PROVIDER OR SUPPLIE	R CE OF CENTRAL INDIANA LLC	1385 N	ADDRESS, CITY, STATE, ZIP COD I BALDWIN AVE DN, IN 46952	
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	<ul> <li>drugs.</li> <li>Based on record reinterview, the hosp received medicatio patient records reviewed medication patient records reviewed medication patient records reviewed medicated indicated "Upon will be disposed of Any unused medicated "Upon will be disposed of Any unused medicated "Upon will be disposed of Any unused medications, when store any medications, when store any medication in the Agency's office transportation in the 3. A document title and Management," will administer the administrative and procedures, in according federal, state laws, Medications are ad Clinical Procedure orders"</li> <li>4. During an agence 10:00 AM, a tall, the tall, the tall tall tall tall tall tall tall tal</li></ul>	view, observation, and ice failed to ensure the patient ns from a pharmacy for 1 of 30 iewed (#1). ed "Medication Disposal," Patient's death, medications funless the family refuses ations will not be returned" ed "Medication Possession and ed "The hospice contract esponsible for delivery of all possible Agency will not on stock for patient use at e the employee documents	L 0691	The Executive Director (ED) will be responsible to help ensure the agency will obtain drugs and biologicals from a pharmacy. The Chief Clinical Officer (CCLO) provided in person education to all nursing staff of 10/27/2021 on policies TX.18 "Medication Possession and Transportation", Form-Medication Transportation Log, HR.27 "Standard of Conduct", TX.01 "Standard of Practice", PE.05 "Patient Care and Safety" RI.1 "IN Patient Rights and Responsibilities", TX.16 "Medication Administration", I 25-30 Article 23. Nurses, Article Indiana State Nurses Assistance Program, Article 4 Advanced Nursing & Prescriptive Authority for Advanced Practice Nursing, Article 5 Prescriptive Authority for Advanced Practice Nursing, Article 2 Standards for the Competent Practice Registered Licensed Practical Nursing, Artic 3 Nurse-Midwives, Title 848 Indiana State Board of Nursing, Central Indiana Plan of Correction/Conditions of Participation/Indiana Hospice Regulations. All nurses were emailed with read receipt the content of the education on 10/27/2021, as well as received a paper copy of all the materia	III 12/08/2021

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 151587	(X2) MULTIPLE CO A. BUILDING B. WING	<u>00</u>	(X3) DATE SURVEY COMPLETED 11/09/2021
	PROVIDER OR SUPPLIE	R CE OF CENTRAL INDIANA LLC	1385 N	ADDRESS, CITY, STATE, ZIP COD BALDWIN AVE N, IN 46952	
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	ION (X5) DBE COMPLETIO DRIATE DATE
	<ul> <li>5. The clinical record on 10/22/21 at 1:00 election date of 5/10 of acute myeloblas achieved remission marrow with excess The record contain Note Report," date name [Registered dose of Morphine 46. During an intervord when asked if they from the metal cabe Manger B's office, "We do have an ermanager's office. I</li> </ul>	A list IDENTIFIATOR INFORMATION ord of Patient #1 was reviewed D PM and indicated a hospice 19/21, with a primary diagnosis tic leukemia not having a (cancer of the blood and bone is immature white blood cells). ed a document titled "Visit d 10/21/21, indicated "Agent ed Nurse I] Narrative New also delivered with visit" riew on 10/22/21 at 1:35 PM, bad ever reused medications inet in Former Patient Care Registered Nurse I indicated, nergency supply in the used liquid morphine for is a brand new, sealed bottle."		referenced. All nurses sig off on the receipt of the material provided & rece and a copy of the receipt placed in the employee f under section II. Those n present came into the off and received their one of training from the Area CI manager (ACM), Area Executive Director (AED) Regional VP of Clinical Operations (RVPCO). Tr was completed by 11/12/ The Area Executive Directo (AED), Executive Directo Area Clinical Manager (A designee will complete random spot checks of o and clinical vehicles for f presence of medications are from deceased patien were not admitted to ser- monthly x 3 months until compliance is met. The A Clinical Manager (ACM) o designee will complete random spot checks of office/Clinical vehicles quarterly for the presence medications not in adhen with policy and procedur medication found, the Ar Clinical Manager (ACM) o designee will report findi Leadership for disciplina action, up to and includin termination. Area Clinical Manager or designee will report findings through o	gned ived was ile ot fice n one inical or aining 2021. ctor r (ED) CM) or ffice the that nts or vice 100% Area or e of rence res. If ea or ngs to ry ng

		CAID SERVICES				AB NO. 0938-039
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 151587	(X2) MULTIPLE A. BUILDING B. WING	construction <u>00</u>	(X3) DATE SURVEY COMPLETED 11/09/2021	
	PROVIDER OR SUPPLIE	R CE OF CENTRAL INDIANA LLC	1385	et address, city, state, zip cod N BALDWIN AVE ION, IN 46952		
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				least quarterly and plan or correction will be implement if applicable. Trends identified during the audits will be reviewed in no less than quarterly and plan of correction and/or training will be updated as indicated to ensure sustain improvement.	ented nese QAPI I the	
L 0693 Bldg. 00	<ul> <li>(1) Labeling. Dru labeled in accord accepted profess include appropria instructions, as w applicable). Based on observat interview, the hosp medications were patient records rev Findings Include:</li> <li>1. A document tith indicated "Upor will be disposed of Any unused medica 2. A document tith indicated "The p hospice's patients a consistent with app and accepted stand containers for indi properly labeled in</li> </ul>	E STORAGE DRUGS gs and biologicals must be lance with currently sional practice and must ate usage and cautionary vell as an expiration date (if ion, record review, and bice failed to ensure labeled correctly for 1 of 30 iewed (#6). ed "Medication Disposal," a Patient's death, medications f unless the family refuses eations will not be returned" ed "Pharmacy Services," bharmaceutical needs of the are managed in a manner blicable State and Federal laws lards of practice Prescription vidual prescriptions are a accordance with the state y regulations and contain	L 0693	The Executive Director (E be responsible to help en- all medications are labele correctly according to pharmacy regulations and accepted professional pra The Chief Clinical Officer (CCLO) provided in perso education to all nursing s 10/27/2021 on policies TX. "Medication Possession a Transportation", Form-Medication Transportation Log, HR.2 "Standard of Conduct", T. "Standard of Practice", PI "Patient Care and Safety" "IN Patient Rights and Responsibilities", TX.16 "Medication Administration	sure d lectice. n taff on 18 and 7 K.01 E.05 RI.1	12/08/202

STATEME	R MEDICARE & MEDIC NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 151587	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SU COMPLE 11/09/2	TED
	PROVIDER OR SUPPLIE	R CE OF CENTRAL INDIANA LLC	1385 N	ADDRESS, CITY, STATE, ZIP COD I BALDWIN AVE DN, IN 46952		
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	Patient's full name name and streng and frequency of a number accesso expiration date . 3. During an agend 10:00 AM, a tall, t observed and foun with deceased pati packages. A gray, was observed to be in the open office a not labeled correct pharmacy prescrip the patient covered indicated that it wa had no pharmacy p labeled with a lase "Dilaudid [a strong which had twenty- "M" on one side of other side, five bot making solutions t a clear bag with no of Narcan (treats n emergency situation type of label on the bisacodyl (treats co the name of the ori unopened bottle of throat), one CVS I box of suppositorio constipation) with bottle with a white round pills that had side with no patier unopened bottle of deficiency anemia	Prescribing physician's name th of drug dose, method, dministration lot and control ory and cautionary instructions		25-30 Article 23. Nurses, A Indiana State Nurses Assi Program, Article 4 Advance Nursing & Prescriptive Auth for Advanced Practice Nursin Article 5 Prescriptive Auth Advanced Practice Nursin Article 2 Standards for the Competent Practice Regis Licensed Practical Nursing 3 Nurse-Midwives, Title 84 Indiana State Board of Nu Central Indiana Plan of Correction/Conditions of Participation/Indiana Hosp Regulations. All nurses v emailed with read receipt content of the education 10/27/2021, as well as rec a paper copy of all the m referenced. All nurses sig off on the receipt of the material provided & receipt placed in the employee fi under section II. Those n present came into the off and received their one or training from the Area CI manager (ACM), Area Executive Director (AED) Regional VP of Clinical Operations (RVPCO). Tra was completed by 11/12/2 The Area Executive Direct (AED) and Area Clinical Manager (ACM) or design will audit 100%, for 3 mor all Medication Transporta Logs which includes nan	stance sed thority sing, ority for g, tered & g, Article 48 rsing, vere t the on seived aterial gned ived was le ot fice n one inical or aining 2021. ctor nee nths, of ation	

Event ID:

PD1P11 Facility ID: 003966

If continuation sheet Page 22 of 80

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 151587	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 11/09/2021	
	PROVIDER OR SUPPLI TO HEART HOSP	<sup>ER</sup> ICE OF CENTRAL INDIANA LLC	1385 N	ADDRESS, CITY, STATE, ZIP COD I BALDWIN AVE NN, IN 46952	COD	
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	that had thirty sm three packs of five (prevent and treat shortness of breat tightness caused b asthma and chron disease). 4. The clinical rec on 10/22/21 at 1:2 election date of 10 of cerebral athero hardening of the v The record contai certification dates indicated orders f Hyoscyamine [ associated with di tract] 0.125 mg [n PRN [as needed] record also contai Note Report," dat Registered Nurse Type SN [skill Home Medicati narcotic/medicatie quantity how [Registered Nurse and relationship tr authorized to disp medications [F During an agency AM, a tall, two do observed and four 20 doses of Ondar for Patient #6. Up	on disposal type strength v disposed RNCM c Case Manager] Full name o patient of person[s] legally ose of controlled drugs and cegistered Nurse J]" office tour on 10/22/21 at 10:00 por, off-white cabinet was nd to have a clear bag with 19 of asetron with a laser label made on peeling back the laser label, a can be observed but not the full		location of pharmacy, d time received, medication received (name, strengt amount dispensed), em- obtaining medication, medication was sealed, stored appropriately, loo medication delivered to of person receiving medication, receiver to indicate if sealed proper count of medication in presence of delivery per ensure proper medication transfer until 100% com is met. Ongoing the Are Clinical Manager (ACM) designee will audit 10% Medication Transportati through the QAPI proce Trends identified during audits will be reviewed in no less than quarterly a plan of correction and/o training will be updated indicated to ensure sust improvement.	ons h, and ployee and cation , name rly and rson to on pliance ea or of the ion Logs ss. g these in QAPI nd the or as	

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE C A. BUILDING	CONSTRUCTION 00	(X3) DATE SURVEY COMPLETED
		151587	B. WING	<u></u>	11/09/2021
NAME OF	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP COD	
HEART	TO HEART HOSPI	CE OF CENTRAL INDIANA LLC		DN, IN 46952	
(X4) ID		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 APPROPRIAT DEFICIENCY)	
TAG	REGULATORY C	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCE	DATE
	-	view on 10/22/21 at 2:15 PM,			
		nyone in the agency had ever			
		ons or improperly labeled them,			
		ator A indicated, "I have not			
		t the count is right," and Former			
		ger B indicated, "The meds			
	them in [sic]."	e destroyed. Some families bring			
_ 0694	418.106(e)(2)(i)	E STORAGE DRUGS			
Bldg. 00		Safe use and disposal of			
Diag. 00		in the patient's home. The			
	-	ve written policies and			
		e management and disposal			
		gs in the patient's home. At			
		ontrolled drugs are first			
	ordered the hosp	-			
	Based on observat	ion, record review, and	L 0694	The Executive Director (ED)	vill 12/08/202
	interview, the hosp	pice failed to ensure		be responsible to help ensure	e
		disposed of properly for 6 of 30		all medications are destroyed	t l
	patient records rev	iewed (#5, 7, 8, 9, 10, 11).		properly according to agency policy and pharmacy	/
	Findings include:			regulations. The Chief Clinical Officer	
		ed "Medication Disposal,"		(CCLO) provided in person	
	· ·	Patient's death, medications		education to all nursing staff	on
	· ·	f unless the family refuses		10/27/2021 on policies TX.18	
	Any unused medic	cations will not be returned"		"Medication Possession and Transportation",	
	2. A document titl	ed "Pharmacy Services,"		Form-Medication	
		rolled drugs are disposed of in		Transportation Log, HR.27	
		tate and Federal regulations		"Standard of Conduct", TX.0"	1
	The hospice maint	ains current and accurate		"Standard of Practice", PE.05	
	records of the rece	ipt and disposition of all		"Patient Care and Safety" RI.	1
	-	the pharmacist and registered		IN "Patient Rights and	
	nurse dispose of th	ne medications"		Responsibilities", TX.16 "Medication Administration"	
	3. A document titl	ed "Medication Administration		25-30 Article 23. Nurses, Articl	

STATEME	R MEDICARE & MEDIO NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 151587	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		(X3) DATE SURVEY COMPLETED 11/09/2021	
	PROVIDER OR SUPPLIE	R CE OF CENTRAL INDIANA LLC	1385 N	ADDRESS, CITY, STATE, ZIP COD N BALDWIN AVE DN, IN 46952		
(X4) ID PREFIX	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION
TAG	and Management, administering the r responsible for known medications/control 4. A document title indicated " Agen patient/caregiver in disposal of discont controlled drugs authorized to dispo- instructed in the fo- unused, unneeded, original containers undesirable substa or cat litter put nondescript contai sealable bags, furth not diverted or acco or pets Throw t trash Upon Pati disposed of unless unused medication 5. During an agence 10:00 AM, a tall, t observed and foun with deceased pati packages. A gray, was observed to be in the open office a were, but not limit disorders), morphi (treats severe ongo anxiety and musch moderate to severe ABHR gel (lorazej haloperidol, and m	R LSC IDENTIFYING INFORMATION indicated " The individual medication/controlled drug is owledge of disposal of olled drugs" ed "Medication Disposal," ney nurse will instruct the in the proper technique for inued medication, including the caregiver legally ose of medications will be of expired drugs out of their mix the drugs with an nee, like used coffee grounds them in impermeable, ners, such as empty cans or her ensuring that the drugs are identally ingested by children hese containers in the outside ent's death, medications will be the family refuses Any is will not be returned" ey office tour on 10/22/21 at wo door, off-white cabinet was d to have multiple medications ents' names on the medication Dyno brand, laser label maker e placed on the side of cabinet area. The medications found ed to, lorazepam (treat anxiety ne sulfate extended release sing pain), diazepam (treats e spasms), Oxycodone (treats e pain), Dilaudid (relieves e pain), Norco (treats pain), pam, diphenhydramine, etoclopramide; treats nausea l fentanyl (treats severe pain).	TAG	Indiana State Nurses Assist Program, Article 4 Advance Nursing & Prescriptive Auth for Advanced Practice Nursi Article 5 Prescriptive Author Advanced Practice Nursing, Article 2 Standards for the Competent Practice Registe Licensed Practical Nursing, 3 Nurse-Midwives, Title 848 Indiana State Board of Nursi Central Indiana Plan of Correction/Conditions of Participation/Indiana Hospic Regulations. All nurses we emailed with read receipt to content of the education o 10/27/2021, as well as rece a paper copy of all the mate referenced. All nurses sign off on the receipt of the material provided & receiv and a copy of the receipt w placed in the employee file under section II. Those not present came into the offic and received their one on a training from the Area Clin manager (ACM), Area Executive Director (AED) of Regional VP of Clinical Operations (RVPCO). Trai was completed by 11/12/20 On 11/2/2021, ACM provide education to Nursing Team HCHB death note and discharge summary and he complete documentation of medication destruction du the death visit. It was identified	ance d ority ing, ity for ered & Article ing, ered & Article ing, ere he n ived ere he n ived eral he an ived erial he d vas et ce for he n ived ed vas et ce he n ived ed vas et ce he n ived ed vas et ce he n ived et vas et ce he n ived et vas et ce he n ived et vas et ce for ho for ho ho for ho ho ho for ho ho ho ho ho ho ho ho ho ho ho ho ho	DATE

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

Event ID:

PD1P11 Facility ID: 003966

If continuation sheet Page 25 of 80

PRINTED: 12/15/2021 FORM APPROVED

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C		· · ·	E SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 151587	A. BUILDING <u>00</u> B. WING		_	pleted 9/2021
NAME OF	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP C	COD	
HEART	TO HEART HOSPI	CE OF CENTRAL INDIANA LLC		N BALDWIN AVE DN, IN 46952		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF COF	RECTION	(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE	HOULD BE	COMPLETI
TAG	REGULATORY C	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE
				during the training th		
		ord of Patient #5 was reviewed		death visit was differ		
		5 PM and indicated a hospice		the SN88 death visit,		
		15/21, with a primary diagnosis		lead to discrepancy of		
		lasm of colon (abnormal cells		information provided		
		bly and destroy body tissue).		medication destructio		
		hed a plan of care for the $0/15/21$ to $12/12/21$ with the		assessments were up	-	
		9/15/21 to 12/13/21, which or, but not limited to, "Ativan		VP EMR Operations of		
		ng [milligram] every 4 [four]		11/3/2021. Nursing St		
		ded] for anxiety/restlessness		made aware they wou		
	-	o contained a document titled		to complete an updat devices in order to re		
		t," dated 9/24/21, completed by		updated death visit n		
	-	, which indicated, "Visit Type		Medication Transport		
	-	e] Hospice Death At Home		was updated 11/3/202	-	
	-	dicate narcotic/medication		11/4/2021, ACM provi		
		strength quantity how		education to all Nurs		
		epam 0.5 mg 12 tabs [tablets]		the changes made to	-	
	"			Medication Transport		
		office tour on 10/22/21 at 10:00		they were all provide	-	
		or, off-white cabinet was		of the updated form a	-	
		d to have an orange bottle with		educated on how to p		
		enty-five small white pills with a		complete form.	lopony	
	-	tion label made for Patient #5.		Area Executive Direc	tor (AED)	
				and Area Clinical Mar	· ·	
	7. The clinical rec	ord of Patient #7 was reviewed		(ACM) or designee w	-	
		0 PM and indicated a hospice		100% of all death disc		
		16/21, with a primary diagnosis		monthly x 3 months u	-	
		tive pulmonary disease (a		of compliance is met		
		ve lung disorders characterized		focus on discharge s		
	0 1 1 0	thlessness). The record		to ensure there is pro		
	contained a plan o	f care for the certification dates		documentation of dis	-	
	-	1, which indicated orders for, but		medication in the pat	-	
		Oxycodone [treats moderate to		residence or education		
	severe pain] 2.5 [t	wo and a half] mg [milligram]		provided to authorize	e agent of	
	every 2 [two] hour	s PRN [as needed] for pain/sob		proper disposal. One	-	
	[shortness of breat	h]" The record also		compliance has been		
	contained a docum	ent titled "Visit Note Report,"		consecutive months,		
	dated 10/9/21, con	pleted by Registered Nurse J,		Area Clinical Manage		
	which indicated, "	Visit Type SN [skilled		designee will audit 10	0% of all	

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 151587	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION <u>00</u>	(X3) DATE SURVEY COMPLETED 11/09/2021		
	NAME OF PROVIDER OR SUPPLIER HEART TO HEART HOSPICE OF CENTRAL INDIANA LLC		1385 N	ADDRESS, CITY, STATE, ZIP COD I BALDWIN AVE DN, IN 46952			
(X4) ID PREFIX TAG	(EACH DEFICIE	' STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL PR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ON DBE PRIATE	(X5) COMPLETI DATE	
	nurse] Hospice De Indicate narcotic/r strength quanti [Registered Nurse and relationship to authorized to disp medications [R During an agency AM, a tall, two do observed and foun bottle of Oxycodo Patient #7. 8. The clinical rect on 10/22/21 at 1:3 election date of 5// squamous cell card in the surface of th and lining of the re The record contain certification dates indicated orders fo Morphine [used pain] 15 [fifteen] r hours PRN [as nee breath] Fentany every 72 [seventy- record also contain Note Report," date Registered Nurse I Type SN [skilld Home Medicat narcotic/medicatio quantity how [eighteen] ml F	ath At Home Medications nedication disposal type ty how disposed RNCM Case Manager] Full name opatient of person[s] legally ose of controlled drugs and egistered Nurse J]" office tour on 10/22/21 at 10:00 or, off-white cabinet was d to have a brand new, sealed ne with a pharmacy label for ord of Patient #8 was reviewed 5 PM and indicated a hospice 7/21, with a primary diagnosis of cinoma of skin (cancer starting ne skin, lining of hollow organs, espiratory and digestive tracts). ned a plan of care for the 5/7/21 to 8/4/21, which or, but not limited to, " to treat treats ongoing severe ng [milligram] every 2 [two] orded] for pain/sob [shortness of Al [treats severe pain] 50 mcg two] hours for pain" The ned a document titled "Visit ed 6/4/21, completed by K, which indicated, "Visit ed nurse] Hospice Death At		discharge summaries for sustained compliance. Findings and action plan indicated) will be reported through QAPI at least quarterly. Trends identified during t audits will be reviewed in no less than quarterly and plan of correction and/or training will be updated a indicated to ensure susta improvement.	(if d hese QAPI d the s		

	NT OF DEFICIENCIES	x1) provider/supplier/clia identification number 151587	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		(X3) DATE SURVEY COMPLETED 11/09/2021	
	NAME OF PROVIDER OR SUPPLIER HEART TO HEART HOSPICE OF CENTRAL INDIANA LLC		1385 N	address, city, state, zip BALDWIN AVE N, IN 46952	COD	
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION	ID PROVIDER'S PLAN OF CC PREFIX (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE TAG DEFICIENCY)		SHOULD BE	(X5) COMPLETI DATE
	AM, a tall, two do observed and four sealed boxes of M unopened, sealed pharmacy-made la 9. The clinical rec on 10/22/21 at 1:4 election date of 9/ of malignant neop (abnormal cells di body tissue). The for the certificatio indicated orders fa Oxycodone [trea [five] mg [milligra needed] for pain to severe pain] 10 times daily for pai a document titled 9/16/21, complete indicated, "Visi Hospice Death At Indicate narcotic/r strength quanti [Registered Nurse and relationship to authorized to disp medications O: Oxycodone ] 30 [th Oxycodone 20 [tw During an agency AM, a tall, two do observed and four with a white cap v with an "OP" sket	office tour on 10/22/21 at 10:00 or, off-white cabinet was at to contain two unopened, forphine and one box of Fentanyl patches, with a abel for Patient #8. ord of Patient #9 was reviewed 0 PM and indicated a hospice 11/21, with a primary diagnosis lasm of unspecified kidney vide uncontrollably and destroy record contained a plan of care n dates 9/11/21 to 12/9/21, which or, but not limited to, " ats moderate to severe pain] 5 am] every 4 [four] hours PRN [as Oxycodone [treats moderate [ten] mg [milligram] 2 [two] n" The record also contained "Visit Note Report," dated d by Registered Nurse J, which t Type SN [skilled nurse] Home Medications nedication disposal type ty how disposed RNCM Case Manager] Full name o patient of person[s] legally ose of controlled drugs and kyContin [brand name for hirty] mg 5 tabs [tablets] venty] mg 1 [one] tab" office tour on 10/22/21 at 10:00 for, off-white cabinet was at to contain one orange bottle with small yellow, round pills ched on one side and a "40 er, of Oxycodone, and one				

	NT OF DEFICIENCIES OF CORRECTION	x1) provider/supplier/clia identification number 151587	ì í	JILDING	nstruction 00		(X3) DATE SURVEY COMPLETED 11/09/2021	
	NAME OF PROVIDER OR SUPPLIER HEART TO HEART HOSPICE OF CENTRAL INDIANA LLC			1385 N	ddress, city, state, zif BALDWIN AVE N, IN 46952	P COD		
(X4) ID		Y STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION			X5)
PREFIX		ENCY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO TH DEFICIENCY)	IE APPROPRIATE	COMPL	
TAG		DR LSC IDENTIFYING INFORMATION		TAG	DEFICIENCE		DA	IE
	-	a white cap, white and gold						
	-	NI" printed on one side and						
	-	he other side, with a						
		abel for Patient #9.						
		cord of Patient #10 was reviewed	1					
		5 PM and indicated a hospice						
		15/21, with a primary diagnosis						
	<b>U</b>	lasm of middle lobe, bronchus,	1					
		cells divide uncontrollably and						
		e). The record contained a plan						
		tification dates 7/15/21 to						
		dicated orders for, but not limited						
		treats severe pain] 25						
		[microgram] every 72						
		rs for pain" The record also						
	contained a docun	nent titled "Visit Note Report,"						
	dated 6/4/21, com	pleted by Registered Nurse L,						
	which indicated, "	Visit Type SN [skilled						
	nurse] Hospice De	eath At Home Medications						
	Indicate narcotic/r	medication disposal type						
		ty how disposed Fentanyl						
	. [sic] 50 [fifty] m	cg patch Destroyed in cat						
	litter, [sic] per po	licy Full name and						
	relationship to pat	ient of person[s] legally						
	authorized to disp	ose of controlled drugs and						
	medications Da	aughter N law [sic]"						
		office tour on 10/22/21 at 10:00						
		oor, off-white cabinet was						
		nd to contain two unopened,	1					
		entanyl patches, with a						
		abel for Patient #10.						
	11. The clinical re	cord of Patient #11 was reviewed						
	on 10/22/21 at 1:5	5 PM and indicated a hospice	1					
	election date of 7/	15/21, with a primary diagnosis						
	of personal history	y of malignant neoplasm of						
		al cells divide uncontrollably	1					
	-	tissue). The record contained a						
		e certification dates 4/17/21 to						
	-	dicated orders for, but not limited						

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CON	NSTRUCTION	(X3) DA	TE SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u> B. WING			COMPLETED 11/09/2021	
				STREET A	DDRESS, CITY, STATE, ZIP	COD	
NAME OF	PROVIDER OR SUPPLIEF	ł			BALDWIN AVE		
HEART	TO HEART HOSPIC	E OF CENTRAL INDIANA LLC		MARION	I, IN 46952		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CO	ORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	1	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	SHOULD BE	COMPLET
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	to, " Hydromorpl	hone [brand name is Dilaudid;					
	relieves moderate to	o severe pain] 8 [eight] mg					
	[milligram] ever	y 4 [four] hours PRN [as					
	needed] for pain	" The record also contained a					
	document titled "Vi	isit Note Report," dated 5/9/21,					
	completed by Regis	stered Nurse M, which					
		Type SN [skilled nurse]					
	Hospice Death At H	Iome Medications Was					
	family educated on	safe disposal of controlled					
	drugs and medication	ons? Disposed of per					
	facility protocol	"					
	During an agency of	ffice tour on 10/22/21 at 10:00					
	AM, a tall, two doo	r, off-white cabinet was					
	observed and found	to contain one orange bottle					
		t had small triangular-shaped					
	white pills with an	"8" etched on one side and a					
	"p/d" etched on the	other side, with a					
	pharmacy-made lab	el for Patient #11.					
	12. During an inter-	view on 10/22/21 at 1:35 PM,					
	when asked if they	had ever seen medications					
		net in Former Patient Care					
		Registered Nurse I indicated,					
		ergency supply in the					
	-	here is no sign out sheet. There					
	are partially used m	ediations in there, but I've					
	never used the parti	al ones."					
	13. During an inter-	view on 10/22/21 at 2:15 PM,					
	when asked why an	yone in the agency had ever					
	relabeled medicatio	ns or improperly labeled them,					
	Former Administra	tor A indicated, "I have not					
	relabeled them, but	the count is right," and Former					
	Patient Care Manag	ger B indicated, "The meds					
	were needing to be	destroyed. Some families bring					
		n asked why medications had					
	not been destroyed	in the patients' homes,					
	Former Administra	tor A, Former Patient Care					
	Manager B, and Ar	ea Manager N indicated, "I do					
	not know."						

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE (	CONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 151587	A. BUILDING B. WING	00	COMPLETED 11/09/2021	
	SUMMARY (EACH DEFICIE)	R CE OF CENTRAL INDIANA LLC STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	1385	T ADDRESS, CITY, STATE, ZIP COD N BALDWIN AVE ON, IN 46952 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE	(X5) Completion Date
_ 0700 Bldg. 00	<ul> <li>(ii) Discrepancies dispensing, admi of controlled drug immediately by the administrator and the appropriate S account of the inva- available to State required by law of Based on observation interview, the hosp discrepancies for c immediately investig administrator for 2 (#5, 6, 7, 8, 9, 11, 23, 24, 25, 26, 27,</li> <li>Findings include:</li> <li>A document title Responsibilities," if family has [sic] the hospice will ensure involving misan by anyone furnishi hospice, are report employees and corr administrator T investigate all alleg furnishing services will immediately ta potential violations investigated Th action in accordance the hospice admini- verified violations</li> </ul>	on, record review, and ice failed to ensure a ontrolled drugs were igated by the pharmacist and/or 3 of 30 patient records reviewed 12, 13, 14, 15, 16, 17, 18, 19, 21, 22, 28, 29). ed "Patient Rights and ndicated "Every patient and eright To be assured that the e that all alleged violations propriation of patient property ng services on behalf of the ed immediately by hospice tracted staff to the hospice he hospice will immediately ged violations involving anyone on behalf of the hospice and ake action to prevent further is while the alleged [sic] is being e hospice will take appropriate ex with state laws as verified by stration and ensure that are reported to the State and nmediately of becoming aware	L 0700	The Executive Director (ED) be responsible to help ensu- the pharmacist and administrator according to agency policy and pharmace regulations immediately investigate all discrepancies for controlled drugs. The Chief Clinical Officer (CCLO) provided in person education to all nursing sta 10/27/2021 on policies TX.1 "Medication Possession an Transportation", Form-Medication Transportation Log, HR.27 "Standard of Conduct", TX. "Standard of Practice", PE. "Patient Care and Safety"; IN "Patient Rights and Responsibilities", TX.16 "Medication Administration 25-30 Article 23. Nurses, Art Indiana State Nurses Assista Program, Article 4 Advanced Nursing & Prescriptive Authori Advanced Practice Nursing	are Sy s ff on 8 d 01 05 RI.1 icle 7 ance prity ng,	12/08/202

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 151587	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		3) DATE SURVEY COMPLETED 11/09/2021
	PROVIDER OR SUPPLIE	R CE OF CENTRAL INDIANA LLC	1385 N	ADDRESS, CITY, STATE, ZIP COD BALDWIN AVE N, IN 46952	
(X4) ID PREFIX		Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETION
TAG	REGULATORY C	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	2. A document titled "Medication Disp	led "Medication Disposal."		Article 2 Standards for the Competent Practice Registered a	e
		Patient's death, medications		Licensed Practical Nursing, Artic	
	-	f unless the family refuses		3 Nurse-Midwives, Title 848	
	-	-		Indiana State Board of Nursing,	
	Any unused medications will not be returned"	ations will not be returned		Central Indiana Plan of	
	3 A document tit	led "Occurrence/Incident		Correction/Conditions of	
		ted " Agency will document		Participation/Indiana Hospice	
	x 0.	urrences/incidents safety		Regulations. <b>All nurses were</b>	
	-	unprofessional and		emailed with read receipt the	
		t deviate from the Agency		content of the education on	
		ght result in injury or potential		10/27/2021, as well as received	
		aregiver or Agency staff		a paper copy of all the material	
	•	clude, but are not limited to		referenced. All nurses signed	
		errors procedure error which			
	-	nd/or injury, falls, medication		off on the receipt of the	
		occurrences/incidents safety		material provided & received	
		ger staff and/or patients		and a copy of the receipt was	
		nduct by licensed staff and		placed in the employee file under section II. Those not	
		luct of unlicensed staff			
		eglect, and misconduct		present came into the office	
	-	Decurrence/Incident Report will		and received their one on one	
		ll occurrences or incidents as		training from the Area Clinical	
	•	by the staff member involved or		Manager (ACM), Area	
		become aware of the incident		Executive Director (AED) or	
	-			Regional VP of Clinical	
	-	be submitted to the immediate ervisor will reviewwill		Operations (RVPCO). Training	
		ess report will be forwarded		was completed by 11/12/2021.	
		d the QAPI committee		Education was provided by the	÷
	analiagement an	a me QAI I commuce		Regional VP of Clinical	
	1 A dogumant tit	led "Pharmacy Services,"		Operations (RVPCO) to the	
		repancies in the acquisition,		Executive Director (ED) and the	
				Alternate Executive Director or	
	storage, dispensing, administration, disposal, or return of controlled drugs are investigated			12/08/2021 on the policy LD.5	
	immediately by the pharmacist and hospice		"Responsibilities of the Administrator" to include but		
	administrator a written report of the discrepancy is completed"	-		not limited to conflict and	
			complaint management as well as communicating with the		
	5. A document tit	led "Medication Administration		governing board and all of	
	and Management,	' indicated " The patient's		agency staff regarding	

	ATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA D PLAN OF CORRECTION IDENTIFICATION NUMBER 151587		(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 11/09/2021
	PROVIDER OR SUPPLIE	R CE OF CENTRAL INDIANA LLC	1385 N	ADDRESS, CITY, STATE, ZIP COD I BALDWIN AVE IN, IN 46952	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE	E COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	DATE
TAG	<ul> <li>physician and Age</li> <li>be notified regarding soon as possible</li> <li>be documented on submitted to Agenciate immediately"</li> <li>6. A document title Administrator," interpretational plant authority for a functions, supervisions or ganizational plant communication will and supervising the process of the Administrator will and supervising the process of the Administrator to imprevising the process of the Administrator to imprevision of the Assumervision of the Assumervision of the performance admission of require in the performance admission, dischar provision of service standards of ethica are maintained"</li> <li>7. During an agence patients of the Aministrator of the Aministrator of the Aministrator of the Aministrator to a submission of service standards of ethica are maintained</li></ul>	ncy Nursing Management will ng any medication errors as . Any medication errors as . Any medication error will the [Incident Report] and cy Nursing Management ed "Responsibilities of the dicated "The Agency assume overall responsibility dministrative and leadership ion of the established and responsibility for ongoing th the Governing Body, as well Agency staff The be responsible for implementing e administrative policies and agency and for administratively vision of all services to a day-to-day basis The e responsibilities of the actude, but not be limited to cation, evaluations, and icable regulations to all Agency completion, maintenance, and dired reports Directing staff of their duties including ge, transfer, revocation, and es to patients Ensuring l business and clinical practice they office tour on 10/22/21 at wo door, off-white cabinet was d to have multiple medications ents' names on the medication	TAG	occurrences and incidents include but not limited to discrepancies for controlle drugs. On 11/2/2021, ACM provided education to Nurs Team on HCHB death note discharge summary and ho complete documentation of medication destruction dur the death visit. It was ident during this training the RN death visit was different fro the SN88 death visit, which lead to discrepancy of information provided on medication destruction. Bo assessments were updated VP EMR Operations 11/3/20 Nursing Staff were made aware they would need to complete an update to their devices in order to receive updated death visit note. F Medication Transportation was updated on 11/3/2021. 11/4/2021, ACM provided education to all Nursing sta the changes made to the Medication Transportation nursing staff were all provi copies of the updated form educated on how to proper complete form. On 12/9/202 ACM and RVPCO educated on Policy EC.5 "Occurrence/Incident	to to d sing and pw to f ring ified 88 pm th by )21. r the form Log On aff of Log; ded and ly 21,
	was observed to be in the open office a	Dyno brand, laser label maker placed on the side of cabinet area. The medications found ed to, lorazepam (treat anxiety		Reporting; and TX.21 "Reporting/Follow-Up of Medication Incidents".	

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

Event ID:

PD1P11 Facility ID: 003966

If continuation sheet Page 33 of 80

PRINTED: 12/15/2021 FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	x1) provider/supplier/clia identification number 151587	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 11/09/2021	
	NAME OF PROVIDER OR SUPPLIER HEART TO HEART HOSPICE OF CENTRAL INDIANA LLC		ADDRESS, CITY, STATE, ZIP COD I BALDWIN AVE DN, IN 46952		
PREFIX (EACH DEFICI	Y STATEMENT OF DEFICIENCIE ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	E (X5) COMPLET DATE	
<ul> <li>disorders), morph (treats severe ong anxiety and musc moderate to sever nausea and vomit to severe pain), N (lorazepam, diphe metoclopramide; fentanyl (treats see</li> <li>8. The clinical rec on 10/22/21 at 1: document titled " 9/24/21, complete indicated, " Vis Hospice Death At Indicate narcotic/ strength quant Lorazepam 0.5 m record failed to in disposed.</li> <li>9. The clinical rec on 10/22/21 at 1: document titled " 10/13/21, comple indicated, " Vis Hospice Death At Indicate narcotic/ strength quant [Registered Nurse and relationship t authorized to disp medications [F record failed to in quantity of the na were disposed.</li> <li>10. The clinical rec</li> </ul>	ine sulfate extended release oing pain), diazepam (treats le spasms), Oxycodone (treats e pain), Ondansetron (prevents ing), Dilaudid (relieves moderate orco (treats pain), ABHR gel enhydramine, haloperidol, and treats nausea and vomiting),		The Area Executive Director (AED) /Area Clinical Manage (ACM) or designee will audit 100% of all death discharge Medication Transportation and all occurrences/medication incidents monthly for 3 more until 100% of compliance iss met. Audit will focus on discharge summaries to en- there is proper documentate of disposal of medication in patient's residence or education was provided to authorize agent of proper disposal. Audit will also for on Medication Transportati Logs which includes name location of pharmacy, date time received, medications received (name, strength, a amount dispensed), employ obtaining medication, medication delivered to, na of person receiving medication, receiver to indicate if sealed properly a count of medication in presence of delivery person ensure proper medication transfer. Occurrences and/of medication incidents will be audited to ensure if a discrepancy is noted, an occurrence or incident is completed and the pharmaca and administrator were not immediately for investigation	r er it er it es, Logs atton nths is sure ion n the cus on and and and and ind yee if ion n the cus on and and and ind gee if ion n the cus on and and and if is and and if is an an an and if is an an an an an and if is an	

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 151587	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	СОМ	(X3) DATE SURVEY COMPLETED 11/09/2021	
	NAME OF PROVIDER OR SUPPLIER		1385 N	ADDRESS, CITY, STATE, ZIP C N BALDWIN AVE DN, IN 46952	COD		
(X4) ID PREFIX TAG	(EACH DEFICIE REGULATORY C	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE / DEFICIENCY)	HOULD BE APPROPRIATE	(X5) COMPLETIC DATE	
	<ul> <li>10/9/21, complete indicated, "Visi Hospice Death At Indicate narcotic/r strength quanti [Registered Nurse and relationship to authorized to dispu- medications [R record failed to ind quantity of the nar were disposed.</li> <li>11. The clinical re on 10/22/21 at 1:3 Note Report," data Registered Nurse I Type SN [skilld Home Medicat narcotic/medicatio  quantity how [eighteen] ml F  Full name and r person[s] legally a controlled drugs a husband]" The type, strength, qua and how they were</li> <li>12. The clinical re on 10/22/21 at 1:4 document titled "V 9/16/21, complete indicate narcotic/r</li> </ul>	n disposal type strength a disposed Morphine 18 entanyl 100 mcg #2 [sic] patches elationship to patient of uthorized to dispose of nd medications [Patient #8's record failed to indicate the ntity of the narcotics disposed		and that appropriate to State authorities of per requirement. One Area Clinical Manage designee will audit 10 death discharges, Me Transportation Logs occurrences/medicat incidents through the process. Trends identified duri audits will be reviewe no less than quarterly plan of	ccurred going the r (ACM) or 0% of the edication and ion e QAPI ing these ed in QAPI		
	[Registered Nurse	Case Manager] Full name patient of person[s] legally					

	NT OF DEFICIENCIES	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 151587	(X2) MULTIPLE C A. BUILDING B. WING	construction 00	COM	(X3) DATE SURVEY COMPLETED 11/09/2021	
	NAME OF PROVIDER OR SUPPLIER HEART TO HEART HOSPICE OF CENTRAL INDIANA LLC		1385 1	i address, city, state, zip N BALDWIN AVE ON, IN 46952	P COD	<b>I</b>	
(X4) ID PREFIX		/ STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THI DEFICIENCY)	I SHOULD BE	(X5) COMPLETIC	
	Oxycodone] 30 [tl Oxycodone 20 [tw record failed to in- disposed. 13. The clinical re on 10/22/21 at 1:5 document titled "V completed by Reg indicated, "Visi Hospice Death At family educated o drugs and medicat facility protocol the type, strength, disposed and how 14. The chart of P 10/22/21 at 6:00 F Report," dated 7/2 Nurse O, indicated nurse] Hospice Dea Was family/caregi disposed of per fa failed to indicate t	cyContin [brand name for hirty] mg 5 tabs [tablets] yenty] mg 1 [one] tab" The dicate how the narcotics were cord of Patient #11 was reviewed 5 PM. The record contained a Visit Note Report," dated 5/9/21, istered Nurse M, which t Type SN [skilled nurse] Home Medications Was in safe disposal of controlled ions? Disposed of per " The record failed to indicate quantity of the narcotics they were disposed. atient #12 was reviewed on M. A document titled "Visit Note 3/21, completed by Registered 4, "Visit Type SN [skilled hat Home Medications ver[s] instructed on safe lied drugs and medications? cility protocol" The record he type, strength, quantity of osed and how they were					
	10/22/21 at 6:05 F Report," dated 6/1 Nurse G, indicated nurse] Hospice Do Indicate narcotic/r strength quanti Morphine Concen	atient #13 was reviewed on M. A document titled "Visit Note 8/21, completed by Registered 4, " Visit Type SN [skilled eath At Home Medications nedication disposal type ty how disposed trate [treats severe ongoing 1 [milliliter] and Ativan [treats					

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 151587	(X2) MULTIPLE C A. BUILDING B. WING	construction 00	COM	(X3) DATE SURVEY COMPLETED 11/09/2021	
	PROVIDER OR SUPPLIE	CE OF CENTRAL INDIANA LLC	1385 N	<sup>°</sup> address, city, state, zii N BALDWIN AVE ON, IN 46952			
(X4) ID PREFIX		' STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO) CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE IE APPROPRIATE	(X5) COMPLETI	
TAG	[sixteen] tabs [tabl relationship to pat authorized to dispo- medications Pt Nurse G]" The and strength of the they were disposed 16. The chart of Pa 10/22/21 at 6:10 P Report," dated 8/3 Practical Nurse P, [skilled nurse] Ho Medications W instructed on safe and medications? protocol" The r strength, quantity how they were dis 17. The chart of Pa 10/22/21 at 6:15 P Report," dated 6/3 Nurse I, indicated, nurse] Hospice De Indicate narcotic/r strength quanti Morphine [treats s [twenty-eight] ml anxiety disorders] [fifteen] tabs [tabla relationship to pat authorized to dispo- medications [P- record failed to ind destroyed in the ho 18. The chart of Pa	atient #14 was reviewed on M. A document titled "Visit Note 0/21, completed by Licensed indicated, "Visit Type SN spice Death At Home as family/caregiver[s] disposal of controlled drugs Disposed of per facility ecord failed to indicate the type, of the narcotics disposed and posed. atient #15 was reviewed on M. A document titled "Visit Note /21, completed by Registered "Visit Type SN [skilled ath At Home Medications nedication disposal type ty how disposed evere ongoing pain] 28 [milliliter] and Lorazepam [treats 1 [one] mg [milligram] 15 ets] Full name and ient of person[s] legally ose of controlled drugs and atient #15's husband]" The dicate how the narcotics were	TAG			DATE	

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 151587	(X2) MULTIPLE C A. BUILDING B. WING	onstruction 00	COM	(X3) DATE SURVEY COMPLETED 11/09/2021	
	PROVIDER OR SUPPLIE	ER CE OF CENTRAL INDIANA LLC	1385 N	ADDRESS, CITY, STATE, ZIP I BALDWIN AVE NN, IN 46952	COD	•	
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	Nurse G, indicated nurse] Hospice De Indicate narcotic/r strength quanti Morphine Concen pain] 27 [twenty-s [treats anxiety diss [tablets] Full na person[s] legally a controlled drugs a hospice nurse" type and strength how they were diss 19. The chart of P 10/22/21 at 6:20 P Report," dated 6/1 Nurse K, indicated nurse] Hospice De Indicate narcotic/r strength quanti Morphine Concen pain] 27 [twenty-ss [treats anxiety diss [milligram] 18 [ei, Full name and rela legally authorized and medications . " The record fai strength of the nar were disposed. 20. The chart of P 10/22/21 at 6:25 P Report," dated 7/6 Nurse Q, indicated nurse] Hospice De Indicate narcotic/r	<ul> <li>8/21, completed by Registered</li> <li>4, " Visit Type SN [skilled</li> <li>eath At Home Medications</li> <li>nedication disposal type</li> <li>ty how disposed</li> <li>trate [treats severe ongoing</li> <li>even] ml [milliliter] and Ativan</li> <li>porders]18 [eighteen] tabs</li> <li>me and relationship to patient of</li> <li>nuthorized to dispose of</li> <li>nd medications wife and</li> <li>The record failed to indicate the</li> <li>of the narcotics disposed and</li> <li>posed.</li> </ul> atient #17 was reviewed on PM. A document titled "Visit Note 7/21, completed by Registered d, " Visit Type SN [skilled eath At Home Medications nedication disposal type ty how disposed trate [treats severe ongoing even] ml [milliliter] and Ativan porders] 0.5 [one-half] mg ghteen] = [sic] 26 [twenty-six] ationship to patient of person[s] to dispose of controlled drugs [Patient #17's granddaughter] led to indicate the type and cotics disposed and how they atient #18 was reviewed on 'M. A document titled "Visit Note /21, completed by Registered d, " Visit Type SN [skilled eath At Home Medications netional disposed and how they atient #18 was reviewed on 'M. A document titled "Visit Note /21, completed by Registered d, " Visit Type SN [skilled eath At Home Medications nedication disposal type ty how disposal type					

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 151587	(X2) MULTIPI A. BUILDIN B. WING			C	(X3) DATE SURVEY COMPLETED 11/09/2021	
	PROVIDER OR SUPPLIE	R CE OF CENTRAL INDIANA LLC	138	EET ADDRI 35 N BAL RION, IN				
(X4) ID PREFIX TAG	(EACH DEFICIE	' STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFI TAG	CF CF	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU ROSS-REFERENCED TO THE APPI DEFICIENCY)	LD BE	(X5) COMPLETH DATE	
	[twenty] ml [millil anxiety disorders] Full name and rela legally authorized and medications . " The record fai the narcotics dispo 21. The chart of Pa 10/22/21 at 6:30 P Report," dated 9/1 Practical Nurse R, [skilled nurse] Ho Medications In disposal type . disposed Morp ongoing pain] I patient of person[s of controlled drug #19's son]" The type, strength, qua and how they were 22. The chart of Pa 10/22/21 at 6:45 P Report," dated 8/1 Nurse I, indicated, nurse] Hospice De Indicate narcotic/r strength quanti Morphine [treats ss [twenty] mg [milli Lorazepam [treats mg Full name a person[s] legally a controlled drugs at	atient #19 was reviewed on M. A document titled "Visit Note 6/21, completed by License indicated, "Visit Type SN spice Death At Home dicate narcotic/medication strength quantity how hine Sulfate [treats severe Full name and relationship to ] legally authorized to dispose a and medications [Patient e record failed to indicate the ntity of the narcotics disposed e disposed. atient #21 was reviewed on M. A document titled "Visit Note 0/21, completed by Registered "Visit Type SN [skilled ath At Home Medications nedication disposal type ty how disposed evere ongoing pain] 20 gram]/ml [milliliter] and anxiety disorders] 0.5 [one half] ind relationship to patient of uthorized to dispose of nd medications [Patient #21's record failed to indicate the						

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 151587	Α.	MULTIPLE CO BUILDING WING	DNSTRUCTION 00		(X3) DATE SURVEY COMPLETED 11/09/2021	
	PROVIDER OR SUPPLIE	R CE OF CENTRAL INDIANA LLC		1385 N	ADDRESS, CITY, STATE, ZIP ( BALDWIN AVE N, IN 46952	COD		
(X4) ID PREFIX TAG	(EACH DEFICIE	' STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLET DATE	
	Report," dated 6/3 Nurse S, indicated nurse] Hospice De Indicate narcotic/r strength quanti Morphine [treats s ml [milliliter] and disorders] 0.5 [one [twenty-four] tabs relationship to pat authorized to dispu- medications [P.	M. A document titled "Visit Note 0/21, completed by Registered ,"Visit Type SN [skilled ath At Home Medications nedication disposal type ty how disposed evere ongoing pain] 15 [fifteen] Lorazepam [treats anxiety e half] mg [milligram] 24 [tablets] Full name and tent of person[s] legally ose of controlled drugs and atient #22's daughter]" The licate how the narcotics were r strength.						
	10/22/21 at 6:55 P Report," dated 9/2 Nurse G, indicated nurse] Hospice De Indicate narcotic/r strength quanti Morphine Concen pain] 25 [twenty-f [treats anxiety diss [milligram] 45 [fo name and relations legally authorized and medications . indicate the type a disposed and how	atient #23 was reviewed on M. A document titled "Visit Note /21, completed by Registered I, " Visit Type SN [skilled ath At Home Medications nedication disposal type ty how disposed trate [treats severe ongoing ive] ml [milliliter] and Ativan orders] 0.5 [one half] mg rty-five] tabs [tablets] Full ship to patient of person[s] to dispose of controlled drugs Wife" The record failed to nd strength of the narcotics they were disposed.						
	10/22/21 at 7:00 P Report," dated 7/1 Nurse L, indicated nurse] Hospice De	atient #24 was reviewed on M. A document titled "Visit Note 5/21, completed by Registered , "Visit Type SN [skilled ath At Home Medications nedication disposal type						

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 151587	(X2) MULTIPL A. BUILDING B. WING	e construction g <u>00</u>	COM	(X3) DATE SURVEY COMPLETED 11/09/2021	
	PROVIDER OR SUPPLIE	R CE OF CENTRAL INDIANA LLC	138	eet address, city, state 5 N BALDWIN AVE RION, IN 46952	, ZIP COD		
(X4) ID PREFIX		Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN (EACH CORRECTIVE AT CROSS-REFERENCED T DEFICIE	CTION SHOULD BE	(X5) COMPLETI	
	strength quanti Kit Full name a person[s] legally a controlled drugs a niece]" The rec strength, and quan 26. The chart of Pe 10/22/21 at 7:10 P Report," dated 8/2 Nurse S, indicated nurse] Hospice De Indicate narcotic/r strength quanti Morphine [treats s ml [milliliter] and disorders] 0.5 [one Full name and rela legally authorized and medications . The record failed t were destroyed. 27. The chart of Pe 10/22/21 at 7:15 P Report," dated 5/3 Nurse G, indicated nurse] Hospice De Indicate narcotic/r strength quanti Morphine Concen pain] 24 [twenty-f anxiety disorders] [twenty-three] tab severe pain] 25 [tw [quantity of one] patient of person[s of controlled drug	R LSC IDENTIFYING INFORMATION         ty how disposed Comfort         and relationship to patient of         uthorized to dispose of         and medications [Patient #24's         ord failed to indicate the type,         tity of the narcotics disposed.         atient #25 was reviewed on         M. A document titled "Visit Note         /21, completed by Registered         , "Visit Type SN [skilled         ath At Home Medications         nedication disposal type         ty how disposed         evere ongoing pain] 15 [fifteen]         Lorazepam [treats anxiety         e half] mg [milligram] 6 [six]         tionship to patient of person[s]         to dispose of controlled drugs         [Patient #25's daughter]"         o indicate how the narcotics         atient #26 was reviewed on         M. A document titled "Visit Note         0/21, completed by Registered         atient #26 was reviewed on         M. A document titled "Visit Note         0/21, completed by Registered         atient #26 was reviewed on         M. A document titled "Visit Note         0/21, completed by Registered         atient #26 was reviewed on         M. A document					

	R MEDICARE & MEDI		_				MB NO. 0938-0
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	· /		NSTRUCTION	r í	E SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		ILDING	00		PLETED
		151587	B. WI	NG		11/0	9/2021
	PROVIDER OR SUPPLIE	D		STREET A	DDRESS, CITY, STATE, ZIP COD	•	
NAME OF 1	I KO VIDEK OK SOI I EIE	R .		1385 N	BALDWIN AVE		
HEART	TO HEART HOSPI	CE OF CENTRAL INDIANA LLC		MARION	N, IN 46952		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTI	ON	(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO	BE	COMPLETI
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	20 77 1 1 1						
		cord of Patient #27 was reviewed					
		) PM. The record contained a					
		isit Note Report," dated					
	· •	ed by Registered Nurse F, which					
	indicated, " Visit	Type SN [skilled nurse]					
	Hospice Death At	Home Medications Was					
	family educated or	n safe disposal of controlled					
	drugs and medicat	ions? Disposed of per					
	facility protocol	." The record failed to indicate					
	the type, strength,	quantity of the narcotics					
		they were disposed.					
	29. The chart of Pa	tient #28 was reviewed on					
	10/22/21 at 7:25 P	M. A document titled "Visit Note					
	Report," dated 6/1	7/21, completed by Registered					
	Nurse K, indicated	, "Visit Type SN [skilled					
		ath At Home Medications					
		nedication disposal type					
		y how disposed					
		ended release; treats severe					
	· ·	thirty] 59 [fifty-nine]					
		en] mg 86 [eighty-six] Ativan					
	· ·	orders] 0.5 [one-half] mg					
		Ativan 1 [one] mg 7 [seven]					
		ats severe pain] 5 [five] mg 120					
	-	ty] Full name and					
		ent of person[s] legally					
	-	ose of controlled drugs and					
	-	atient #28's son]" The record					
		he type and strength of the					
	narcotics disposed	and how they were disposed.					
	30. The chart of P	tient #29 was reviewed on					
		M. A document titled "Visit Note					
		9/21, completed by Registered					
	-						
		, "Visit Type SN [skilled					
		ath At Home Medications					
		nedication disposal type					
	strength quantit	y how disposed					
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	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 151587	(X2) MULTIPLE C A. BUILDING B. WING	00	00 con 11/	
	PROVIDER OR SUPPLIE	R CE OF CENTRAL INDIANA LLC	1385 N	ADDRESS, CITY, STATE, ZIP CO N BALDWIN AVE DN, IN 46952	D	
(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 SHO) CROSS-REFERENCED TO THE APF DEFICIENCY)	ULD BE	(X5) COMPLETIC DATE
0000	anxiety] Full na person[s] legally an controlled drugs ar The record failed to and quantity of the 31. During an inter when asked if they from the metal cab Manger B's office, "We do have an en manager's office. T are partially used n never used the part 32. During an inte when asked why m destroyed in the pa Administrator A, F	evere pain] and Ativan [treats me and relationship to patient of athorized to dispose of ad medications " [sic]" to indicate the type, strength, narcotics disposed. view on 10/22/21 at 1:35 PM, had ever seen medications inet in Former Patient Care Registered Nurse I indicated, hergency supply in the There is no sign out sheet. There mediations in there, but I've ial ones." rview on 10/22/21 at 2:15 PM, hedications had not been tients' homes, Former former Patient Care Manager B, D indicated, "I do not know."				
Bldg. 00	investigation of on hospice agency. Complaint # IN003 findings		S 0000			

	T OF DEFICIENCIES DF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 151587	(X2) MULTIPL A. BUILDIN B. WING	e construction g <u>00</u>	COMP	(X3) DATE SURVEY COMPLETED 11/09/2021	
	ROVIDER OR SUPPLIE	<sup>R</sup> CE OF CENTRAL INDIANA LLC	138	EET ADDRESS, CITY, STATE, ZIP COD 5 N BALDWIN AVE RION, IN 46952			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION 1/9; 2021.	ID PREFIZ TAG	CROSS-REFERENCED TO THE APPR	D BE	(X5) COMPLETION DATE	
8 0509 Bldg. 00	Active Continuous Active Assisted Li Census: 10 Active Skilled Nur Census: 79 Active Respite Pat Unduplicated cens 418.52(b)(4)(ii) EXERCISE OF F PROPRTY/PERS [The hospice mur (ii) Immediately in violations involvir on behalf of the H take action to pre violations while th verified. Investiga of all alleged viol accordance with Based on record re failed to fully inve the complaint was Findings include: 1. A document title Administrator," in the responsibilities include, but not lir complaint manage A document title	batient (GIP) Census: 0 Care (CC) Patient Census: 0 ving Facility (ALF) Patient rsing Facility (SNF) Patient ient Census: 0 us: 450 RIGHTS/RESPECT FOR SON	S 0509	The Executive Director w responsible to help ensu- violations are immediate investigated on all allege violations involving anyo- furnishing services on b the hospice and will immediately take action prevent further potential violations while the allege violation is being verified Executive Director will h ensure that investigation documentation of all allege	re that ly ed one ehalf of to ed d. elp is and	12/22/202	

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 151587	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 11/09/2021	
	PROVIDER OR SUPPLIE	R CE OF CENTRAL INDIANA LLC	1385 N	ADDRESS, CITY, STATE, ZIP COD N BALDWIN AVE DN, IN 46952	D	
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	E (X5) E COMPLETIO DATE	
	<ul> <li>and to this end ma recommend chang behalf of himself of staff, to governme of his or her choic  to be assured th investigate all alle</li> <li>2. During a review complaint dated 6/ complaint indicate Date of Event (6) Revocation Typ  Patient had fall possible hip fx [fra chose to seek aggr hospice POC [plan 6/16/21"</li> <li>3. During a review complaint indicate  Date of Event FSN [sic] nurse  Type D [Cor  [Former Patient administrator on-c [Registered Nurse  Date Resolved</li> <li>4. During an interv when asked if all of a system wide app</li> </ul>	y present grievances or es in policies and services on or herself or other to the facility ntal offices or to another person e within or outside of the facility e hospice will immediately ged violations" of the agency complaint log, a (4/21 was reviewed. The d "Date reported 6/4/21 5/4/21 Complaint be H [Billing/Payment Issue] in her home that resulted in acture] Family and Patient essive treatment outside of the n of care] Date Resolved v of the agency complaint log, a (25/21 was reviewed. The d "Date reported 9/26/21 9/25 & 9/26 [sic] Complaint called with medication concerns nmunication] Actions Taken Care Manager B] and all spoke with FSN [sic] and D] made PRN [as needed] visit		procedures to help ensure this was not a systemic iss Education was provided by Regional VP of Clinical Operations (RVPCO) to the Executive Director (ED) and Alternate Executive Director 12/08/2021 on the policy LI "Responsibilities of the Administrator" to include to not limited to conflict and complaint management. Education was provided by Chief Clinical Officer (CCL) all staff on 11/27/2021 on R and Responsibilities indicate every patient is entitled to exercise their right to press grievances or recommend change and to be assured the agency will investigate alleged violations. Educate was provided to all staff or 12/9/2021 by the Regional V Clinical Operations (RVPC) and the Area Clinical Mana (ACM) on policy RI.5 "Resolution of Patient Conflicts, Grievances or Complaints". The Agency V immediately investigate all complaints made by a patient a patient's family or guardi or a patient's health care provider. On 12/9/2021, AC and RVPCO educated all nurses on Policy EC.5 "Occurrence/Incident Report and TX. 21 "Reporting/Follor Medication Incidents".	that sue. y the d the or on D.5 out y the O) to tights ating ent that all ion N VP of O) ger will ent, an, M ting"	

	R MEDICARE & MEDI					OMB NO. 0938-039	
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 151587	(X2) MUI A. BUII B. WIN	<u></u>	CON	(X3) DATE SURVEY COMPLETED 11/09/2021	
	PROVIDER OR SUPPLIE	R CE OF CENTRAL INDIANA LLC		STREET ADDRESS, CITY, STATE, ZIP CO 1385 N BALDWIN AVE MARION, IN 46952	DD		
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	P	ID PROVIDER'S PLAN OF CORR REFIX (EACH CORRECTIVE ACTION SHU CROSS-REFERENCED TO THE AF TAG DEFICIENCY)	ECTION OULD BE PROPRIATE	(X5) COMPLETION DATE	
				The Regional VP of Cli Operations (RVPCO) o designee will audit 100 complaints or alleged violations for 3 months 100%, compliance is m ensure that an immedi investigation occurred follow-up and with a resolution. Ongoing th Clinical Manager (ACM designee will audit the complaint log through process. Trends identified durin audits will be reviewed no less than quarterly plan of correction and training will be update indicated to help ensu sustained improvemen	r 0% of all s or until net to ate l with he Area 1) or the QAPI ng these d in QAPI and the /or d as re		
S 0512 Bldg. 00	<ul> <li>(1) Receive effect symptom control conditions related</li> <li>Based on record reinterview, the hosp Registered Nurse (symptoms related for 2 of 30 (#2, 3)</li> <li>Findings include:</li> <li>1. A document title Responsibilities,"</li> </ul>	E PATIENT a right to the following: tive pain management and from the hospice for d to the terminal illness; eview, observation, and bice failed to ensure the (RN) effectively managed to the patient's terminal illness clinical records reviewed.	S 051	12 The Executive Director responsible to help en the Rights and Respor of the patients have be followed and that all p have received effective management and sym control related to the t illness. Education was provide Regional VP of Clinica Operations (RVPCO) a	sure that nsibilities een atients e pain ptom erminal ed by the I	12/22/202	

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

	R MEDICARE & MEDI						IB NO. 0938-039
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	· /		ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	151587	A. BU B. WI	ILDING NG	00	COMPI 11/09	
	PROVIDER OR SUPPLIE			1385 N	ADDRESS, CITY, STATE, ZIP COD BALDWIN AVE N, IN 46952		
(X4) ID	SUMMARY	Y STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTI	ON	(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPRO DEFICIENCY)	) BE )PRIATE	COMPLETION
TAG		OR LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	<ul> <li>hospice for the conillness"</li> <li>2. A document titti indicated "The didentify physical, spiritual needs related be addressed in or well-being, comford dying process data assessment based of practice will indicate will indicate will indicate treatment chara descriptors path of pain frequent impact of pain or treatment that p strategies and fact symptoms associa"</li> <li>3. The clinical rec on 11/8/21 at 12:0 election date of 9/ of cerebral atheros hardening of the w During a home vis Patient #2, Register completing wound</li> </ul>	symptom control from the nditions related to the terminal led "Patient Assessments," comprehensive assessment will psychosocial, emotional, and ated to terminal illness that will der to promote the patient's rrt, and dignity throughout the A comprehensive pain on accepted clinical standards clude history of pain and its acteristics of pain intensity factors such as activities, care, precipitate or exacerbate pain ors to reduce pain additional ted with painnausea pain ord of Patient #2 was reviewed 0 PM and indicated a hospice 23/21 with a primary diagnosis sclerosis (thickening and valls of the arteries in the brain). sit on 11/9/21 at 10:00 AM with ered Nurse F was observed d care. The Registered Nurse e patient's pain before starting			Area Clinical Manager (Ad on 11/22/2021 and 11/23/2 all nursing staff on "Patie Assessments" which incl that in the initial comprehensive assessme well as subsequent comprehensive assessme the assessment will inclu is not limited to a comple pain assessment under accepted standards of pr and treatments. The Regi VP of Clinical Operations (RVPCO) and the Area Cli Manager (ACM) provided education to all nursing s 11/22/2021 and 11/23/202 "Patient Rights and Responsibilities" indicati that all patients have the to receive effective pain management and sympto control. POLICY REVIEW/HANDOUTS incl PE.1 "Patient Assessment TX.30 "Pain Management TX.30 "Pain Management TX.30 "Corders For Care"; T "Medication List and	2021 to ent luded ent, as ents, de but te actice onal inical itaff on 1 on ng right om uded: its"; " e and bice ";	
	4. The clinical rec on 11/8/21 at 1:00 election date of 8/ of cerebral atheros hardening of the w During a home vis	ord of Patient #3 was reviewed PM and indicated a hospice 14/21 with a primary diagnosis sclerosis (thickening and valls of the arteries in the brain). sit on 11/9/21 at 11:30 AM with ered Nurse G was observed			Monitoring"; RI.1 IN "Pati Rights and Responsibiliti 10/27/2021, the Chief Clin Officer (CCLO) provided education to all nursing s "Patient Rights and Responsibilities" and pol RI.1 IN "Patient Rights an	es. On ical staff on icy	

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If continuation sheet

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 151587	(X2) MULTIPLE C A. BUILDING B. WING	00 00	(X3) DATE SURVEY COMPLETED 11/09/2021	
	PROVIDER OR SUPPLIE	R CE OF CENTRAL INDIANA LLC	1385 N	ADDRESS, CITY, STATE, ZIP COD I BALDWIN AVE DN, IN 46952		
(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)	TE	(X5) COMPLETIC DATE
	<ul><li>failed to assess the wound care.</li><li>5. During an interv when asked if an a</li></ul>	care. The Registered Nurse patient's pain before starting view on 11/9/21 at 2:00 PM, ssessment of pain take place starts, Administrator E,		Responsibilities", indicating that all patients have the righ to receive effective pain management and symptom control. The Area Clinical Manager (ACM) or designee will audit 100% of all active patients' comprehensive assessments 3 months or until 100%, compliance is met to ensure pain assessment is being completed on admission and ongoing, specifically prior to wound treatment. Ongoing t Area Clinical Manager (ACM) designee will audit 10% of active patient records comprehensive assessments through the QAPI process. Trends identified during thes audits will be reviewed in QA no less than quarterly and th plan of correction and/or training will be updated as indicated to ensure sustainer improvement.	s for a i he or s se vPI ie	
S 0522 Bldg. 00	an initial assess the election of ho with §418.24 is c physician, patien that the initial ass	stered nurse must complete nent within 48 hours after spice care in accordance omplete (unless the t, or representative requests sessment be completed in				
	less than 48 hour Based on record re	s.) wiew and interview, the	S 0522	The Executive Director will b responsible to help ensure the	-	12/22/202

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	. ,	PLE CONSTRUCTION	· · ·	E SURVEY PLETED	
ND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 151587	A. BUILDI B. WING	NG <u>00</u>	_	)9/2021	
NAME OF	PROVIDER OR SUPPLIE	R		REET ADDRESS, CITY, STATE, ZIP	COD		
HEART	TO HEART HOSPI	CE OF CENTRAL INDIANA LLC		ARION, IN 46952			
X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CC	DRRECTION	(X5)	
REFIX	,	NCY MUST BE PRECEDED BY FULL	PREI	CROSS-REFERENCED TO THE	SHOULD BE APPROPRIATE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION	TA			DATE	
	-	(RN) failed to assess the		the hospice register			
		nedication use as part of the		will complete an initi			
	clinical records rev	sessment for 2 of 30 (#2, 3)		assessment within 4			
	clinical records rev	viewed.		after the election of I	•		
	Findings include:			care unless the phys			
	Findings include.			representative reque assessment be com			
	1 A document titl	ed "Patient Assessments,"		less than 48 hours, t			
		comprehensive assessment will		an assessment of the			
		psychosocial, emotional, and		ongoing medication	•		
		ated to terminal illness that will		of the comprehensiv	-		
	-	der to promote the patient's		assessment. The Ex			
		rt, and dignity throughout the		Director will help ens	sure that		
	-	current medical conditions,		all patients have the			
		o-morbid psychiatric diagnoses		receive effective pair	-		
	or history"			management and sy	mptom		
				control.			
	2. The clinical reco	ord of Patient #2 was reviewed		Education was provi	ded by the		
	on 11/8/21 at 1:00	PM and indicated a hospice		Regional VP of Clinic	cal		
		23/21 with a primary diagnosis		Operations (RVPCO)	and the		
		clerosis (thickening and		Area Clinical Manage	er (ACM)		
	hardening of the w	valls of the arteries in the brain).		on 11/22/2021 and 11			
				all nursing staff on "			
	-	it on 11/9/21 at 10:00 AM with		Assessments" which			
	, 0	ered Nurse F was observed		that in the initial ass			
		care. The Registered Nurse		will be completed wi			
		patient's current medications		hours after the elect			
	for any changes.	ord of Patient #3 was reviewed		hospice care unless			
		PM and indicated a hospice		physician or represe request the assessm			
		14/21 with a primary diagnosis		completed less than			
		clerosis (thickening and		The assessment will			
		valls of the arteries in the brain).		that pain has been a			
		)-		and effective pain			
	During a home vis	it on 11/9/21 at 11:30 AM with		management and sy	mptom		
	-	ered Nurse G was observed		control are in place i	-		
	-	care. The Registered Nurse		accordance with sta			
		patient's current medications		practice and under t			
	for any changes.			direction of the phys	ician or		
				nurse practitioner. P			

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	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 151587	(X2) MULTIPLE C A. BUILDING B. WING	0NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 11/09/2021
	PROVIDER OR SUPPLIE	R CE OF CENTRAL INDIANA LLC	1385 N	address, city, state, zip cod N BALDWIN AVE DN, IN 46952	
(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 F CROSS-REFERENCED TO THE APPROP DEFICIENCY)	E COMPLETIO
	when asked if an a looking at all med	view on 11/9/21 at 2:00 PM, ssessment should include cations to ensure accuracy of use, Administrator E, indicated		REVIEW/HANDOUTS inclu PE.1 "Patient Assessment TX.30 "Pain Management" TX.07" Implementing Care Treatment"; TX. 25 "Hospi Care In A Nursing Facility" TX.5 "Orders For Care"; T2 "Medication List and Monitoring"; RI.1 IN "Patie Rights and Responsibilitie The Area Clinical Manager (ACM) or designee will aud 100% of all active patients initial assessments for 3 m to ensure a pain assessme being completed on admis and ongoing, specifically p to wound treatment. Ongo the Area Clinical Manager (ACM) or designee will aud 10% of active patient recon comprehensive assessme through the QAPI process. Trends identified during th audits will be reviewed in 0 no less than quarterly and plan of correction and/or training will be updated as indicated to ensure sustain improvement. /p>	s"; and ce f; K.17 nt s". lit nonths ent is sion prior ping lit rds nts esse QAPI the
S 0579 Bldg. 00	of practice to pre infections and co	t follow accepted standards vent the transmission of mmunicable diseases, of standard precautions.			
		on, record review, and	S 0579	The Executive Director wil responsible to help ensure	12/22/202

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEME	R MEDICARE & MEDIONT OF DEFICIENCIES	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 151587		ILDING	DNSTRUCTION 00	(X3) DATH COMP	MB NO. 0938-039 E SURVEY DETED D/2021
NAME OF PROVIDER OR SUPPLIER HEART TO HEART HOSPICE OF CENTRAL INDIANA LLC				1385 N	ADDRESS, CITY, STATE, ZIP COD BALDWIN AVE N, IN 46952		
(X4) ID PREFIX	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO	BE	(X5) COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	-	pice failed to ensure all			the accepted standards of	F	
		ed agency infection control			practice to prevent the		
		dures and standard precautions sit observations (#2, 3).			transmission of infections	and	
		sit observations $(\#2, 5)$ .			communicable diseases, including the use standar	4	
	Findings include:				precautions are followed.		
	i manigo menude.				Executive Director will he		
	1. A policy titled "	'Infection Control Program,"			ensure that all staff practi	-	
		Agency's infection control			proper hand hygiene		
		ased on the following criteria			techniques in the prevent	ion	
		ate, and local laws and			and spread of infection ar		
		e Infection Control Program will			communicable diseases.		
	include Implem	nenting appropriate preventative			The Area Clinical Manage	r	
	procedures implementing appro	lementing appropriate measures			(ACM) provided education	to all	
		n Management will be			staff on 11/17/2021 and		
	-	ordinating all activities related			11/18/2021 on policies IC.	03	
	to the Infection Co	ontrol Program"			"Hand Hygiene" and IC.12	Bag	
					Technique indicating the		
		"Bag Technique," indicated "			practice of proper hand		
		d on a clean, safe surface If			washing or use of hand		
	-	, a barrier is to be placed			sanitizer to include prope		
	-	When the visit is completed,			infection control before a		
		ant is cleaned using alcohol, and/or antimicrobial soap and			after removing gloves and		
	· ·	te, hands are washed, and			ensure a proper barrier is		
		oplies are returned to the bag			for the bag technique duri the patient visit. Hand	ng	
	"	sphes are retained to the bag			Hygiene competencies wi	th all	
					staff providing direct patie		
	3. A policy titled	"Hand Hygiene," indicated "			care were completed on		
		f providing patient/client care			11/17/2021 and 11/18/2021	to	
	•••	r hand hygiene techniques if			ensure that hand washing		
		bly soiled, staff may use an			occurring or the use of ha		
	alcohol-based hand	d rub for routinely			sanitizer is used in accord		
	decontaminating hands in all other clinical				with infection control poli	cies	
		d below Alternatively, staff			and procedures to include	Э,	
	-	vith an antimicrobial soap and			when removing gloves or		
		l situations described below					
		nds after contact with			treatments. Competencie	s on	
	-	tact skin, even when gloves are			Bag Technique will be		
	worn Decontan	ninate hands after contact with			completed for all staff		

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PRINTED: 12/15/2021

FORM APPROVED

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 151587	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	СОМ	(X3) DATE SURVEY COMPLETED 11/09/2021	
	NAME OF PROVIDER OR SUPPLIER HEART TO HEART HOSPICE OF CENTRAL INDIANA LLC		1385 N	ADDRESS, CITY, STATE, ZIP COE I BALDWIN AVE DN, IN 46952	)		
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOL) CROSS-REFERENCED TO THE APP DEFICIENCY)	TION ILD BE ROPRIATE	(X5) COMPLETIC DATE	
	<ul> <li>body fluids or exc nonintact skin, and not visibly soiled moving from a cor- body site during p Decontaminate ha objects [including immediate vicinity</li> <li>4. A policy titled Supplies and Equi Nurse/HHA [hom Prevent contaminated contaminated supp Stethoscope Fr patient Nurse S each use Pulse each use Pulse each use Therm</li> <li>5. During a home Patient #2 (election Nurse F was obser The Registered Nat touching multiple same gauze, pullir without changing hygiene, and touch touching the wour</li> <li>6. During a home Patient #3 (election Nurse G was obser The Registered Nat using proper bag t barrier technique, the wound with th</li> <li>7. During an inter- when asked if all th</li> </ul>	retions, mucous membranes, d wound dressings if hands are Decontaminate hands if ntaminated body sit to a clean atient/client care nds after contact with inanimate medical equipment] in the y of the patient/client" "Cleaning and Management of pment," indicated "Item e health aide] Bag Notes tition by not placing blies back inside bag equency between each bcissors Frequency After Oximeter Frequency after nometer" visit on 11/9/21 at 10:00 AM with n date of 9/23/21), Registered twed completing wound care. urse (RN) was observed areas of the wound with the ng glasses from their pocket gloves or completing hand hing their charting tablet after ad then not cleaning the tablet. visit on 11/9/21 at 11:30 AM with n date of 8/14/21), Registered rved completing wound care. urse (RN) was observed not echnique, not using proper and touching multiple areas of		providing direct patient 12/17/2021. Monitoring will be comp by a review of competer completed on all new hi 3 months or until 100%, compliance has been m Results will be reported QAPI committee and rep to the Governing Body annually. Trends identified during audits will be reviewed no less than quarterly a plan of correction and/o training will be updated indicated to ensure sus improvement.	care by oleted ncies ires for et. to the ported g these in QAPI nd the or as	DATE	

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 151587	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	COMPL	(X3) DATE SURVEY COMPLETED 11/09/2021	
	PROVIDER OR SUPPLIE	R CE OF CENTRAL INDIANA LLC	1385 N	address, city, state, zip cod I BALDWIN AVE NN, IN 46952			
	T			1		(117)	
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	E	(X5) COMPLETION DATE	
	Administrator E, i	ndicated "Yes."					
8 0580 Bldg. 00		st maintain a coordinated gram for the surveillance,					
	identification, pre investigation of ir diseases that- (1) Is an integral	evention, control, and infectious and communicable part of the hospice's quality performance improvement	S 0580		ha	12/22/202	
	interview, the hosp infection control p	ion, record review, and bice failed to ensure COVID recautions were followed for 3 visit observations (#2, 3, 4).	5 0380	The Executive Director will be responsible to maintain a coordinated agency-wide program for the surveillance, identification, prevention, control and investigation of infections and communicable	ce, f ble	12/22/202	
<ol> <li>A policy titled "Infection Control indicated " The Agency's infection program will be based on the following Current federal, state, and local laws regulations The Infection Control include Implementing appropriate procedures implementing appropriate procedures implementing appropriate to control infection Management responsible for coordinating all active to the Infection Control Program"</li> </ol>	Agency's infection control ased on the following criteria ate, and local laws and e Infection Control Program will nenting appropriate preventative elementing appropriate measures n Management will be profinating all activities related		diseases, and that this is a integral part of the hospice quality assessment and performance improvement program. The Executive Director will ensure COVID infection control precautio are followed and that screenings by all discipline will be complete prior to entering the patients home/room.	's ns			
	Addendum Infecti indicated " The A current informatio provided by local, related to any infe- epidemic The A patients/client and	"Infection Control Program ous Disease Pandemic," Agency will stay abreast of n and practice guidelines state, and federal agencies ctious outbreak, pandemic, or Agency will identify staff will signs and symptoms well as those considered at risk		home/room. The Regional VP of Clinica Operations (RVPCO) and the Area Clinical Manager (AC educated all staff on 12/08/ on policies IC.02 "Infection Control Program" and IC.2 "Infection Control Program Addendum Infectious Dise Pandemic" indicating	ne M) 2021 a N		

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	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 151587	(X2) MULTIPLE ( A. BUILDING B. WING	construction 00	(X3) DATE COMPI 11/09	
NAME OF	PROVIDER OR SUPPLIE	R		t address, city, state, zip cod N BALDWIN AVE		
HEART	TO HEART HOSPI	CE OF CENTRAL INDIANA LLC	MARI	ON, IN 46952		
X4) ID		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 APPROPRIA	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE
	for the infection			screening for COVID sympto		
		ing Nurse will ensure all		of patients/care givers occu		
	-	d staff are screened for risk		prior to entering the patients		
		signs and symptoms of the		home/room. The Regional V	/P	
		by the most recent data		of Clinical Operations (RVP)	•	
	available"			and the Area Clinical Manag	er	
				(ACM) educated all staff on		
	3. During a home	visit on 11/9/21 at 10:00 AM with		12/09/2021 on Policy IC.13		
	Patient #2 (election	n date of 9/23/21), Registered		"Infectious Disease		
	Nurse F was obser	ved completing wound care.		Pandemic/Coronavirus".		
	The Registered Nu	rse (RN) was observed		The Area Clinical Manager		
	screening patient f	or COVID symptoms after		(ACM) or designee will audit	t	
	already having phy	vsical contact with the patient.		100% of patient records for	3	
				months to ensure all staff		
	4. During a home	visit on 11/9/21 at 11:30 AM with		providing direct patient care	)	
	Patient #3 (election	n date of 8/14/21), Registered		will complete screening price		
	Nurse G was obser	rved completing wound care.		to entering the patients		
		urse (RN) was observed		home/room and before		
	-	or COVID symptoms after		providing care until 100%,		
		vsical contact with the patient.		compliance is met. Ongoing	1	
	5 51 .	1		the Area Clinical Manager		
	5. During a home	visit on 10/18/21 at 10:00 AM		(ACM) or designee will audit	ł	
	-	ection date of 8/14/21), Certified		10% of active patient record		
		observed completing wound		comprehensive assessment		
		Nurse Aide was observed		through the QAPI process.		
		or COVID symptoms after		ACM/designee will do an		
	0.1	vsical contact with the patient.		on-sight field visit with care		
	uneauly naving phy	stear contact with the patient.		staff for demonstration of		
	6 During an inters	view on 11/9/21 at 2:00 PM,		understanding of screening		
	-	taff needed to screen patients		prior to patient visit to be		
		oms before they have physical		completed by 12/30/2021. If	an	
		Administrator E, confirmed				
	"Yes."			employee demonstrates lac		
	105.			of understanding, re-educat will occur and another field		
				visit will be performed until		
				compliance is met.	<b>60</b>	
				Trends identified during the		
				audits will be reviewed in Q		
				no less than quarterly and the	ie	
				plan of correction and/or		1

State Form

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	R MEDICARE & MEDI					•	IB NO. 0938-039
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 151587	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING			(X3) DATE SURVEY COMPLETED 11/09/2021	
	PROVIDER OR SUPPLIE	R CE OF CENTRAL INDIANA LLC	•	1385 N	ADDRESS, CITY, STATE, ZIP COD N BALDWIN AVE DN, IN 46952		
(X4) ID PREFIX	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI/	ATE	(X5) COMPLETION
TAG	REGULATORY C	R LSC IDENTIFYING INFORMATION		TAG	training will be updated as indicated to ensure sustained	ed i	DATE
S 0691 Bldg. 00	<ul> <li>community or insistock drugs and it</li> <li>(2) The hospice it</li> <li>directly in its own</li> <li>(i) Have a written</li> <li>promotes dispen</li> <li>(ii) Maintain current</li> <li>the receipt and divide</li> <li>drugs.</li> <li>Based on record resistories</li> <li>Based on record resistories</li> <li>Based on record resistories</li> <li>and drugs.</li> <li>Based on record resistories</li> <li>Findings include:</li> <li>A document title</li> <li>indicated "Upor</li> <li>will be disposed of</li> <li>Any unused medication</li> <li>A document title</li> <li>Transport," indication</li> <li>pharmacy will be medications, when</li> <li>store any medication</li> <li>the Agency's office</li> <li>transportation in the</li> <li>A document title</li> </ul>	and biologicals from titutional pharmacists or biologicals itself. hat provides inpatient care facility must: policy in place that sing accuracy; and ent and accurate records of isposition of all controlled eview, observation, and bice failed to ensure the patient ons from a pharmacy for 1 of 30	S 06	591	The Executive Director (ED) be responsible to help ensu the agency will obtain drugs and biologicals from a pharmacy. The Chief Clinical Officer (CCLO) provided in person education to all nursing staf 10/27/2021 on policies TX.18 "Medication Possession and Transportation", Form-Medication Transportation Log, HR.27 "Standard of Conduct", TX.0 "Standard of Practice", PE.0 "Patient Care and Safety" RI "IN Patient Rights and Responsibilities", TX.16 "Medication Administration" 25-30 Article 23. Nurses, Artic Indiana State Nurses Assistan Program, Article 4 Advanced Nursing & Prescriptive Author	re ; f on ; d )1 )5 !.1 ', IC cle 7 nce	12/08/202

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEMEN	R MEDICARE & MEDIC IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 151587	(X2) MULTIPLE C A. BUILDING B. WING	onstruction 00	(X3) DATE COMPI	
	ROVIDER OR SUPPLIE	R CE OF CENTRAL INDIANA LLC	1385 N	address, city, state, zip coi 1 BALDWIN AVE DN, IN 46952	)	
	O HEART HOSPI SUMMARY (EACH DEFICIE) REGULATORY O will administer the administrative and procedures, in accor federal, state laws, Medications are ac Clinical Procedure orders" 4. During an agene 10:00 AM, a tall, t (found in the clinic observed and foun with deceased pati packages. These m not limited to a bra morphine. 5. The clinical recc on 10/22/21 at 1:00 election date of 5/1 of acute myeloblas achieved remission marrow with excess The record contain Note Report," date name [Register				UTUD BE PROPRIATE URSING, thority for ing, he distered & ng, Article 848 lursing, spice were pt the n on eceived material signed file not office on one Clinical	(X5) COMPLETION DATE
	when asked if they from the metal cab Manger B's office, "We do have an er manager's office. I	view on 10/22/21 at 1:35 PM, thad ever reused medications inet in Former Patient Care Registered Nurse I indicated, mergency supply in the used liquid morphine for a brand new, sealed bottle."		Regional VP of Clinical Operations (RVPCO). T was completed by 11/12 The Area Executive Direct (AED), Executive Direct Area Clinical Manager ( designee will complete random spot checks of and clinical vehicles for presence of medication are from deceased patie were not admitted to see monthly x 3 months un	2/2021. ector cor (ED) ACM) or office r the us that ents or ervice	

Event ID: PD1P11 Facility ID: 003966 If continuation sheet Page 56 of 80

	NT OF DEFICIENCIES OF CORRECTION	x1) provider/supplier/clia identification number 151587	(X2) MULTIPLE A. BUILDING B. WING	construction <u>00</u>	(X3) DATE SURVEY COMPLETED 11/09/2021	
	PROVIDER OR SUPPLIE	R CE OF CENTRAL INDIANA LLC	STREET ADDRESS, CITY, STATE, ZIP COD 1385 N BALDWIN AVE MARION, IN 46952			
(X4) ID PREFIX TAG	(EACH DEFICIE	' STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION	
				compliance is met. The Ar Clinical Manager (ACM) or designee will complete random spot checks of office/clinical vehicles quarterly for the presence medications not in adhere with policy and procedure medication found, the Area Clinical Manager (ACM) or designee will report findin Leadership for disciplinary action, up to and including termination. Area Clinical Manager or designee will report findings through Q/ least quarterly and plan of correction will be impleme if applicable. Trends identified during th audits will be reviewed in 0 no less than quarterly and plan of correction and/or training will be updated as indicated to ensure sustail improvement.	of nce s. If a gs to / API at ented hese QAPI the	
S 0693 Bldg. 00	<ol> <li>Labeling. Dru labeled in accord accepted profess include appropria</li> </ol>	E STORAGE DRUGS gs and biologicals must be ance with currently sional practice and must ate usage and cautionary yell as an expiration date (if	5.0/02			
	interview, the hosp	ion, record review, and bice failed to ensure labeled correctly for 1 of 30	S 0693	The Executive Director (EI be responsible to help ens all medications are labeled correctly according to	sure	

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C A. BUILDING	· · · · · · · · · · · · · · · · · · ·	X3) DATE SURVEY	
AND PLAN	I OF CORRECTION	IDENTIFICATION NUMBER 151587	A. BUILDING B. WING	00	COMPLETED 11/09/2021	
NAME OF	PROVIDER OR SUPPLI	ER		ADDRESS, CITY, STATE, ZIP COD		
HEART	TO HEART HOSP	ICE OF CENTRAL INDIANA LLC		I BALDWIN AVE DN, IN 46952		
(X4) ID	SUMMAR	Y STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIE	ENCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLET	
TAG	REGULATORY O	OR LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
	patient records rev	viewed (#6).		pharmacy regulations and		
				accepted professional practic	e.	
	Findings Include:			The Chief Clinical Officer		
				(CCLO) provided in person		
		ed "Medication Disposal,"		education to all nursing staff	on	
	-	n Patient's death, medications		10/27/2021 on policies TX.18		
	-	f unless the family refuses		"Medication Possession and		
	Any unused medi	cations will not be returned"		Transportation",		
				Form-Medication		
		ed "Pharmacy Services,"		Transportation Log, HR.27		
		pharmaceutical needs of the		"Standard of Conduct", TX.01		
		are managed in a manner		"Standard of Practice", PE.05		
	-	plicable State and Federal laws		"Patient Care and Safety" RI.1	1	
	-	dards of practice Prescription		"IN Patient Rights and		
		ividual prescriptions are		Responsibilities", TX.16		
		n accordance with the state		"Medication Administration",		
		y regulations and contain		25-30 Article 23. Nurses, Article		
		e Prescribing physician's name		Indiana State Nurses Assistanc	e	
		gth of drug dose, method,		Program, Article 4 Advanced		
		administration lot and control		Nursing & Prescriptive Authority		
		ory and cautionary instructions		for Advanced Practice Nursing,		
	expiration date	···"		Article 5 Prescriptive Authority f	or	
	2 During an and	cy office tour on 10/22/21 at		Advanced Practice Nursing,		
	0 0	two door, off-white cabinet was		Article 2 Standards for the		
		nd to have multiple medications		Competent Practice Registered		
		ients' names on the medication		Licensed Practical Nursing, Arti 3 Nurse-Midwives, Title 848	cie	
	-	Dyno brand, laser label maker		Indiana State Board of Nursing		
		e placed on the side of cabinet		Central Indiana Plan of	,	
		area. The medications that were		Correction/Conditions of		
	•	tly included, a bottle with a		Participation/Indiana Hospice		
		ption label that had the name of		Regulations. <b>All nurses were</b>		
		d by a laser-printer label, which		emailed with read receipt the		
	-	as for "Michael," a bottle that		content of the education on		
		prescription label, but was		10/27/2021, as well as received	ч	
		er-printer label that indicated		a paper copy of all the materia		
		g narcotic pain medication],"		referenced. All nurses signed		
	-	-two small, white pills with an		off on the receipt of the		
		of the pill and a "2 [two]" on the		material provided & received		
		ttles of sterile water (used for		and a copy of the receipt was		

# DEPARTMENT OF HEALTH AND HUMAN SERVICES

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 151587	A. BUILDING B. WING	00	COMPLETED 11/09/2021	
	PROVIDER OR SUPPLIE	R CE OF CENTRAL INDIANA LLC	1385 N	ADDRESS, CITY, STATE, ZIP COD I BALDWIN AVE DN, IN 46952		
X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECT	ION (X5)	
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
	-	hat will be given by injection) in		placed in the employee f	ile	
	a clear bag with no	name on the label, two boxes		under section II. Those n	ot	
	of Narcan (treats n	arcotic overdose in an		present came into the off	fice	
	emergency situation	on) that were sealed with no		and received their one or	n one	
		em, ten suppositories of		training from the Area CI	inical	
		onstipation) in a clear bag with		manager (ACM), Area		
		iginal patient marked out, one		Executive Director (AED)	or	
	-	Biotene (treats dry mouth and		Regional VP of Clinical		
		Health branded unopened green		Operations (RVPCO). Tra	aining	
		es of bisacodyl (treats		was completed by 11/12/		
		no label on them, one orange		The Area Executive Direc	ctor	
		top with thirty small white		(AED) and Area Clinical		
	round pills that had	d an "EP904" scored into one		Manager (ACM) or design	nee	
	side with no patier	nt name on the label, one white		will audit 100%, for 3 mo	nths, of	
	unopened bottle of	f ferrous sulfate (treats iron		all Medication Transport	ation	
	deficiency anemia	), one orange bottle with a white		Logs which includes nan	ne and	
		e (used to treat excessive		location of pharmacy, da	te and	
		name on the prescription label		time received, medication	ns	
	that had thirty sma	ll white round pills in it, and		received (name, strength	, and	
	three packs of five	vials each of Albuterol		amount dispensed), emp	loyee	
		difficulty breathing, wheezing,		obtaining medication,		
	shortness of breath	n, coughing, and chest		medication was sealed, a	and	
		y lung diseases such as		stored appropriately, loc	ation	
	asthma and chroni	c obstructive pulmonary		medication delivered to,	name	
	disease).			of person receiving		
				medication, receiver to		
		ord of Patient #6 was reviewed		indicate if sealed properl	y and	
		5 PM and indicated a hospice		count of medication in		
		/7/21, with a primary diagnosis		presence of delivery pers		
		clerosis (thickening and		ensure proper medicatio		
	-	valls of the arteries in the brain).		transfer until 100% comp		
		ed a plan of care for the		is met. Ongoing the Area		
		10/7/21 to 1/4/22, which		Clinical Manager (ACM) of		
		r, but not limited to, "		designee will audit 10% o		
-		used to control symptoms		Medication Transportation	-	
		sorders of the gastrointestinal		through the QAPI proces		
		illigram] every 4 [four] hours		Trends identified during		
		or increased secretions" The		audits will be reviewed in		
		ned a document titled "Visit		no less than quarterly an		
	NI-4- David Walada	d 10/13/21, completed by		plan of correction and/or		

Event ID: PD1P11 Facility ID: 003966

If continuation sheet

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	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 151587	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION <u>00</u>	(X3) DATE SURVEY COMPLETED 11/09/2021
	PROVIDER OR SUPPLIE	R CE OF CENTRAL INDIANA LLC	1385 N	ADDRESS, CITY, STATE, ZIP COD I BALDWIN AVE DN, IN 46952	
(X4) ID PREFIX	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	
TAG	Registered Nurse J Type SN [skille Home Medicati narcotic/medicatio quantity how [Registered Nurse and relationship to authorized to dispo medications [R During an agency AM, a tall, two do observed and foun 20 doses of Ondan for Patient #6. Upo	n disposal type strength disposed RNCM Case Manager] Full name patient of person[s] legally use of controlled drugs and egistered Nurse J]" office tour on 10/22/21 at 10:00 or, off-white cabinet was d to have a clear bag with 19 of setron with a laser label made on peeling back the laser label, a	TAG	DEFICIENCY) training will be updated as indicated to ensure sustaine improvement.	DATE
S 0694	name of the prior p 5. During an interv when asked why a relabeled medicati Former Administra relabeled them, bu Patient Care Mana were needing to be them in [sic]." 418.106(e)(2)(i) LABEL DISPOSE	iew on 10/22/21 at 2:15 PM, nyone in the agency had ever ons or improperly labeled them, itor A indicated, "I have not t the count is right," and Former ger B indicated, "The meds destroyed. Some families bring			
Bldg. 00	controlled drugs hospice must hav procedures for th of controlled drug the time when co ordered the hosp Based on observat	on, record review, and	S 0694	The Executive Director (ED) be responsible to help ensu	re
	-	ice failed to ensure lisposed of properly for 6 of 30		all medications are destroyed properly according to agence	

TATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
ND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLE	ETED
		151587	B. WING		11/09/2021	
			STREE	T ADDRESS, CITY, STATE, ZIP COD		
IAME OF I	PROVIDER OR SUPPLIE	R	1385	N BALDWIN AVE		
IEART -	TO HEART HOSPI	CE OF CENTRAL INDIANA LLC	MARI	ON, IN 46952		
X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
REFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE
	patient records rev	iewed (#5, 7, 8, 9, 10, 11).		policy and pharmacy		
	•			regulations.		
	Findings include:			The Chief Clinical Officer		
	U			(CCLO) provided in person		
	1. A document title	ed "Medication Disposal,"		education to all nursing stat	fon	
		Patient's death, medications		10/27/2021 on policies TX.18		
	-	f unless the family refuses		"Medication Possession and		
	-	ations will not be returned"		Transportation",	<b>,</b>	
	They unused medie	ations will not be retained		Form-Medication		
	2 A document title	ed "Pharmacy Services,"		Transportation Log, HR.27		
		colled drugs are disposed of in		"Standard of Conduct", TX.	<b>h</b> 4	
		tate and Federal regulations				
	<u>^</u>	e		"Standard of Practice", PE.		
	-	ains current and accurate		"Patient Care and Safety" R	1.1	
		ipt and disposition of all		IN "Patient Rights and		
		. the pharmacist and registered		Responsibilities", TX.16		
	nurse dispose of th	e medications"		"Medication Administration	-	
				25-30 Article 23. Nurses, Arti		
		ed "Medication Administration		Indiana State Nurses Assista	nce	
	-	' indicated " The individual		Program, Article 4 Advanced		
	-	nedication/controlled drug is		Nursing & Prescriptive Author	-	
	-	owledge of disposal of		for Advanced Practice Nursin	g,	
	medications/contro	olled drugs"		Article 5 Prescriptive Authorit	y for	
				Advanced Practice Nursing,		
	4. A document title	ed "Medication Disposal,"		Article 2 Standards for the		
	indicated " Ager	ncy nurse will instruct the		Competent Practice Register	ed &	
	patient/caregiver in	n the proper technique for		Licensed Practical Nursing, A	rticle	
	disposal of discont	inued medication, including		3 Nurse-Midwives, Title 848		
	controlled drugs	. the caregiver legally		Indiana State Board of Nursir	ng,	
	authorized to dispo	ose of medications will be		Central Indiana Plan of		
	instructed in the fo	llowing procedure Take		Correction/Conditions of		
		or expired drugs out of their		Participation/Indiana Hospice		
		mix the drugs with an		Regulations. All nurses were		
		nce, like used coffee grounds		emailed with read receipt th		
		them in impermeable,		content of the education on		
	· ·	ners, such as empty cans or		10/27/2021, as well as receiv		
		her ensuring that the drugs are		a paper copy of all the mate		
		identally ingested by children		referenced. All nurses signe		
		hese containers in the outside		off on the receipt of the		
	-	ent's death, medications will be		material provided & receive	ч	
	-	the family refuses Any		and a copy of the receipt wa		

Event ID: PD1P11 Facility ID: 003966

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
ND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMP	LETED
		151587	B. W	ING		11/09	/2021
				STREET	ADDRESS, CITY, STATE, ZIP COD		
	PROVIDER OR SUPPLIE				BALDWIN AVE		
HEART	TO HEART HOSPI	CE OF CENTRAL INDIANA LLC		MARIO	N, IN 46952		
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 DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	unused medication	is will not be returned"			placed in the employee file		
					under section II. Those not		
		cy office tour on $10/22/21$ at			present came into the office		
		wo door, off-white cabinet was			and received their one on on	-	
		d to have multiple medications			training from the Area Clinic	al	
	-	ents' names on the medication			manager (ACM), Area		
		Dyno brand, laser label maker			Executive Director (AED) or		
		e placed on the side of cabinet			Regional VP of Clinical		
	-	area. The medications found			Operations (RVPCO). Training		
		ed to, lorazepam (treat anxiety			was completed by 11/12/202		
		ne sulfate extended release			On 11/2/2021, ACM provided		
		ping pain), diazepam (treats			education to Nursing Team of	on	
		e spasms), Oxycodone (treats			HCHB death note and		
		e pain), Dilaudid (relieves			discharge summary and how	v to	
		e pain), Norco (treats pain),			complete documentation of		
		pam, diphenhydramine,			medication destruction durir	-	
		etoclopramide; treats nausea			the death visit. It was identif	ied	
	and vomiting), and	l fentanyl (treats severe pain).			during the training the RN88		
					death visit was different from	n	
		ord of Patient #5 was reviewed			the SN88 death visit, which		
		5 PM and indicated a hospice			lead to discrepancy of		
		15/21, with a primary diagnosis			information provided on		
		lasm of colon (abnormal cells			medication destruction. Both		
		bly and destroy body tissue).			assessments were updated I	by	
		ed a plan of care for the			VP EMR Operations on		
		9/15/21 to 12/13/21, which			11/3/2021. Nursing Staff were		
		r, but not limited to, "Ativan			made aware they would need		
		ng [milligram] every 4 [four]			to complete an update to the		
	-	ded] for anxiety/restlessness			devices in order to receive the		
		o contained a document titled			updated death visit note. Fo		
	-	t," dated 9/24/21, completed by			Medication Transportation L	og	
	-	, which indicated, "Visit Type			was updated 11/3/2021. On		
	-	e] Hospice Death At Home			11/4/2021, ACM provided		
		dicate narcotic/medication			education to all Nursing staf	fof	
		strength quantity how			the changes made to the		
		epam 0.5 mg 12 tabs [tablets]			Medication Transportation L		
	"				they were all provided copies	S	
		office tour on 10/22/21 at 10:00			of the updated form and		
		or, off-white cabinet was			educated on how to properly	/	
	observed and foun	d to have an orange bottle with			complete form.		

# DEPARTMENT OF HEALTH AND HUMAN SERVICES

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 151587	(X2) MULTIPLE C A. BUILDING B. WING	<u>00</u>	(X3) DATE SURVEY COMPLETED 11/09/2021
	PROVIDER OR SUPPLIE	<sup>R</sup> CE OF CENTRAL INDIANA LLC	1385 N	ADDRESS, CITY, STATE, ZIP CO I BALDWIN AVE DN, IN 46952	DD
(X4) ID PREFIX TAG	(EACH DEFICIE) REGULATORY O a white top and tw	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION enty-five small white pills with a	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY) Area Executive Director	OULD BE PPROPRIATE COMPLETION DATE DATE
	<ul> <li>7. The clinical records on 10/22/21 at 1:30 election date of 7/10 of chronic obstruct group of progressiby increasing bread contained a plan of 7/16/21 to 10/13/2 not limited to, "4 severe pain] 2.5 [two every 2 [two] hour [shortness of bread contained a docum dated 10/9/21, con which indicated, " nurse] Hospice De Indicate narcotic/m strength quantit [Registered Nurse and relationship to authorized to disport for the surface of the disport of the of Oxycodor Patient #7.</li> <li>8. The clinical records on 10/22/21 at 1:33 election date of 5/7 squamous cell card in the surface of the and lining of the record contained the record contai</li></ul>	tion label made for Patient #5. ord of Patient #7 was reviewed 0 PM and indicated a hospice 16/21, with a primary diagnosis tive pulmonary disease (a ve lung disorders characterized thlessness). The record f care for the certification dates 1, which indicated orders for, but 0xycodone [treats moderate to wo and a half] mg [milligram] s PRN [as needed] for pain/sob h]" The record also tent titled "Visit Note Report," npleted by Registered Nurse J, Visit Type SN [skilled ath At Home Medications nedication disposal type y how disposed RNCM Case Manager] Full name patient of person[s] legally ose of controlled drugs and egistered Nurse J]" office tour on 10/22/21 at 10:00 or, off-white cabinet was d to have a brand new, sealed ne with a pharmacy label for ord of Patient #8 was reviewed 5 PM and indicated a hospice 7/21, with a primary diagnosis of tinoma of skin (cancer starting e skin, lining of hollow organs, spiratory and digestive tracts). red a plan of care for the 5/7/21 to 8/4/21, which		and Area Clinical Mana (ACM) or designee will 100% of all death discl monthly x 3 months un of compliance is met. focus on discharge su to ensure there is prop documentation of disp medication in the patie residence or education provided to authorize proper disposal. Once compliance has been consecutive months, t Area Clinical Manager designee will audit 10° discharge summaries sustained compliance Findings and action pl indicated) will be repo through QAPI at least quarterly. Trends identified durin audits will be reviewed no less than quarterly plan of correction and training will be update indicated to ensure su improvement.	I audit harges ntil 100% Audit will ummaries per bosal of ent's n was agent of e 100% met for 3 then the for % of all for lan (if these d in QAPI and the l/or ed as

State Form

PRINTED: 12/15/2021 FORM APPROVED

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 151587	JILDING	nstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 11/09/2021		
	NAME OF PROVIDER OR SUPPLIER HEART TO HEART HOSPICE OF CENTRAL INDIANA LLC		1385 N	DDRESS, CITY, STATE, ZIP CO BALDWIN AVE N, IN 46952	3, ZIP COD		
(X4) ID PREFIX		Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP	UT D BE	(X5) COMPLETI	
TAG		OR LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE	
	Morphine [used pain] 15 [fifteen] n hours PRN [as nee breath] Fentany every 72 [seventy- record also contain Note Report," data Registered Nurse 7 Type SN [skille Home Medicat narcotic/medicatio quantity how [eighteen] ml F Full name and r person[s] legally a	or, but not limited to, " to treat treats ongoing severe mg [milligram] every 2 [two] eded] for pain/sob [shortness of yl [treats severe pain] 50 mcg etwo] hours for pain" The ned a document titled "Visit ed 6/4/21, completed by K, which indicated, "Visit ed nurse] Hospice Death At ions Indicate on disposal type strength y disposed Morphine 18 Fentanyl 100 mcg #2 [sic] patches elationship to patient of nuthorized to dispose of nd medications [Patient #8's					
	AM, a tall, two do observed and foun sealed boxes of M unopened, sealed 1 pharmacy-made la 9. The clinical rec on 10/22/21 at 1:4 election date of 9/ of malignant neop (abnormal cells di body tissue). The for the certificatio	office tour on 10/22/21 at 10:00 or, off-white cabinet was d to contain two unopened, orphine and one box of Fentanyl patches, with a bel for Patient #8. ord of Patient #9 was reviewed 0 PM and indicated a hospice 11/21, with a primary diagnosis lasm of unspecified kidney vide uncontrollably and destroy record contained a plan of care n dates 9/11/21 to 12/9/21, which or, but not limited to, "					
	Oxycodone [trea [five] mg [milligra needed] for pain . to severe pain] 10 times daily for pai	ar, but not ninned to, tts moderate to severe pain] 5 am] every 4 [four] hours PRN [as Oxycodone [treats moderate [ten] mg [milligram] 2 [two] n" The record also contained "Visit Note Report," dated					

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 151587	A. BUII	X2) MULTIPLE CONSTRUCTION A. BUILDING D B. WING			(X3) DATE SURVEY COMPLETED 11/09/2021	
	NAME OF PROVIDER OR SUPPLIER HEART TO HEART HOSPICE OF CENTRAL INDIANA LLO							
(X4) ID PREFIX		' STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	P	ID REFIX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPI	LD BE	(X5) COMPLETIO	
TAG	REGULATORY C	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	OFRIATE	DATE	
TAG	<ul> <li>9/16/21, completed indicated, " Visi Hospice Death At Indicate narcotic/r strength quanti [Registered Nurse and relationship to authorized to dispumedications Op Oxycodone] 30 [th Oxycodone 20 [tw During an agency AM, a tall, two do observed and foun with a white cap w with an "OP" skete [forty]" on the oth orange bottle with capsules with "AN "167" printed on the pharmacy-made la 10. The clinical re on 10/22/21 at 1:4 election date of 7/ of malignant neop or lung (abnormal destroy body tissu of care for the cert 9/12/21, which ind to, " Fentanyl [t [twenty-five] mcg [seventy-two] hou</li> </ul>	d by Registered Nurse J, which t Type SN [skilled nurse] Home Medications nedication disposal type ty how disposed RNCM Case Manager] Full name patient of person[s] legally ose of controlled drugs and cyContin [brand name for hirty] mg 5 tabs [tablets] enty] mg 1 [one] tab" office tour on 10/22/21 at 10:00 or, off-white cabinet was d to contain one orange bottle rith small yellow, round pills ched on one side and a "40 er, of Oxycodone, and one a white cap, white and gold I'' printed on one side and ne other side, with a		TAG			DATE	
	dated 6/4/21, comp which indicated, " nurse] Hospice De Indicate narcotic/r strength quanti	pleted by Registered Nurse L, Visit Type SN [skilled ath At Home Medications nedication disposal type ty how disposed Fentanyl cg patch Destroyed in cat						

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 151587	(X2) MULTIPLE CO A. BUILDING B. WING	COM	(X3) DATE SURVEY COMPLETED 11/09/2021	
	PROVIDER OR SUPPLIE	R CE OF CENTRAL INDIANA LLC	1385 N	ADDRESS, CITY, STATE, ZIP C BALDWIN AVE N, IN 46952	COD	
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION SF CROSS-REFERENCED TO THE A DEFICIENCY)	N SHOULD BE COMPL	
	relationship to pat authorized to disp medications Da During an agency AM, a tall, two do observed and four sealed boxes of Fe pharmacy-made la 11. The clinical re on 10/22/21 at 1:5 election date of 7/ of personal history pancreas (abnorma and destroy body to plan of care for the 7/15/21, which ind to, " Hydromory relieves moderate [milligram] evon needed] for pain document titled "W completed by Reg indicated, " Visi Hospice Death At family educated of drugs and medicat facility protocol During an agency AM, a tall, two do observed and four with a white top the white pills with ar "p/d" etched on the pharmacy-made la 12. During an inter when asked if they from the metal cal	licy Full name and ient of person[s] legally ose of controlled drugs and aughter N law [sic]" office tour on 10/22/21 at 10:00 or, off-white cabinet was d to contain two unopened, entanyl patches, with a bel for Patient #10. cord of Patient #11 was reviewed 5 PM and indicated a hospice 15/21, with a primary diagnosis v of malignant neoplasm of al cells divide uncontrollably tissue). The record contained a e certification dates 4/17/21 to dicated orders for, but not limited ohone [brand name is Dilaudid; to severe pain] 8 [eight] mg ery 4 [four] hours PRN [as " The record also contained a 7/sit Note Report," dated 5/9/21, istered Nurse M, which t Type SN [skilled nurse] Home Medications Was n safe disposal of controlled ions? Disposed of per " office tour on 10/22/21 at 10:00 or, off-white cabinet was d to contain one orange bottle nat had small triangular-shaped a "8" etched on one side and a e other side, with a bel for Patient #11. rview on 10/22/21 at 1:35 PM, v had ever seen medications pinet in Former Patient Care , Registered Nurse I indicated,				

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 151587	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 11/09/2021	
	PROVIDER OR SUPPLIE	R CE OF CENTRAL INDIANA LLC	1385 N	ADDRESS, CITY, STATE, ZIP COD I BALDWIN AVE DN, IN 46952		
(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 APPROPRI DEFICIENCY)	ATE CC	(X5) DMPLETION DATE
S 0700 Bldg. 00	manager's office. T are partially used r never used the part 13. During an inter- when asked why a relabeled medicati- Former Administra relabeled them, bu Patient Care Mana were needing to be them in [sic]." Wh not been destroyed Former Administra Manager B, and A not know." 418.106(e)(3)(ii) LABEL DISPOSE (ii) Discrepancies dispensing, admi of controlled drug immediately by th administrator and the appropriate S account of the im- available to State required by law o Based on observat interview, the hosp discrepancies for c immediately inves administrator for 2	view on 10/22/21 at 2:15 PM, nyone in the agency had ever ons or improperly labeled them, itor A indicated, "I have not it the count is right," and Former ger B indicated, "The meds destroyed. Some families bring en asked why medications had in the patients' homes, itor A, Former Patient Care rea Manager N indicated, "I do E STORAGE DRUGS in the acquisition, storage, nistration, disposal, or return is must be investigated the pharmacist and hospice where required reported to tate authority. A written vestigation must be made and Federal officials if r regulation. on, record review, and ice failed to ensure a ontrolled drugs were igated by the pharmacist and/or 3 of 30 patient records reviewed 12, 13, 14, 15, 16, 17, 18, 19, 21, 22,	S 0700	The Executive Director (ED) be responsible to help ensu the pharmacist and administrator according to agency policy and pharmac regulations immediately investigate all discrepancies for controlled drugs. The Chief Clinical Officer (CCLO) provided in person education to all nursing staf	re y s	2/08/202

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 151587	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 11/09/2021	
	PROVIDER OR SUPPLIE	R CE OF CENTRAL INDIANA LLC	1385	T ADDRESS, CITY, STATE, ZIP CC N BALDWIN AVE ON, IN 46952	DD	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AF	ECTION DULD BE	(X5) COMPLETI
TAG	REGULATORY C	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE
	family has [sic] the hospice will ensur- involving misa- by anyone furnish hospice, are report employees and con administrator T investigate all alle furnishing services	indicated " Every patient and e right To be assured that the e that all alleged violations opropriation of patient property ng services on behalf of the ed immediately by hospice heracted staff to the hospice he hospice will immediately ged violations involving anyone is on behalf of the hospice and ake action to prevent further		"Medication Possession Transportation", Form-Medication Transportation Log, HI "Standard of Conduct" "Standard of Practice" "Patient Care and Safe IN "Patient Rights and Responsibilities", TX.1 "Medication Administr 25-30 Article 23. Nurses	R.27 ', TX.01 ', PE.05 ety"; RI.1 I6 ation", IC	
	potential violation investigated Th action in accordan the hospice admin verified violations local bodies [sic] i of the violations	s while the alleged [sic] is being e hospice will take appropriate ce with state laws as verified by stration and ensure that are reported to the State and mmediately of becoming aware		Indiana State Nurses As Program, Article 4 Adva Nursing & Prescriptive A for Advanced Practice N Article 5 Prescriptive Au Advanced Practice Nurs Article 2 Standards for t Competent Practice Res Licensed Practical Nurs	ssistance anced Authority Nursing, uthority for sing, the gistered &	
	indicated "Upor will be disposed of Any unused medic	Patient's death, medications funless the family refuses ations will not be returned" ed "Occurrence/Incident		3 Nurse-Midwives, Title Indiana State Board of I Central Indiana Plan of Correction/Conditions o Participation/Indiana Ho	848 Nursing, f	
	Reporting," indicated "Agency will document and report all occurrences/incidents safety hazards, employee unprofessional and misconduct that deviate from the Agency operations and might result in injury or potential harm to a patient/caregiver or Agency staff Adverse Events include, but are not limited to provision of care errors procedure error which results in trauma and/or injury, falls, medication errors unusual occurrences/incidents safety hazards that endanger staff and/or patients unprofessional conduct by licensed staff and employee misconduct of unlicensed staff including abuse, neglect, and misconduct		Regulations. All nurses emailed with read rece content of the education 10/27/2021, as well as a a paper copy of all the referenced. All nurses off on the receipt of the material provided & receipt and a copy of the receipt placed in the employed under section II. Those present came into the and received their one training from the Area	e were ipt the on on received material signed e ceived ipt was e file e not office on one		

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 151587	(X2) MULTIPLE C A. BUILDING B. WING	00	X3) DATE SURVEY COMPLETED 11/09/2021	
	PROVIDER OR SUPPLIE TO HEART HOSPI	R CE OF CENTRAL INDIANA LLC	1385 N	ADDRESS, CITY, STATE, ZIP COD N BALDWIN AVE DN, IN 46952		
(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 APPROPRI, DEFICIENCY)	ATE (X5) COMPLET DATE	
	<ul> <li>Procedure An O be completed on a defined in policy, the first person to The report will be supervisor super document awarened to management an 4. A document titt indicated " Discussionage, dispensing return of controlle immediately by the administrator a discrepancy is con 5. A document titt and Management, physician and Age be notified regardi soon as possible be documented on submitted to Agen immediately"</li> <li>6. A document titt Administrator," in Administrator will and authority for a functions, supervise organizational plan communication will and supervising the provide the provident of the functions of the A supervising the provide the provident of the functions of the A supervising the provident of the provident</li></ul>	Decurrence/Incident Report will Il occurrences or incidents as by the staff member involved or become aware of the incident e submitted to the immediate rvisor will reviewwill ess report will be forwarded d the QAPI committee led "Pharmacy Services," repancies in the acquisition, g, administration, disposal, or d drugs are investigated e pharmacist and hospice written report of the		Manager (ACM), Area Executive Director (AED) or Regional VP of Clinical Operations (RVPCO). Traini was completed by 11/12/202 Education was provided by Regional VP of Clinical Operations (RVPCO) to the Executive Director (ED) and Alternate Executive Director 12/08/2021 on the policy LD. "Responsibilities of the Administrator" to include bu not limited to conflict and complaint management as v as communicating with the governing board and all of agency staff regarding occurrences and incidents to include but not limited to discrepancies for controlled drugs. On 11/2/2021, ACM provided education to Nursi Team on HCHB death note at discharge summary and how complete documentation of medication destruction duri the death visit. It was identifi during this training the RN8 death visit was different from the SN88 death visit, which lead to discrepancy of information provided on medication destruction. Bot assessments were updated VP EMR Operations 11/3/202 Nursing Staff were made aware they would need to complete an update to their devices in order to receive t	ing 1. the the on 5 ut vell o i ng ind w to ng iied 8 m h by 21.	

PRINTED: 12/15/2021 FORM APPROVED

# DEPARTMENT OF HEALTH AND HUMAN SERVICES

NTERS FO	VTERS FOR MEDICARE & MEDICAID SERVICES				OMB NO. 0938-039
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 151587	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(x3) date survey completed 11/09/2021
	PROVIDER OR SUPPLIE	CE OF CENTRAL INDIANA LLC	1385 N	ADDRESS, CITY, STATE, ZIP COD I BALDWIN AVE DN, IN 46952	
(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 APPROPR	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
		nclude, but not be limited to		updated death visit note. F	orm
	-	cation, evaluations, and		Medication Transportation	Log
		licable regulations to all Agency		was updated on 11/3/2021.	On
	-	completion, maintenance, and		11/4/2021, ACM provided	
	-	ired reports Directing staff		education to all Nursing sta	ff of
	-	e of their duties including		the changes made to the	
		ge, transfer, revocation, and		Medication Transportation	-
	-	es to patients Ensuring		nursing staff were all provid	
		l business and clinical practice		copies of the updated form	
	are maintained'	1		educated on how to proper	-
				complete form. On 12/9/202	
		cy office tour on $10/22/21$ at		ACM and RVPCO educated	staff
		0 AM, a tall, two door, off-white cabinet was		on Policy EC.5	
		d to have multiple medications	e medication Reporting; an r label maker "Reporting/Fo	"Occurrence/Incident	
	-	ents' names on the medication		Reporting; and TX.21	
		Dyno brand, laser label maker		"Reporting/Follow-Up of	
		e placed on the side of cabinet		Medication Incidents".	
	-	area. The medications found			
		ed to, lorazepam (treat anxiety		The Area Executive Directo	
		ne sulfate extended release		(AED) /Area Clinical Manage	
		bing pain), diazepam (treats		(ACM) or designee will audi	
		e spasms), Oxycodone (treats		100% of all death discharge	
		e pain), Ondansetron (prevents		Medication Transportation	-
		ng), Dilaudid (relieves moderate		and all occurrences/medica	
		orco (treats pain), ABHR gel		incidents monthly for 3 mon	
		nhydramine, haloperidol, and		until 100% of compliance is	
	_	reats nausea and vomiting),		met. Audit will focus on	
	fentanyl (treats sev	vere pain).		discharge summaries to en	
	8 The aliniaal read	ord of Patient #5 was reviewed		there is proper documentat	
				of disposal of medication ir patient's residence or	
	on 10/22/21 at 1:15 PM. The record contained a document titled "Visit Note Report," dated			1.	
		d by Registered Nurse I, which		education was provided to	
	· •	t Type SN [skilled nurse]		authorize agent of proper	
		Home Medications		disposal. Audit will also for	
	-	nedication disposal type		on Medication Transportation	
		ty how disposed		Logs which includes name	
		g 12 tabs [tablets]" The		location of pharmacy, date	anu
		dicate how the narcotics were		time received, medications	nd
		neare now the harcoulds were		received (name, strength, a	
	disposed.			amount dispensed), employ	ree

State Form

Event ID: PD1P11 Facility ID: 003966 If continuation sheet Page 70 of 80

PRINTED: 12/15/2021

FORM APPROVED

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 151587	(X2) MULTIPLE C A. BUILDING B. WING	construction 00	СОМ	(X3) DATE SURVEY COMPLETED 11/09/2021	
	PROVIDER OR SUPPLIE	R CE OF CENTRAL INDIANA LLC	1385 N	° ADDRESS, CITY, STATE, ZIP N BALDWIN AVE ON, IN 46952	COD		
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	RRECTION SHOULD BE APPROPRIATE	(X5) COMPLETIC DATE	
	<ul> <li>9. The clinical records on 10/22/21 at 1:2 document titled "V 10/13/21, complete indicated, " Visit Hospice Death At Indicate narcotic/m strength quantitie [Registered Nurse and relationship to authorized to disport failed to inderect quantity of the nark were disposed.</li> <li>10. The clinical rection on 10/22/21 at 1:3 a document titled "10/9/21, completed indicated, " Visit Hospice Death At Indicate narcotic/m strength quantitie [Registered Nurse and relationship to authorized to disposed.</li> <li>10. The clinical rection on 10/22/21 at 1:3 a document titled "10/9/21, completed indicated, " Visit Hospice Death At Indicate narcotic/m strength quantitie [Registered Nurse and relationship to authorized to disport failed to inderect quantity of the nark were disposed.</li> <li>11. The clinical rection on 10/22/21 at 1:3 Note Report," date Registered Nurse I Type SN [skille Home Medications</li> </ul>	ord of Patient #6 was reviewed 5 PM. The record contained a Visit Note Report," dated ed by Registered Nurse J, which a Type SN [skilled nurse] Home Medications nedication disposal type ty how disposed RNCM Case Manager] Full name patient of person[s] legally ose of controlled drugs and egistered Nurse J]" The dicate the type, strength, cotics disposed and how they cord of Patient #7 was reviewed 0 PM. The record also contained 'Visit Note Report," dated d by Registered Nurse J, which a Type SN [skilled nurse] Home Medications nedication disposal type ty how disposed RNCM Case Manager] Full name o patient of person[s] legally ose of controlled drugs and egistered Nurse J]" The licate the type, strength, cotics disposed and how they		obtaining medication medication was sealed stored appropriately, medication delivered of person receiving medication, receiver indicate if sealed pro- count of medication presence of delivery ensure proper medication transfer. Occurrence medication incidents audited to ensure if a discrepancy is noted occurrence or incide completed and the pl and administrator was immediately for invest and that appropriate to State authorities of per requirement. On Area Clinical Manage designee will audit 11 death discharges, Me Transportation Logs occurrences/medication incidents through the process. Trends identified dur audits will be review no less than quarter plan of	ed, and , location I to, name to perly and in person to cation s and/or s and/or s will be a l, an ont is harmacy ere notified stigation, reporting occurred going the er (ACM) or 0% of the edication and tion e QAPI ring these ed in QAPI		

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 151587	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		COM	(X3) DATE SURVEY COMPLETED 11/09/2021	
	NAME OF PROVIDER OR SUPPLIER HEART TO HEART HOSPICE OF CENTRAL INDIANA LLC		1385 N	ADDRESS, CITY, STATE, ZIP BALDWIN AVE N, IN 46952	COD		
(X4) ID PREFIX TAG	(EACH DEFICIE	' STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION) CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETI DATE	
	<ul> <li>[eighteen] ml F</li> <li> Full name and r</li> <li>person[s] legally a</li> <li>controlled drugs a</li> <li>husband] The</li> <li>type, strength, qua</li> <li>and how they were</li> <li>12. The clinical re</li> <li>on 10/22/21 at 1:4</li> <li>document titled "V</li> <li>9/16/21, completed</li> <li>indicated, " Visi</li> <li>Hospice Death At</li> <li>Indicate narcotic/r</li> <li>strength quanti</li> <li>[Registered Nurse</li> <li>and relationship to</li> <li>authorized to disposed</li> <li>medications Op</li> <li>Oxycodone] 30 [th</li> <li>Oxycodone] 30 [th</li> <li>Oxycodone 20 [tw</li> <li>record failed to ine</li> <li>disposed.</li> <li>13. The clinical re</li> <li>on 10/22/21 at 1:5</li> <li>document titled "V</li> <li>completed by Reg</li> <li>indicated, " Visi</li> <li>Hospice Death At</li> <li>family educated on</li> <li>drugs and medicati</li> <li>facility protocol</li> <li>the type, strength,</li> <li>disposed and how</li> <li>14. The chart of Participation</li> </ul>	<ul> <li>disposed Morphine 18</li> <li>entanyl 100 mcg #2 [sic] patches</li> <li>elationship to patient of uthorized to dispose of and medications [Patient #8's record failed to indicate the ntity of the narcotics disposed e disposed.</li> <li>cord of Patient #9 was reviewed 0 PM. The record contained a Visit Note Report," dated d by Registered Nurse J, which t Type SN [skilled nurse] Home Medications nedication disposal type ty how disposed RNCM Case Manager] Full name o patient of person[s] legally ose of controlled drugs and tyContin [brand name for nirty] mg 5 tabs [tablets] renty] mg 1 [one] tab" The dicate how the narcotics were</li> <li>cord of Patient #11 was reviewed 5 PM. The record contained a Visit Note Report," dated 5/9/21, istered Nurse M, which t Type SN [skilled nurse] Home Medications Was n safe disposal of controlled ions? Disposed of per " The record failed to indicate quantity of the narcotics they were disposed.</li> </ul>					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER 151587	(X2) MULTIPLE C A. BUILDING B. WING	COM	(X3) DATE SURVEY COMPLETED 11/09/2021	
	NAME OF PROVIDER OR SUPPLIER HEART TO HEART HOSPICE OF CENTRAL INDIANA LLC (X4) ID SUMMARY STATEMENT OF DEFICIENCIE		STREET ADDRESS, CITY, STATE, ZI 1385 N BALDWIN AVE MARION, IN 46952		, COD	
(X4) ID PREFIX TAG	(EACH DEFICIE	/ STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE / DEFICIENCY)	HOULD BE	(X5) COMPLETIC DATE
	Nurse O, indicated nurse] Hospice De Was family/caregi disposal of control Disposed of per fa failed to indicate t the narcotics dispo- disposed. 15. The chart of Pe 10/22/21 at 6:05 P Report," dated 6/1 Nurse G, indicated nurse] Hospice De Indicate narcotic/r strength quanti Morphine Concen pain] 30 [thirty] m anxiety disorders] [sixteen] tabs [tab] relationship to pat authorized to disp medications Pt Nurse G]" The and strength of the they were disposed 16. The chart of Pe 10/22/21 at 6:10 P Report," dated 8/3 Practical Nurse P, [skilled nurse] Ho Medications W instructed on safe and medications? protocol" The r	atient #14 was reviewed on M. A document titled "Visit Note 0/21, completed by Licensed indicated, "Visit Type SN spice Death At Home as family/caregiver[s] disposal of controlled drugs Disposed of per facility record failed to indicate the type, of the narcotics disposed and				

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 151587	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING				(X3) DATE SURVEY COMPLETED 11/09/2021	
NAME OF PROVIDER OR SUPPLIER HEART TO HEART HOSPICE OF CENTRAL INDIANA LLC		STREET ADDRESS, CITY, STATE, ZIP COD 1385 N BALDWIN AVE MARION, IN 46952						
(X4) ID PREFIX		Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	II PRE	) EFIX	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE J DEFICIENCY)	HOULD BE	(X5) COMPLET	
	10/22/21 at 6:15 P Report," dated 6/3 Nurse I, indicated, nurse] Hospice De Indicate narcotic/r strength quanti Morphine [treats ss [twenty-eight] ml anxiety disorders] [fifteen] tabs [tabl relationship to pat authorized to disp medications [P record failed to ind destroyed in the he 18. The chart of P 10/22/21 at 7:45 P Report," dated 6/1 Nurse G, indicated nurse] Hospice De Indicate narcotic/r strength quanti Morphine Concen pain] 27 [twenty-ss [treats anxiety dise [tablets] Full na person[s] legally a controlled drugs a hospice nurse" type and strength of how they were dise 19. The chart of P	atient #16 was reviewed on M. A document titled "Visit Note 8/21, completed by Registered 1, "Visit Type SN [skilled eath At Home Medications nedication disposal type ty how disposed trate [treats severe ongoing even] ml [milliliter] and Ativan orders]18 [eighteen] tabs me and relationship to patient of uthorized to dispose of nd medications wife and The record failed to indicate the of the narcotics disposed and posed.						
	Report," dated 6/1 Nurse K, indicated nurse] Hospice De	M. A document titled "Visit Note 7/21, completed by Registered d, "Visit Type SN [skilled eath At Home Medications nedication disposal type						

STATEMENT OF DEFICIENCIES       X1) PROVIDER/SUPPLIER/CLIA         AND PLAN OF CORRECTION       IDENTIFICATION NUMBER         151587         NAME OF PROVIDER OR SUPPLIER         HEART TO HEART HOSPICE OF CENTRAL INDIANA LLC		IDENTIFICATION NUMBER	(X2) MULTIPL A. BUILDING B. WING	e construction g <u>00</u>	CON	(X3) DATE SURVEY COMPLETED 11/09/2021	
		138	eet address, city, stat 5 N BALDWIN AVE RION, IN 46952	E, ZIP COD			
(X4) ID PREFIX		Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	X (EACH CORRECTIVE A	TO THE APPROPRIATE	(X5) COMPLETIC	
TAG	strength quanti Morphine Concen pain] 27 [twenty-s [treats anxiety disc [milligram] 18 [ei, Full name and rela legally authorized and medications . " The record fai strength of the nar were disposed. 20. The chart of P 10/22/21 at 6:25 P Report," dated 7/6 Nurse Q, indicated nurse] Hospice De Indicate narcotic/r strength quanti Morphine [treats [twenty] ml [milli anxiety disorders] Full name and rela legally authorized and medications . " The record fai the narcotics dispo 21. The chart of P 10/22/21 at 6:30 P Report," dated 9/1 Practical Nurse R, [skilled nurse] Ho Medications In disposal type . disposed Morp ongoing pain] I patient of person[s of controlled drug	OR LSC IDENTIFYING INFORMATION         ty how disposed         trate [treats severe ongoing         even] ml [milliliter] and Ativan         orders] 0.5 [one-half] mg         ghteen] = [sic] 26 [twenty-six]         ationship to patient of person[s]         to dispose of controlled drugs         [Patient #17's granddaughter]         led to indicate the type and         cotics disposed and how they         atient #18 was reviewed on         PM. A document titled "Visit Note         /21, completed by Registered         d, "Visit Type SN [skilled         eath At Home Medications         medication disposal type         ty how disposed         severe ongoing pain] 20         liter]/ml and Ativan [treats         0.5 [one-half] mg [milligram]         ationship to patient of person[s]         to dispose of controlled drugs         [Patient #18's daughter in law]         led to indicate the quantity of         osed.         atient #19 was reviewed on         M. A document titled "Visit Note         6/21, completed by License         indicate, "Visit Type SN         spice Death At Home         dicate narcotic/medication <th>TAG</th> <th></th> <th></th> <th>DATE</th>	TAG			DATE	

AND PLAN OF CORRECTION IDENTIFIE		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 151587	(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION 00	CON	(X3) DATE SURVEY COMPLETED 11/09/2021	
NAME OF PROVIDER OR SUPPLIER HEART TO HEART HOSPICE OF CENTRAL INDIANA LLC			STREET A 1385 N MARION	D	•		
(X4) ID PREFIX	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APF DEFICIENCY)	ULD BE	(X5) COMPLETI	
TAG		R LSC IDENTIFYING INFORMATION ntity of the narcotics disposed e disposed.	TAG			DATE	
	10/22/21 at 6:45 P Report," dated 8/1 Nurse I, indicated, nurse] Hospice De Indicate narcotic/r strength quanti Morphine [treats s [twenty] mg [milli Lorazepam [treats mg Full name a person[s] legally a controlled drugs at	atient #21 was reviewed on M. A document titled "Visit Note 0/21, completed by Registered "Visit Type SN [skilled ath At Home Medications nedication disposal type y how disposed evere ongoing pain] 20 gram]/ml [milliliter] and anxiety disorders] 0.5 [one half] nd relationship to patient of uthorized to dispose of nd medications [Patient #21's record failed to indicate the cotics destroyed.					
	10/22/21 at 6:50 P Report," dated 6/3 Nurse S, indicated nurse] Hospice De Indicate narcotic/r strength quanti Morphine [treats s ml [milliliter] and disorders] 0.5 [one [twenty-four] tabs relationship to pat authorized to dispu- medications [P record failed to ine destroyed and thei 24. The chart of Pa	Attient #22 was reviewed on M. A document titled "Visit Note 0/21, completed by Registered ,"Visit Type SN [skilled ath At Home Medications hedication disposal type y how disposed evere ongoing pain] 15 [fifteen] Lorazepam [treats anxiety e half] mg [milligram] 24 [tablets] Full name and ent of person[s] legally ose of controlled drugs and attient #22's daughter]" The licate how the narcotics were r strength.					
	Report," dated 9/2	/21, completed by Registered I, " Visit Type SN [skilled					

AND PLAN OF CORRECTION IDENTIFICATION NUMBER 151587 NAME OF PROVIDER OR SUPPLIER HEART TO HEART HOSPICE OF CENTRAL INDIANA LLC			(X2) MULTIPLE C A. BUILDING B. WING	construction 00	COM	X3) DATE SURVEY COMPLETED 11/09/2021	
			1385 N	ADDRESS, CITY, STATE, ZIP N BALDWIN AVE ON, IN 46952	COD	D	
(X4) ID PREFIX		Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	SHOULD BE	(X5) COMPLETI	
TAG	REGULATORY O	DR LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	EAPPROPRIATE	DATE	
	Indicate narcotic/r strength quanti Morphine Concen pain] 25 [twenty-f [treats anxiety dise [milligram] 45 [fo name and relation legally authorized and medications indicate the type a disposed and how 25. The chart of P 10/22/21 at 7:00 F Report," dated 7/1 Nurse L, indicated nurse] Hospice Do Indicate narcotic/r strength quanti Kit Full name a person[s] legally a controlled drugs a niece]" The rec strength, and quart 26. The chart of P 10/22/21 at 7:10 F Report," dated 8/2 Nurse S, indicated nurse] Hospice Do Indicate narcotic/r strength quanti Morphine [treats s ml [milliliter] and disorders] 0.5 [on	eath At Home Medications nedication disposal type ty how disposed trate [treats severe ongoing ive] ml [milliliter] and Ativan orders] 0.5 [one half] mg rty-five] tabs [tablets] Full ship to patient of person[s] to dispose of controlled drugs Wife" The record failed to and strength of the narcotics they were disposed. atient #24 was reviewed on PM. A document titled "Visit Note 5/21, completed by Registered A, "Visit Type SN [skilled eath At Home Medications nedication disposal type ty how disposed Comfort nd relationship to patient of suthorized to dispose of nd medications [Patient #24's cord failed to indicate the type, tity of the narcotics disposed. atient #25 was reviewed on PM. A document titled "Visit Note /21, completed by Registered atient #25 was reviewed on PM. A document titled "Visit Note /21, completed by Registered I, "Visit Type SN [skilled eath At Home Medications nedication disposal type ty how disposed we evere ongoing pain] 15 [fifteen] Lorazepam [treats anxiety e half] mg [milligram] 6 [six]					
	Full name and rela legally authorized and medications.	ationship to patient of person[s] to dispose of controlled drugs [Patient #25's daughter]" to indicate how the narcotics					

	R MEDICARE & MEDI						OMB NO. 0938-0	
	NT OF DEFICIENCIES OF CORRECTION	x1) provider/supplier/clia identification number 151587	r í	JILDING	NSTRUCTION	CON	(X3) DATE SURVEY COMPLETED 11/09/2021	
	PROVIDER OR SUPPLIE	R CE OF CENTRAL INDIANA LLC		1385 N E	ddress, city, state, zip ( BALDWIN AVE I, IN 46952	COD		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE	HOULD BE	(X5) COMPLETI	
TAG	REGULATORY C were destroyed.	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	10/22/21 at 7:15 P Report," dated 5/3 Nurse G, indicated nurse] Hospice De Indicate narcotic/m strength quantit Morphine Concern pain] 24 [twenty-fr anxiety disorders] [twenty-three] tabs severe pain] 25 [tw [quantity of one] patient of person[s of controlled drugs	Atient #26 was reviewed on M. A document titled "Visit Note 0/21, completed by Registered 1, "Visit Type SN [skilled ath At Home Medications hedication disposal type y how disposed rate [treats severe ongoing bur] ml [milliliter], Ativan [treats 0.5 [one half] mg [milligram] 23 is [tablets], Fentanyl [treats wenty-five] mcg [micrograms] X1 Full name and relationship to ] legally authorized to dispose is and medications Disposed he record failed to indicate how disposed.						
	on 10/22/21 at 7:2 document titled "V 10/11/21, complet indicated, " Visit Hospice Death At family educated on drugs and medicat facility protocol the type, strength,	cord of Patient #27 was reviewed 0 PM. The record contained a Visit Note Report," dated ed by Registered Nurse F, which : Type SN [skilled nurse] Home Medications Was a safe disposal of controlled ions? Disposed of per ." The record failed to indicate quantity of the narcotics they were disposed.						
	10/22/21 at 7:25 P Report," dated 6/1 Nurse K, indicated nurse] Hospice De Indicate narcotic/n strength quantit	Atient #28 was reviewed on M. A document titled "Visit Note 7/21, completed by Registered I, "Visit Type SN [skilled ath At Home Medications hedication disposal type y how disposed tended release; treats severe						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 151587	(X2) MULTIPLE C A. BUILDING B. WING	COM	(X3) DATE SURVEY COMPLETED 11/09/2021	
	PROVIDER OR SUPPLIE	R CE OF CENTRAL INDIANA LLC	1385 N	ADDRESS, CITY, STATE, ZIP N BALDWIN AVE DN, IN 46952	COD	
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THI DEFICIENCY)	I SHOULD BE E APPROPRIATE	(X5) COMPLETIC DATE
	Morphine 15 [fifted [treats anxiety disa [milligram] 6 [six] Oxycodone [treats [one hundred twert relationship to patt authorized to disposed authorized to disposed 30. The chart of Patting 10/22/21 at 7:30 P Report," dated 9/1 Nurse L, indicated nurse] Hospice Dec Indicate narcotic/r strength quantit Morphine [treats st anxiety] Full nat person[s] legally at controlled drugs at The record failed th and quantity of the 31. During an inter when asked if they from the metal calt Manger B's office, "We do have an er manager's office," are partially used the never used the part 32. During an inter when asked why m destroyed in the part Administrator A, I	thirty] 59 [fifty-nine] en] mg 86 [eighty-six] Ativan orders] 0.5 [one-half] mg   Ativan 1 [one] mg 7 [seven] ats severe pain] 5 [five] mg 120 tty] Full name and ient of person[s] legally ose of controlled drugs and atient #28's son]" The record he type and strength of the and how they were disposed. atient #29 was reviewed on M. A document titled "Visit Note 9/21, completed by Registered d, " Visit Type SN [skilled eath At Home Medications nedication disposal type ty how disposed evere pain] and Ativan [treats ame and relationship to patient of uthorized to dispose of nd medications " [sic]" to indicate the type, strength, e narcotics disposed. rview on 10/22/21 at 1:35 PM, v had ever seen medications binet in Former Patient Care . Registered Nurse I indicated, nergency supply in the There is no sign out sheet. There mediations in there, but I've tial ones."				

	EPARTMENT OF HEALTH AND HUMAN SERVICES ENTERS FOR MEDICARE & MEDICAID SERVICES							
	STATEMENT OF DEFICIENCIES       X1) PROVIDER/SUPPLIER/CLIA         AND PLAN OF CORRECTION       IDENTIFICATION NUMBER         151587				NSTRUCTION 00	(X3) DATE COMPL 11/09/	ETED	
	ROVIDER OR SUPPLIEF	E OF CENTRAL INDIANA LLC		1385 N	ADDRESS, CITY, STATE, ZIP COD BALDWIN AVE N, IN 46952			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE		

