PRINTED: 08/08/2017 FORM APPROVED

	MEDICARE & MEDIC	_			OMB NO. 0938-0391	
STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED	
		151511	B. WING		07/05/2017	
	ROVIDER OR SUPPLIER		950 NO	ADDRESS, CITY, STATE, ZIP CODE PRTH MERIDIAN STREET, SUI APOLIS, IN 46204	TE 700	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE	
L 0000						
Bldg. 00	complaint invest	ber: IN00225849; efficiencies cited.	L 0000			
	Facility #: 1515  Medicaid #: 200					
		une 26, 27, 28, July 5;				
	_	e site location in fering inpatient services ce with 42 CFR 418.110.				
L 0503 Bldg. 00	requirements of si chapter regarding					

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

(X6) DATE

Any defiencystatement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

TITLE

PRINTED: 08/08/2017 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING 00 COMPLETED 151511 B. WING 07/05/2017 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 950 NORTH MERIDIAN STREET, SUITE 700 INDIANA UNIVERSITY HEALTH HOSPICE INDIANAPOLIS, IN 46204 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG  $\mathsf{TAG}$ information to the patient concerning its policies on advance directives, including a description of applicable State law. Summary statement: The L 0503 08/05/2017 patients will receive the Indiana Based on document review and policy State Department of Health review the agency failed to provide Advance Directive Guide in their updated written information to patients agency admission packet provided at the time of admission. regarding advance directives for 1 of 1 agency. **Action Plan:** Findings include: 1. The Agency has replaced the Advance Directive Forms in Agency's admission packet with 1. The agency provided a hospice The Indiana State Department of admission packet to surveyor on 6/28/17 Health updated and revised at 2:45 PM Advance Directive Packet. 2.Provide Staff education before August 5, 2017, around 2. The Indiana State Department of the Advance Directive Packet and Health Advance Directives guide was in the need to replace in current the admission packet which indicated admission packets and distribute dates, "March 1999 Revised May 2004." to current patients. This education, provided via written educational materials and 3. The Indiana State Department of interactive discussion of the Health had an updated and revised materials with clinical team Advance Directives packet dated July members, is scheduled for completion by 8-5-17. 2013 which is the current Advance 1.Education and Directives packet to be given to patients. discussion at each region The agency admission packet failed to location's staff meeting and evidence the most recent Advance completed by August 5th. Directives packet given to patients. 4. The agencies policy titled **Prevention Plan:** "PATIENT'S RIGHTS AND ·The Agency's Clinical Director RESPONSIBILITIES," Policy #:

EBR.P10 revised February 2015 stated

will annually review for any

revisions and/or updates to the

PRINTED: 08/08/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 151511		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY  COMPLETED  07/05/2017	
	PROVIDER OR SUPPLIER  UNIVERSITY HEALTH HOSPICE	950 NO	ADDRESS, CITY, STATE, ZIP CODE ORTH MERIDIAN STREET, SUIT APOLIS, IN 46204	「E 700	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE	
L 0512 Bldg. 00	"Procedures: D 18. Receive written information about Advance Directives."  5. The agencies Job description titled "Director-Statewide Clinical Home Health and Hospice," dated April 14, 2016 stated, "Incumbent is responsible for maintaining compliance in process, policy and service for all Statewide Homecare and Hospice activities Acts as the CMS [Centers for Medicaid and Medicare] Administrator for Home Health and Hospice."  418.52(c)(1) RIGHTS OF THE PATIENT The patient has a right to the following: (1) Receive effective pain management and symptom control from the hospice for conditions related to the terminal illness;  Based on record review, policy review, and interview the agency failed to provide effective pain management and	L 0512	Indiana State Department of Health Advance Directive Guid The Clinical Director will be responsible for monitoring thes corrective actions to ensure the this deficiency is corrected and will not recur.  Completion Date: August 5 2017  Summary statement: The patients will receive effective pranagement and symptom control from the hospice for conditions related to the termine.	de. se at d d d d d d d d d d d d d d d d d d	
	symptom control for 3 of 10 records reviewed (#1, 2, 9).		illness. Action Plan:		
	Findings include:  1. The clinical record of patient #1 was reviewed and indicated a start of care date of 2/2/17. The record contained a plan of care dated 2/2/17-5/2/17, which		1.Policies CES.P10 Pain and Symptom Management and BR.P10 Patient Rights and Responsbilities were reviewed and no changes were recommended for this policy.		

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

Event ID:

URIR11

Facility ID: 005128

If continuation sheet

Page 3 of 60

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	A. BUILDING <u>00</u> COMPLETED			ETED
		151511	B. W	ING		07/05/	2017
				STREET	ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF 1	PROVIDER OR SUPPLIEF	R			ORTH MERIDIAN STREET, SUI	FE 700	
ΙΝΙΠΙΛΝΙΛ	UNIVERSITY HEA	I TH HOSDICE			IAPOLIS, IN 46204	16 700	
	UNIVERSITTIEA	ETTTIOSFICE		INDIAN	AFOLIS, IN 40204		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI		TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
	indicated "SN [S	Skilled Nurse] 1-2 x			1.Policy CES.P10 was		
	[times] week x 1	3 weeks SN 5 PRN			developed February 2009 , las	it	
	[as needed]: sym	nptom management,			reviewed and updated on		
		family request. Instruct			February 2015 and was design to communicate effective pain		
	_				management and symptom		
		r on around the clock			contract guidelines.		
	medication admi				2.Policy BR.P10 was		
		pain medication log,			developed February 2009, last	t	
	Assess/instruct p	patient/caregiver on			reviewed and updated on		
	medication admi	inistration, side effects,			February 2015 and was design		
	actions, and effe	ctiveness AID 1-2 x			to communicate patient rights	and	
		s Provide personal			responsibility guidelines.		
	care and assistan	•					
					4 Danida Otaff an advention		
	_	ily living] SC			1.Provide Staff re-education		
	[Spiritual Couns	elor] 8 PRN: Provide			around Policy CES.P10 Pain a Symptom Management and	ina	
	relation-based sp	oiritual care SC 1 x			BR.P10 Patient Rights and		
	day x 1 day."				Responsibilities before August	5.	
					2017, includes information aro		
	A The Skil	led Nursing Facility			patient rights, pain and sympton	om	
		nt resided in provided			management, and the job		
		•			expectations of the Hospice R		
		s notes and orders to			This education will become pa		
		isit to SNF on 6/27/17 at			of the new employee orientation		
	9:45 AM.				1.This education, provide     via written educational materia		
	a. The	SNF Resident Progress			and interactive discussion of the materials with clinical team	IC	
		egistered Nurse (RN) on			members, is scheduled for		
		17 at 12:37 AM indicated			completion by 8-5-17.		
	1 *				2.Education and discussi	on	
		nt daughter asked me to			will take place at each region		
		s her mother. Resident			location's staff meeting and		
		Rate] increased to 32			completed by August 5th.		
	and frothy bile c	olored secretions coming					
		outh. Writer completed			Prevention Plan:		
		administered another			The agency's Clinical Direct	tor	
		ine and morphine 0.25 ml			<ul> <li>The agency's Clinical Direct will incorporate the education</li> </ul>	'OL	
		-			presentation into the new		
	[milliliter]. Med	ls were ineffective.			presentation into the new		

PRINTED: 08/08/2017 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	r í		ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. B B. W	UILDING	00	COMPL	
		151511	B. W	ING		07/05/	2017
NAME OF P	PROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP CODE		
15.15.145.14		1 TH 1100 PHOT			RTH MERIDIAN STREET, SU	ITE 700	
INDIANA	UNIVERSITY HEA	ALTH HOSPICE		INDIAN	APOLIS, IN 46204		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	employee orientation process		DATE
	_	ospice agency] On call			The Clinical Director will be	<b>.</b>	
	_	ated that it sounds like re			responsible for monitoring the	ese	
	_	n be done. Writer			corrective actions to ensure t		
	-	idents daughter would			this deficiency is corrected an	ıd	
	1	eone from the hospice to			will not recur.		
		ice nurse] replied I will			Completion Date: August	5,	
		urse and see if she can			2017	-	
		hospice nurse ever					
	•	writer never received a					
		ospice." The record					
		ee that symptoms were					
		ospice failed to make a					
	visit to assist wit	th symptom management.					
	h The	SNF medication orders for					
		mptom management					
		"Morphine concentrate					
	` •	oral every 2 hours as					
		pain or air hunger					
	•	ntrate 0.5 ml (10 mg)					
	1	rs as needed for moderate					
		er Hyoscyamine tablet					
		gram] sublingual 1-2 tabs					
	-	RN for secretions." The					
		evidence that the hospice					
	_	facility nurse over the					
	_	dose medications					
	appropriately for	r symptom management.					
	B. The ager	ncy medication list had					
	_	ders for breakthrough					
		gement which indicated,					
		ate (Concentrate) by					
	•	100 mg/5 ml Administer					
	mouni solundii l	100 mg/5 mi / tullillistel					

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

Event ID:

URIR11

Facility ID: 005128

If continuation sheet

Page 5 of 60

		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		UILDING	00	COMPL	
		151511	B. W	'ING		07/05/	/2017
NAME OF P	PROVIDER OR SUPPLIER		_	STREET A	DDRESS, CITY, STATE, ZIP CODE	_	
					RTH MERIDIAN STREET, SUI	TE 700	
INDIANA	UNIVERSITY HEA	LTH HOSPICE	INDIANAPOLIS, IN 46204				
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
		ur as needed pain or					
		The agency failed to					
		order was available to					
		ot on SNF medication					
	orders.						
	_	ncy document titled					
		ertification and Plan of					
		"May increase morphine					
		requency to every 30					
	minutes for unco	ontrolled shortness of					
	breath or until pa	atient appears					
	comfortable A	tropine Sulfate 1%					
	Ophthalmic Dro	ps: Administer 3 drops					
	by mouth or und	er tongue every 30					
	minutes times 3	then every 2 hours as					
	needed for exces	sive secretions." The					
	agency failed to	ensure that these orders					
		SNF as they were not					
	on SNF medicati						
	a. The a	igency document titled					
		Notes" indicated "Call					
		se that patient has					
	copious secretion	•					
	-	d has scop patches on.					
	• •	ne. Explained no longer					
	•	rders given for mouth					
	_	" The agency failed to					
	_	oine order to the facility					
		lers for symptom					
		icis for symptom					
	management.						
	2 The clinical r	ecord of patient #2 was					
1	2. The chineal f	ccora or patient π2 was	ı				I

PRINTED: 08/08/2017 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151511	ľ	ILDING	NSTRUCTION  00	(X3) DATE COMPL <b>07/05</b> /	ETED	
	PROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP CODE  950 NORTH MERIDIAN STREET, SUITE 700 INDIANAPOLIS, IN 46204				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE	
	date of 1/20/17. plan of care date	dicated a start of care The record contained a d 1/20/17-4/19/17, which 2 x week x 1 week."						
	"Hospice v16.3 2017," indicated Breathing labore wheezing:bilat [i rest No educated dying-Symptom failed to evidence hospice nurse for comfort at initial.							
	"Home Care & F Concern Form," 2/20/17 from par indicated "[Patie and suffered in p Investigation res reviewed adm written scripts of facility." The re documentation to facility, only on fails to evidence	ults: Charting was ission nurse delivered f Morphine and Ativan to cord failed to evidence hat scripts were taken to the complaint form, and that the nurse completed on admission to provide						
		n interview on 7/5/17 at ministrator stated that in						

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

Event ID:

URIR11

Facility ID: 005128

If continuation sheet

Page 7 of 60

PRINTED: 08/08/2017 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 00 COMPI	
151511 B. WING 07/05	
STREET ADDRESS, CITY, STATE, ZIP CODE	.2311
NAME OF PROVIDER OR SUPPLIER  950 NORTH MERIDIAN STREET, SUITE 700	
INDIANA UNIVERSITY HEALTH HOSPICE INDIANAPOLIS, IN 46204	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION  PREFIX (FACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY)	COMPLETION DATE
such a short time we were unable to	D.T.E
control patients pain.	
3. The clinical record of patient #9 was	
reviewed and indicated a start of care	
date of 6/19/17. The record contained a	
plan of care dated 6/19/17-9/16/17, which	
indicated "SN 1-2 x week x 13 weeks	
MSS [Medical Social Services] 1-3 x	
month x 3 months AID 2 x week x 1	
week SC 1-3 x month x 3 months."	
The agency failed to provide the SNF	
with medication orders for symptom management as ordered.	
management as ordered.	
A. The SNF that patient resided in	
provided the residents medication orders	
and written hospice progress notes from	
hospice staff to surveyor upon visit to	
SNF on 6/28/17 at 8:57 AM.	
a. The agency document titled	
"Patient Progress Notes," had an entry	
written on 6/20/17 that indicated "Pt	
[Patient] admitted to services 6/19. RN	
performed assessment New orders received RVTO [Read back verified	
telephone order] from [Nurse	
Practitioner] Roxanol 5 mg Q [every] 1	
hour SL [Sublingual] PRN for pain/SOB	
[shortness of breath], lorazepam intensol	
0.5 mg Q 2 hours SL PRN for anxiety, &	
Atropine 3 gtts [drops] Q 1 hour for	
secretions."	

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

Event ID:

URIR11

Facility ID: 005128

If continuation sheet

Page 8 of 60

PRINTED: 08/08/2017 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO UILDING	NSTRUCTION 00	(X3) DATE COMPL		
ANDIEM	or conduction	151511	B. W		00	07/05/	
		101011			DDDEGG CITY OT LTE ZID CODE	01700	72017
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE RTH MERIDIAN STREET, SUI	TE 700	
INDIANA	UNIVERSITY HEA	LTH HOSPICE			APOLIS, IN 46204	12 700	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	CY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD) CROSS-REFERENCED TO THE APPROPRIES.		TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	h The	SNF document titled					
		r Report," indicated					
	*	1%, 3 drops Q 1 hour for					
		' The SNF medication					
		evidence the hospice					
	to them.	ol or Lorazepam orders					
	to them.						
	4 The agencies	policy titled "PAIN					
	_	M MANAGEMENT,"					
		10 revised February 2015					
	1	STATEMENTS: The					
		team ensures that					
	patients receive						
	. ^	l symptom control from					
		OCEDURES: D. If the					
		eiving relief from the					
		lication or dosage, the					
	•	ne contracted pharmacy,					
		ical Director, and/or					
	_	ian, and carries out the					
		etion(s) ordered by the					
	physician."	ction(s) ordered by the					
	physician.						
	5. The agencies	Job description titled					
		vide Clinical Home					
		pice," dated April 14,					
	_	cumbent is responsible					
	· ·	compliance in process,					
	_	ce for all Statewide					
		Iospice activities Acts					
		nters for Medicaid and					
	_	nistrator for Home					
							İ

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

Event ID:

URIR11

Facility ID: 005128

If continuation sheet

Page 9 of 60

PRINTED: 08/08/2017 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151511	(X2) MULTIPL A. BUILDING B. WING	E CONSTRUCTION  G 00	C	DATE SURVEY OMPLETED 7/05/2017	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE  950 NORTH MERIDIAN STREET, SUITE 700 INDIANAPOLIS, IN 46204				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES  CY MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)  LICE "	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCE)	AN OF CORRECTION E ACTION SHOULD BE D TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE	
	6. The agencies "RN-Hospice," of stated, "Assumed Hospice care as procedures. Main records so that p and goals are acceptated and chang occur Initiate attending physic familiarity with and rules and reg federal bodies we delivery of hospices possibility for on-call duty as swith services possible for on-call d	Job description titled lated September 15, 2014 is responsibility for per Hospice policies and intains up to date patient roblems, plans, actions curately and clearly less are reflected as they less communication with lians Demonstrates policies of the agency gulations of state and hich relate to the lice services Assumes revening and weekend cheduled and consistent licies."  Lerview on 6/8/17 at 1:50 C stated it is up to the leand/or the case in prescription and get					

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

Event ID:

URIR11

Facility ID: 005128

If continuation sheet

Page 10 of 60

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		151511	B. W	ING		07/05/	2017
				STREET A	ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIER	S.			ORTH MERIDIAN STREET, SUI	TF 700	
INDIANA	UNIVERSITY HEA	LTH HOSPICE		INDIANAPOLIS, IN 46204			
(X4) ID		TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	· ·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
L 0522 Bldg. 00	418.54(a) INITIAL ASSESSI The hospice regis an initial assessm the election of hos with §418.24 is co physician, patient, requests that the i completed in less Based on docum failed to complet assessment for 1 (#2).  Findings include  1. The clinical r reviewed and include of 1/20/17. plan of care date indicated "SN [S] [times] week x 1  A. The hosp "Hospice v16.3 is 2017," indicated Respiration 22Physical\Respi with oxygen sup [bilateral] Dys education this vi Physical\Skin\Ex- intact multiple intact multiple	MENT tered nurse must complete ent within 48 hours after spice care in accordance implete (unless the or representative nitial assessment be than 48 hours.) ment review the agency te a thorough initial of 10 records reviewed  ecord of patient #2 was dicated a start of care The record contained a dd 1/20/17-4/19/17, which skilled Nursing] 1-2 x week."  bice document titled Initial visit-on 1-20- "Vital signs Pulse 102 Blood Pressure 103/47 fratory: Breathing labored port, wheezing:bilat spnea at rest No sit valuation Skin integrity: e bruising Extremities: yanotic nailbeds, Upper,	LO		Summary statement: The hospice registered nurse must complete an initial assessmen within 48 hours after the electi of hospice care in accordance with CFR 418.24 is complete (unless the physician, patient, representative requests that the initial assessment be completed in less than 48 hours,) all of the per current policy Admission—Comprehensive Assessment of the Patient PFC.A45—Action planned:  Clinical leaders reviewed pertinent policy: Admission—Comprehensive Assessment of the Patient PFC.A45—1.Policy PFC.A	t on or ne ed is . Of t ned e e, No	08/05/2017

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY						
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. B	UILDING	COMPLETED			
		151511	B. W	ING		07/05/2017		
			_	STREET A	ADDRESS, CITY, STATE, ZIP CODE			
NAME OF I	PROVIDER OR SUPPLIEF			950 NORTH MERIDIAN STREET, SUITE 700				
	UNIVERSITY HEA	LTH HOSPICE		INDIANAPOLIS, IN 46204				
(X4) ID		TATEMENT OF DEFICIENCIES		ID	(X5)			
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION		
TAG	<del> </del>	LSC IDENTIFYING INFORMATION)		TAG	·	DATE		
		Is the patient aware of			re-educate Hospice staff on th inter-disciplinary requirements			
		Are significant others			and time frames associated w			
		sis?: Yes, Patient			comprehensive assessment.			
	Coping: unknow	n Actively			3.Timely completion of th	ie		
	dying-Symptom	s: Dyspnea			initial assessment by			
	Caregiver/family	y Accepting of death			inter-disciplinary group to inclumedical, nursing, psychosocia			
	Environment\Sa	fety: Fall risk assessment			emotional, and spiritual	.1,		
	tool." The initial	assessment failed to			assessments will be added to			
	evidence patient	's, psychosocial,			monthly chart audits.			
	^	piritual status related to			·How the actions will improv	е		
	_	ess and related conditions			the processes: Anticipated			
					outcome of this education, and chart audits is that hospice sta			
	2 The agencies	Job description titled			will be fully aware and maintai			
	_	vide Clinical Home			compliance with the policy and			
					expectations.			
	-	pice," dated April 14,			·Procedures for implementing	ıg		
		cumbent is responsible			the plan of correction for this			
	_	compliance in process,			deficiency: 1.This education, provide	nd l		
		ce for all Statewide			via written educational materia			
		Iospice activities Acts			and interactive discussion of the			
	as the CMS [Cer	nters for Medicaid and			materials with clinical team			
	Medicare] Admi	nistrator for Home			members, is scheduled for			
	Health and Hosp	pice."			completion by 8-5-17.  2.Education and discussi	ion		
					will take place at each region	OII		
	3. The agencies	Job description titled			location's staff meeting and			
	"Manager-Clinic	cal Operations," dated			completed by August 5th.			
	May 28, 2013 st	ated, "Assures the						
		nce of staff Maintains						
	-	ountability for quality						
	_	Maintains knowledge of						
	•	areas of clinical and						
	•	esponsibility Assures						
	_	1						
	•	with all state and						
	national regulato	-						
	I Accountable for	daily unit operations.						

PRINTED: 08/08/2017 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION IDENTIFICATION NUMBER:  151511	A. BUILDING <u>OC</u> B. WING		COMPLETED 07/05/2017		
	ROVIDER OR SUPPLIER UNIVERSITY HEALTH HOSPICE	STREET ADDRESS, CITY, STATE, ZIP CODE  950 NORTH MERIDIAN STREET, SUITE 700 INDIANAPOLIS, IN 46204				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PROVIDER'S PLAN OF CORRECTION EACH CORRECTIVE ACTION SHOULD BE OSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE		
	4. The agencies Job description titled "RN-Hospice," dated September 15, 2014 stated, "Assumes responsibility for Hospice care as per Hospice policies and procedures. Maintains up to date patient records so that problems, plans, actions and goals are accurately and clearly stated and changes are reflected as they occur Initiates communication with attending physicians Demonstrates familiarity with policies of the agency and rules and regulations of state and federal bodies which relate to the delivery of hospice services Assumes responsibility for evening and weekend on-call duty as scheduled and consistent with services policies."					
L 0530 Bldg. 00	418.54(c)(6) CONTENT OF COMPREHENSIVE ASSESSMENT [The comprehensive assessment must take into consideration the following factors:] (6) Drug profile. A review of all of the patient's prescription and over-the-counter drugs, herbal remedies and other alternative treatments that could affect drug therapy. This includes, but is not limited to, identification of the following:  (i) Effectiveness of drug therapy (ii) Drug side effects (iii) Actual or potential drug interactions					

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

Event ID:

URIR11

Facility ID: 005128

If continuation sheet

Page 13 of 60

PRINTED: 08/08/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 151511		X2) MULTIPLE CONSTRUCTION				ETED	
	ROVIDER OR SUPPLIER			950 NO	ADDRESS, CITY, STATE, ZIP CODE DRTH MERIDIAN STREET, SUI IAPOLIS, IN 46204	TE 700	
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	(v) Drug therapy currently associated with laboratory monitoring.  Based on record review, policy review		L 0:	530	Summary statement: The agency ensures in writing a		08/05/2017
	and interview, the complete a curre	ne agency failed to nt and accurate w for 5 of 10 records			patient-specific comprehensiv assessment that identifies the patient's needs for hospice ca the need for physical, psychosocial, emotional, and spiritual care to the terminal	res,	
	reviewed and incodate of 2/2/17. The plan of care date indicated "SN [S [times] week x 1 [as needed]: sympatient comfort, patient/caregiver medication adminates of patient actions, and effer week x 13 weeks care and assistant [Activities of data [Spiritual Counsel of 2/2/2/2/2/2/2/2/2/2/2/2/2/2/2/2/2/2/2/	ecord of patient #1 was dicated a start of care The record contained a d 2/2/17-5/2/17, which killed Nurse] 1-2 x 3 weeks SN 5 PRN aptom management, family request. Instruct on around the clock nistration and pain medication log, patient/caregiver on nistration, side effects, ctiveness Aid 1-2 x s Provide personal ce with ADL's			illness that must be addressed order to promote the hospice patient's well-being. The assessment includes all areas necessary for the palliation an management of the terminal illness and related conditions. The comprehensive assessme includes the following but not limited to: the nature and condition causing admission, complications and risk factors that affect care planning, functional status (including the patient's ability to understand participate in his or her own caimminence of death, severity of symptoms, and a review of all patient's medications. The medication review includes all prescriptions, over- the- count drugs, herbal remedies, and of alternative treatments that counffect drug therapy. Patient medications in the comprehensive assessment we	e and are), of the er ther uld	
	day x 1 day." Th	ne record showed tween the facility and			be evaluated for effectiveness drug therapy, drug side effects actual or potential drug interactions, duplicate drug therapy, and drug therapy		

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

Event ID:

URIR11

Facility ID: 005128

If continuation sheet

Page 14 of 60

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		151511	B. Wl	ING		07/05/	/2017
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	R			ORTH MERIDIAN STREET, SUI	TF 700	
INDIANA	UNIVERSITY HEA	LTH HOSPICE			IAPOLIS, IN 46204	12 700	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
					currently associated with		
	A. The agency's document titled				laboratory monitoring. In addi		
	"Medication Sta	tus," indicated			the comprehensive assessme must include data elements th		
	"Haloperidol La				allow for measurement of	iai	
	Concentrate 2 MG/ML [Milligrams per Milliliter]. Administer 0.5 ml (1 mg) by				outcomes and is updated in th	ne	
					patient record assessment		
	_	, ,,			changes based on IDG		
		tongue every 2 hours as			discussion every 15 days, and	d as	
	needed for agitat	tion."			needed per current policy		
					Admission- Comprehensive		
	a. The	facilities document titled			Assessment of The Patient		
	"Order history,"	indicated "Haloperidol			PFC.A45.		
		ate 2 mg/ml; 1 ml			·Action planned: 1.Clinical leaders review	ha	
		2 hours PRN for			pertinent policy: Admission-	cu	
	agitation."	2 Hours Fixed Tor			Comprehensive Assessment	of	
	agitation.				The Patient PFC.A45, no		
					changes were recommended	for	
	_	ncy document titled			this policy.		
	"Medication Sta	tus," indicated			1.Policy PFC.A45 was		
	"Morphine Sulfa	te (Concentrate) By			developed February 2009, las	it	
	Mouth Solution	100 MG/5 ML 0.5 ml			reviewed and updated on February 2015 and was desig	nod	
	every hour as ne	eded PRN pain or			to establish guidelines for a	neu	
	1 -	er standing order set."			comprehensive assessment.		
	greathess p	or summing or act set.			2.Clinical leaders provide	ed	
	h Tha	facilities document titled			education to Hospice staff on		
					procedures for the		
		indicated "Morphine			comprehensive assessment a	ınd	
	1	nl; Give 0.5 ml every 2			complete medication review.		
	hours for pain."				3.Random chart audit via	1	
					clinical record review will be conducted to monitor complia	nce	
	c. The	Agency document titled			with policy Admission –		
		Certification and Plan of			Comprehension Assessment	of	
	Care," indicated "May increase morphine				The Patient PFC.A45 includin		
	-	requency to every 30			the documentation within the		
		ontrolled shortness of			EMR.		
					·How the actions will improv	re .	
	breath or until pa				the processes: Anticipated	ul4	
	comfortable." T	he agency failed to			outcome of this education, is t	nat	

PRINTED: 08/08/2017 FORM APPROVED OMB NO. 0938-0391

				NSTRUCTION	(X3) DATE SURVEY		
AND PLAN O	OF CORRECTION				00		
		151511	B. W	ING		07/05/	2017
AND PLAN O	SUMMARY S (EACH DEFICIENT REGULATORY OR  Provide this order  2. The clinical reviewed and include of 9/30/16. plan of care date indicated "SN 1-Instruct patient/c clock medication maintenance of JInstruct patient/c poorly controlled Assess/Instruct/non narcotic admi	IDENTIFICATION NUMBER: 151511  ALTH HOSPICE  TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)  The to the facility.  The record of patient #5 was dicated a start of care The record contained a and 5/28/17-7/26/17, which as x week x 9 weeks.  The record contained a manner of the patient with the patient and pain medication log, the patient with the patient of th		JILDING ING STREET A 950 NO	DDDRESS, CITY, STATE, ZIP CODE RTH MERIDIAN STREET, SUITAPOLIS, IN 46204  PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIADEFICIENCY)  is that hospice staff will be fully aware and compliant with the policy and expectations.  Procedures for implementing the plan of correction for this deficiency:  1. This education, provide via written educational material and interactive discussion of the materials with clinical team members, is scheduled for completion by 8-5-17.  2. Education and discussion will take place at each region location's staff meeting and completed by August 5th.  The Clinical Director will be	COMPL 07/05/ FE 700	ETED
	Instruct patient/o poorly controlled Assess/Instruct/o on narcotic adm actions, and effe medication dose physician order weeks Provide p assistance with A The record evide doses for Hyose The record evide facility did not h record evidence but was an activ the facility had a was not evidence  A. The agen "Medication Sta	caregiver on reporting d pain to Hospice, monitor patient/caregiver inistration, side effects, ctiveness, Titrate for comfort per AID 1-2 x week x 9 ersonal care and ADL's, Companionship." enced discrepancies of yamine and Robitussin. enced Miralax which the lave as an order. The d tylenol as discontinued er order at the facility, and an order for CBD which ed in hospice record.			will take place at each region location's staff meeting and completed by August 5th.	se at	
	hours as needed	outh packet daily PO {by					

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

Event ID:

URIR11

Facility ID: 005128

If continuation sheet

Page 16 of 60

PRINTED: 08/08/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	UILDING	00	COMPL	ETED
		151511	B. W	ING		07/05/	2017
NAME OF I	DROVIDED OD GUDDI IEI			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	C		950 NO	RTH MERIDIAN STREET, SUI	ΓE 700	
	UNIVERSITY HEA				APOLIS, IN 46204		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCE		DATE
	mouth] Robitussin Chest Congestion by Mouth Syrup 100 mg/5 ml 10 ml every hours as needed PO 10 ml q6h [every 6 hours] prn coughTylenol by						
	mouth tablet 325	5 mg 2 tablet three times					
	a day PO Give 2	tablets (650 mg) by					
	mouth three time	es a day end date:					
	4/27/17."						
	B. The facil	lity document titled					
	"Physician Orde	r report," indicated					
	1 *	(OTC) 325 mg; 650 mg					
		a dayHyoscyamine					
		olingual 0.125 mg every 4					
		for excessive secretions					
		ough-Chest Congestion					
	I	ours PRN cough/cold					
		xtra-strength, spray twice					
	_	nd] swallow as dietary					
	supplement."						
	2 TT 1: 1	1 6					
		record of patient #8 was					
		dicated a start of care					
		The record contained a					
		ed 3/31/17-6/28/17, which					
	indicated "SN 1-	-2 x week x 14 weeks."					
	The record evide	enced discrepancies of					
	doses for Oxygen, Tylenol, and Calcium						
	Carbonate.						
	A The area	nav dagumant titlad					
		ncy document titled					
		tus," indicated "Oxygen 3					
		needed for shortness of					
	breath nasal can	nula Calcium					

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

Event ID:

URIR11

Facility ID: 005128

If continuation sheet Page 17 of 60

PRINTED: 08/08/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 151511		(X2) MULTIPLE A. BUILDING B. WING	CONSTRUCTION  00	(X3) DATE COMPI 07/05	LETED			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE  950 NORTH MERIDIAN STREET, SUITE 700 INDIANAPOLIS, IN 46204					
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODECTION OF THE APPRODESSION OF THE APPROPRIES OF THE	D BE	(X5) COMPLETION DATE		
	Chewable 500 m PRN daily for in Acetaminophen	aid by mouth tablet ag 1 tablet as needed PO digestion by mouth tablet 500 mg hours as needed PO for						
	"Physician Orde "Acetaminophen times a day PRN Carbonate) 2 tab indigestion M	ity document titled r report," indicated 500 mg 2 tablets three Antacid (Calcium once daily PRN for ay titrate oxygen (1-4 ntain sats greater than						
	reviewed and ind date of 6/19/17. plan of care date indicated "SN 1- MSS [Medical S month x 3 month	ecord of patient #9 was dicated a start of care The record contained a d 6/19/17-9/16/17, which 2 x week x 13 weeks ocial Services] 1-3 x as AID 2 x week x 1 x month x 3 months."						
	"Medication State "Morphine Sulfate 0.25 ml every he pain/shortness of Intensol by mout 0.25 ml every 2 anxiety." These	te by mouth 20 mg/ml bur as needed PO for f breath Lorazepam th concentrate 2 mg/ml thours as needed PO for medication orders were by medication orders.						

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

Event ID:

URIR11

Facility ID: 005128

If continuation sheet

Page 18 of 60

PRINTED: 08/08/2017 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  151511		ľ í	JILDING	<u>00</u>	COMPL 07/05/	ETED		
	PROVIDER OR SUPPLIER UNIVERSITY HEA		STREET ADDRESS, CITY, STATE, ZIP CODE  950 NORTH MERIDIAN STREET, SUITE 700 INDIANAPOLIS, IN 46204					
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE	
	"Patient progress that was in the he facility indicated RTVO [Received Order] from [ord for Roxanol 5 mg SL[sublingual] P [shortness of bre 0.5 mg Q 2 hours facility failed to these medication 5. The agencies "MEDICATION Policy #: CES.M 2015 stated "POI The pharmaceuti hospice's patients manner consister and Federal laws of practice Pl Medications are basis and are ava and seven days a A drug profile is patient and inclu current medication The RN Case home medication profi	RN for pain/SOB ath], lorazepam intensol s SL PRN anxiety." The have written orders for s.  policy titled -MANAGEMENT," 35 revised February LICY STATEMENTS:						

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

Event ID:

URIR11

Facility ID: 005128

If continuation sheet

Page 19 of 60

PRINTED: 08/08/2017 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			IULTIPLE CO. UILDING	NSTRUCTION 00	(X3) DATE COMPL			
ANDIEM	or conduction	151511	B. W		00	07/05/		
		101011			DDDDGG CITY OTLETE TIP CODE	017007	2017	
NAME OF F	PROVIDER OR SUPPLIEF	8	STREET ADDRESS, CITY, STATE, ZIP CODE  950 NORTH MERIDIAN STREET, SUITE 700					
INDIANA	UNIVERSITY HEA	LTH HOSPICE			APOLIS, IN 46204	12 700		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE	
		nedications are listed						
	accurately."							
	6 The agencies	Job description titled						
		vide Clinical Home						
		pice," dated April 14,						
	_	cumbent is responsible						
		compliance in process,						
		ce for all Statewide						
		Iospice activities Acts						
		nters for Medicaid and						
	_	nistrator for Home						
	Health and Hosp							
	_							
	7. The agencies	Job description titled						
	"Manager-Clinic	cal Operations," dated						
	May 28, 2013 st	ated, "Assures the						
	clinical compete	nce of staff Maintains						
	twenty four acco	ountability for quality						
	patient care N	Maintains knowledge of						
	best practices in	areas of clinical and						
	~	esponsibility Assures						
	_	with all state and						
	national regulato	•						
	Accountable for	daily unit operations.						
	8 The agencies	Job description titled						
	_	dated September 15, 2014						
		s responsibility for						
	1	per Hospice policies and						
		ntains up to date patient						
	l ~	roblems, plans, actions						
	and goals are accurately and clearly							
	~	es are reflected as they						
	٠		ı				I	

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

Event ID:

URIR11

Facility ID: 005128

If continuation sheet

Page 20 of 60

PRINTED: 08/08/2017 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING 00			(X3) DATE SURVEY  COMPLETED			
		151511	B. WI			07/05/		
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE  950 NORTH MERIDIAN STREET, SUITE 700					
INDIANA	UNIVERSITY HEA	LTH HOSPICE		INDIAN	APOLIS, IN 46204			
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Έ	(X5) COMPLETION DATE	
	attending physici familiarity with p and rules and reg federal bodies white delivery of hospi responsibility for on-call duty as so with services pole	ce services Assumes evening and weekend cheduled and consistent						
L 0543 Bldg. 00	patients and their individualized writt established by the group in collaborat physician (if any), representative, and	hospice interdisciplinary tion with the attending						
	review, and interestablish an indivorsity of care for 6 of 1 3, 4, 6, 8, 9).  Findings include  1. The clinical reviewed and included of 1/20/17.	ent review, policy view the agency failed to vidualized written plan 0 records reviewed (#2,  : ecord of patient #2 was licated a start of care The record contained a d 1/20/17-4/19/17, which	L 0:	543	Summary statement: The agency ensures the plan of ca contains all services necessary for the palliation and management of the terminal illness and related conditions. The plan of care includes the following but not limited to: interventions to manage pain a symptoms, a detailed statement of the scope and the frequency services necessary to meet the specific patient and family nee measurable outcomes anticipation implementing and coordinating the of care, drugs and treatments necessary to	and nt / of e ds, ted	08/05/2017	

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

Event ID:

URIR11

Facility ID: 005128

If continuation sheet Page 21 of 60

PRINTED: 08/08/2017 FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X3) DATE SURVEY X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING 00 COMPLETED 151511 B. WING 07/05/2017 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 950 NORTH MERIDIAN STREET, SUITE 700 INDIANA UNIVERSITY HEALTH HOSPICE INDIANAPOLIS, IN 46204 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE  $\mathsf{TAG}$ meet the needs of the patient, indicated "SN 1-2 x week x 1 week." medical supplies and appliances The record failed to evidence necessary to meet the needs of individualization when building the the patient, and documentation careplan because it listed all the standing from the IDG of the patient or orders rather than ones the patient was representative ( level of understanding, involvement and utilizing. agreement with the plan of care). Patient and family will participate A. The Plan of care contained a full in the development of the plan of care to individualize the patient list of all the hospice standing orders and need. In addition, interdisciplinary did not evidence individualization of care team is required to standing orders based on needs of the document in the patient record patient. updates to the plan of care as directed by the initial assessment, comprehensive assessment, 2. The clinical record of patient #3 was updated patient assessment, reviewed and indicated a start of care changes based on IDG date of 2/28/17. The record contained a discussion every 15 days, and as needed per current policy Plan of plan of care dated 2/28/17-5/28/17, which Care PFC.P15. indicated "SN 1-2 x week x 13 weeks ... ·Action planned: MSS [Medical Social Services] 1 x week 1.Clinical leaders reviewed x 1 week, 4 PRN: Assess, changes and pertinent policy: PFC.P15 Plan of Care, and no changes were requests. Provide counseling, emotional recommended for this policy. support, unconditional positive regard ... 1.Policy PFC.P15 was AID 1 x week x 1 week, 3-4 x week x 12 developed February 2009, last weeks. SC 4 PRN: assessments, changes, reviewed and updated on requests." The record failed to evidence February 2015 and was designed to establish guidelines for a individualization when building the comprehensive assessment. careplan because it listed all the standing 2.Clinical leaders plan to orders rather than ones the patient was educate Hospice staff on the utilizing. procedures for the comprehensive assessment and complete medication review. A. The Plan of care contained a full 3.Random chart audit via

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

list of all the hospice standing orders and

did not evidence individualization of

standing orders based on needs of the

Event ID:

URIR11

Facility ID: 005128

If continuation sheet

clinical record review will be

conducted to monitor compliance with policy PFC.P15 Plan of Care.

Page 22 of 60

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		151511	B. WI	ING		07/05/	2017
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	t .			RTH MERIDIAN STREET, SUIT	TE 700	
INDIANA	UNIVERSITY HEA	I TH HOSPICE			APOLIS, IN 46204	12 700	
					74 0210, 114 1020 1		
(X4) ID		TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL			CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	·How the actions will improve		DATE
	patient.				the processes: Anticipated	5	
					outcome of this education is th	at	
		ecord of patient #4 was			is that hospice staff will be fully		
	reviewed and indicated a start of care				aware and compliant with the		
	date of 11/15/16	. The record contained a			policy and expectations.		
	plan of care date	ed 5/14/17-7/12/17, which			·Procedures for implementin	g	
	•	x week x 9 weeks			the plan of correction for this		
		ounseling, financial			deficiency: 1.This education, provide	d	
		ce referrals, AID 2 x			via written educational materia		
	•	SC 1-2 x month." The			and interactive discussion of the	ne	
	record failed to				materials with clinical team		
		when building the			members, is scheduled for		
		_			completion by 8-5-17.  2.Education and discussion	on	
	•	e it listed all the standing			will take place at each region	OH	
		n ones the patient was			location's staff meeting and		
	utilizing.				completed by August 5th.		
					·The Clinical Director will be		
	A. The Plan	of care contained a full			responsible for monitoring thes		
	list of all the hos	pice standing orders and			corrective actions to ensure th		
	did not evidence	individualization of			this deficiency is corrected and will not recur.	,	
	standing orders l	pased on needs of the			·A quarterly clinical record		
	patient.				review tool and shared visit too	ol	
	1				has been developed for hospid	се	
	4 The clinical r	ecord of patient #6 was			and will begin now with these		
		dicated a start of care			audits for second quarter 2017		
		The record contained a			Results of the Clinical Reco	-	
					shared with clinical leaders to	iiu	
	•	d 5/10/17-8/7/17, which			pass on to staff. Data and trer	nds	
		x week x 13 weeks			will be reviewed in the Agency		
		13 weeks provide			QAPI meetings.		
	•	d assistance with ADL's."					
	The record failed to evidence						
	individualization	when building the					
	careplan because it listed all the standing						
	orders rather tha	n ones the patient was					
	utilizing.	•					
			1		<u> </u>		

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

Event ID:

URIR11

Facility ID: 005128

If continuation sheet Page 23 of 60

PRINTED: 08/08/2017 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  151511		ì	UILDING	00	COMPL 07/05	ETED		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE  950 NORTH MERIDIAN STREET, SUITE 700 INDIANAPOLIS, IN 46204					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES  CY MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE	
	list of all the hos	n of care contained a full spice standing orders and individualization of based on needs of the						
	reviewed and indate of 3/31/17. plan of care date indicated "SN 1- The record failed individualization careplan because	record of patient #8 was dicated a start of care  The record contained a red 3/31/17-6/28/17, which red x week x 14 weeks."  It does not evidence a when building the red it listed all the standing an ones the patient was						
	list of all the hos	of care contained a full spice standing orders and individualization of based on needs of the						
	reviewed and indate of 6/19/17. plan of care date indicated "SN 1-MSS 1-3 x monty week x 1 week months." The reindividualization	record of patient #9 was dicated a start of care  The record contained a and 6/19/17-9/16/17, which are 2 x week x 13 weeks at x 3 months AID 2 x SC 1-3 x month x 3 are cord failed to evidence a when building the at it listed all the standing						

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

Event ID:

URIR11

Facility ID: 005128

If continuation sheet

Page 24 of 60

PRINTED: 08/08/2017 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		l í		INSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		UILDING	00	COMPL	
		151511	B. W	ING		07/05/	2017
NAME OF P	ROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
			950 NORTH MERIDIAN STREET, SUITE 700				
INDIANA	UNIVERSITY HEA	LTH HOSPICE		INDIAN	APOLIS, IN 46204		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		n ones the patient was					
	utilizing.						
	A. The Plan	of care contained a full					
	list of all the hos	pice standing orders and					
	did not evidence	individualization of					
	standing orders l	pased on needs of the					
	patient.						
	7. The agencies	policy titled "PLAN OF					
	CARE," Policy #	#: PFC.P15 revised					
	October 2015 sta	ated, "POLICY					
		: Hospice care and					
		d to patients and their					
	•	ccordance with an					
		vritten plan of care					
		ne hospice IDG in					
	_	th the patient's attending					
		y) PROCEDURES: B.					
		of care includes all					
		ry for the palliation and					
	_	the terminal illness and					
		ns H. The plan of care					
		updated by the IDG					
		more frequently if					
	needed."						
		Job description titled					
		vide Clinical Home					
	-	pice," dated April 14,					
	2016 stated, "Inc	cumbent is responsible					
	for maintaining	compliance in process,					
	policy and service	ce for all Statewide					
	Homecare and H	Iospice activities Acts					
			1				l l

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

Event ID:

URIR11

Facility ID: 005128

If continuation sheet

Page 25 of 60

PRINTED: 08/08/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		l í		NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		UILDING	00	COMPL	
		151511	B. W	ING		07/05/	2017
NAME OF F	ROVIDER OR SUPPLIER	3		STREET A	DDRESS, CITY, STATE, ZIP CODE		
					RTH MERIDIAN STREET, SUI	TE 700	
INDIANA	UNIVERSITY HEA	LTH HOSPICE		INDIAN	APOLIS, IN 46204		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	-	nters for Medicaid and					
	Medicare] Admi	nistrator for Home					
	Health and Hosp	pice."					
	9. The agencies	Job description titled					
	"Manager-Clinic	cal Operations," dated					
	May 28, 2013 st	ated, "Assures the					
	clinical compete	nce of staff Maintains					
	twenty four acco	ountability for quality					
	patient care N	Maintains knowledge of					
	_	areas of clinical and					
	-	esponsibility Assures					
	_	with all state and					
	national regulato						
	_	daily unit operations.					
	Accountable for	daily unit operations.					
	10 The agencie	s Job description titled					
	_	dated September 15, 2014					
		s responsibility for					
	•	per Hospice policies and					
	_	ntains up to date patient					
	_	roblems, plans, actions					
	_	-					
	-	curately and clearly					
		ges are reflected as they					
		es communication with					
		ians Demonstrates					
		policies of the agency					
		gulations of state and					
		hich relate to the					
		ice services Assumes					
	-	r evening and weekend					
	-	cheduled and consistent					
	with services po	licies."					

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

Event ID:

URIR11

Facility ID: 005128

If continuation sheet

Page 26 of 60

PRINTED: 08/08/2017 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ULTIPLE CO JILDING	ONSTRUCTION	(X3) DATE S COMPL	
ANDILAN	or connection	151511	B. W		00	07/05/	
		101011			ADDRESS CITY STATE ZID CODE	011001	2017
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE ORTH MERIDIAN STREET, SUI	ΓΕ 700	
INDIANA	UNIVERSITY HEA	LTH HOSPICE			APOLIS, IN 46204	TE 700	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓΕ	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCT)		DATE
		aterview on 7/5/17 at					
	•	ministrator stated that the					
	_	are on the plan of care					
	because it is their						
		nt from physicians.					
		anding order is pulled order when it is utilized					
	and that is how the						
	individualization						
	marviduanzation						
L 0545	418.56(c)						
DI 1 00	CONTENT OF PL						
Bldg. 00		develop an individualized e for each patient. The					
	·	reflect patient and family					
		tions based on the					
	problems identified						
	comprehensive, as comprehensive as	sessments. The plan of					
		all services necessary for					
		management of the					
	terminal illness and including the follow	d related conditions,					
		viilig.	L 0:	545	·Summary statement: The		08/05/2017
	Based on record	review and interview the			agency ensures the plan of ca		20, 00, 201,
		develop a complete plan			contains all services necessar	y	
	ر ،	0 records reviewed (#2,			for the palliation and management of the terminal		
	7).				illness and related conditions.		
	,				The plan of care includes the		
	Findings include	·			following but not limited to: interventions to manage pain a	and	
					symptoms, a detailed stateme		
	1. The clinical re	ecord of patient #2 was			of the scope and the frequency		
		licated a start of care			services necessary to meet the		
	date of 1/20/17.	The record contained a			specific patient and family nee measurable outcomes anticipa		
	plan of care date	d 1/20/17-4/19/17, which			from implementing and	itou	

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

Event ID:

URIR11

Facility ID: 005128

If continuation sheet

Page 27 of 60

STATEMEN	EMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. Bl	UILDING	00	COMPL	ETED
		151511	B. W	ING		07/05/	2017
				STREET A	ADDRESS, CITY, STATE, ZIP CODE	1	
NAME OF I	PROVIDER OR SUPPLIER	8			ORTH MERIDIAN STREET, SU	ITE 700	
	UNIVERSITY HEA	LTH HOSPICE	_	INDIAN	IAPOLIS, IN 46204		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIDEFICIENCY)	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG			DATE
	_	Skilled Nursing] 1-2 x			coordinating the of care, drug and treatments necessary to	js	
		week." The initial			meet the needs of the patien	t.	
	assessment faile	d to evidence patient's,			medical supplies and applian		
	complete physic	al, psychosocial,			necessary to meet the needs		
	emotional and sp	piritual status which led			the patient, and documentation		
	_	e individualized plan of			from the IDG of the patient or	•	
	*	onents of plan of care			representative ( level of	,	
	were not comple				understanding, involvement a		
	were not compic	nou.			agreement with the plan of ca In addition, interdisciplinary of		
	A 771	1 1 (2)			team is required to documen		
	A. The agency's document titled				the patient record updates to		
	"Home Health Certification and Plan of				plan of care as directed by th		
	Care," indicated	incomplete Nutritional			initial assessment,		
	Requirements, A	Allergies, Functional			comprehensive assessment,		
	limitations, Acti	vities permitted, Mental			updated patient assessment,		
		nosis. These areas were			changes based on IDG		
		plan of care and not			discussion every 15 days, an needed per current policy Pla		
		e admitting nurse.			Care PFC.P15.	111 01	
	addressed by the	admitting hurse.			·Action planned:		
	D D				1.Clinical leaders review	/ed	
	_	in interview on 7/5/17 at			pertinent policy: Plan of Care	9	
	· ·	ministrator stated that the			PFC.P15, no changes were		
	_	itted when actively dying			recommended for this policy.		
		focus and the reason			2.Policy PFC.P15 was developed February 2009, la	et	
	there was missir	ng info on the plan of			reviewed and updated on	οι	
	care.				February 2015 and was design	aned	
					to establish guidelines for a	,	
	2. The clinical r	record of patient #7 was			comprehensive assessment.		
		dicated a start of care			3.Clinical leaders plan to		
		The record contained a			educate Hospice staff on the		
					procedures for the completer	ness	
	•	ed 6/19/17-9/16/17, which			of the plan of care. 4.Random chart audit vi	ء ا	
		x day x 13 days, 5 x			clinical record review will be	u	
		MSS [Medical Social			conducted to monitor complia	ance	
	Services] 1-2 x v	week x 1 week SC			with policy Admission – Plan		
	[Spiritual Couns	selor] 2-4 x month x 3			Care PFC.P15 including plan		
	months." The re	ecord failed to evidence			care individualization.		

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			ULTIPLE CO	ONSTRUCTION	(X3) DATE S	URVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPLE	ETED
		151511	B. W	ING		07/05/2	2017
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER				RTH MERIDIAN STREET, SUIT	TE 700	
ΙΝΟΙΔΝΔ	UNIVERSITY HEA	I TH HOSPICE			APOLIS, IN 46204	L 700	
					Al OLIO, IIV 40204		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	that the completi	ng clinician signed and			·How the actions will improve	Э	
	dated the created	l plan of care.			the processes: Anticipated		
					outcome of this education, is the is that hospice staff will be fully		
	A The ager	ncy's document titled			aware and compliant with the	′	
	1	ertification and Plan of			policy and expectations.		
					·Procedures for implementin	a	
	· ·	incomplete Clinician's			the plan of correction for this	~	
		as left blank on the plan			deficiency:		
	of care and not a	ddressed by the			1.This education, provide		
	admitting nurse.				via written educational materia		
	B. During an interview on 7/5/17 at 2:07 PM, employee F stated that there was a box that was not checked on the				and interactive discussion of the	ne	
					materials with clinical team		
					members, is scheduled for completion by 8-5-17.		
					2.Education and discussion	on I	
					will take place at each region		
	-	signs the document from			location's staff meeting and		
	completing clinic	cian.			completed by August 5th.		
					·The Clinical Director will be		
	C. During a	n interview on 7/5/17 at			responsible for monitoring thes		
	2:08 PM, the adr	ninistrator stated that			corrective actions to ensure the		
	this was missed	by the auditor.			this deficiency is corrected and	,	
					will not recur.  ·A quarterly clinical record		
	3 The agencies	policy titled "PLAN OF			review tool and shared visit too	ol I	
		#: PFC.P15 revised			has been developed for hospid		
	1				and will begin now with these		
	October 2015 sta	-			audits for second quarter 2017		
		Hospice care and			·Results of the Clinical Reco		
		d to patients and their			Reviews will be documented a	nd	
	families are in ac	ecordance with an			shared with clinical leaders to	, do	
	individualized, v	vritten plan of care			pass on to staff. Data and trer will be reviewed in the Agency		
	established by th	e hospice IDG in			QAPI meetings.	٠	
	1	th the patient's attending					
		r) PROCEDURES: B.					
		of care includes all					
		ry for the palliation and					
	_	the terminal illness and					
	related condition	s H. The plan of care					

PRINTED: 08/08/2017 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER:  151511	l í	UILDING	<u>00</u>	COMPL 07/05/	ETED
	PROVIDER OR SUPPLIER			950 NO	DDRESS, CITY, STATE, ZIP CODE RTH MERIDIAN STREET, SUIT APOLIS, IN 46204	E 700	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION DATE
		updated by the IDG more frequently if					
	"Director-Statew Health and Hosp 2016 stated, "Inc for maintaining of policy and service Homecare and H as the CMS [Cer	Job description titled ride Clinical Home rice," dated April 14, numbent is responsible compliance in process, see for all Statewide rospice activities Acts atters for Medicaid and mistrator for Home rice."					
	"Manager-Clinic May 28, 2013 state clinical competer twenty four accordinate patient care Most practices in organizational reunit compliance national regulato	Job description titled all Operations," dated ated, "Assures the nee of staff Maintains untability for quality faintains knowledge of areas of clinical and esponsibility Assures with all state and ary standards daily unit operations.					
	"RN-Hospice," d stated, "Assumes Hospice care as p procedures. Main records so that p	Job description titled lated September 15, 2014 is responsibility for per Hospice policies and intains up to date patient roblems, plans, actions curately and clearly					

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

Event ID:

URIR11

Facility ID: 005128

If continuation sheet

Page 30 of 60

PRINTED: 08/08/2017 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151511	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 07/05/2017
	ROVIDER OR SUPPLIER		950 NO	ADDRESS, CITY, STATE, ZIP CODE DRTH MERIDIAN STREET, SUI NAPOLIS, IN 46204	ΓE 700
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
L 0555 Bldg. 00	stated and chang occur Initiate attending physic familiarity with pand rules and reg federal bodies with delivery of hospiresponsibility for on-call duty as swith services poly with services poly coordinate with system of communaccordance with the provided in accordance with the provided in accordance with records review, and interensure that services accordance with records reviewed.  1. The clinical reviewed and include of 2/28/17.	es are reflected as they es communication with fans Demonstrates policies of the agency gulations of state and thich relate to the ce services Assumes revening and weekend cheduled and consistent ficies."  OF SERVICES to develop and maintain a mication and integration, in the hospice's own policies polytope care and services are lance with the plan of care. The record contained a start of care.  Ecord of patient #3 was dicated a start of care. The record contained a	L 0555	Summary statement: The hospice must develop and maintain a system of communication and integration accordance with the hospice's own policies and procedures, ensure that the care and servi are provided in accordance with plan of care per current policies and procedures. Hospice Care for Nursh Facility Residents – Coordination of Care per Care PFC.H20  Action planned:	08/05/2017  n, in to ces th dicy
	indicated "SN [S	d 2/28/17-5/28/17, which killed Nursing] 1-2 x 3 weeks MSS		·Clinical leaders reviewed pertinent policy: HOSPICE C/FOR NURSING FACILITY	ARE

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

Event ID:

URIR11

Facility ID: 005128

If continuation sheet

Page 31 of 60

STATEMEN	MENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		151511	B. W	ING		07/05/	/2017
			<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIEF	₹			ORTH MERIDIAN STREET, SUI	TE 700	
INDIANA	UNIVERSITY HEA	LTH HOSPICE			IAPOLIS, IN 46204		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	<u> </u>	DATE
	-	Services] 1 x week x 1			RESIDENTS – COORDINATI OF CARE PFC.H20 and no	ON	
	week, 4 PRN: A	ssess, changes and			changes were recommended	for	
	requests. Provide	e counseling, emotional			this policy.s policy.	101	
	support, uncond	itional positive regard			1.Policy PFC.H20 was		
	AID 1 x week x	1 week, 3-4 x week x 12			developed February 2009, las	t	
		itual Counselor] 4 PRN			reviewed and updated on Mar		
		essments, changes,			2015 and was designed to en	sure	
		record failed to evidence			that a written plan of care is	_	
	-				established and maintained for each facility patient and is	)I	
	an order for 6 mg of alprazalam as well as notification to the physician that patient received more alprazalam than physician ordered.				developed and coordinated w	ith	
					the hospice IDG in consultation		
					with facility representatives ar		
					the patient's attending physici	an.	
					2.Clinical leaders plan to		
	A. The age	ncy's document titled			re-educate Hospice staff on		
	"Chart/Clinical 1	Notes," dated 3/3/17			requirement that all care provi	ided	
		caregiver] gave 6 mg			to hospice patients in nursing facility must be in accordance		
	[milligram] alpra				with a coordinated hospice pla		
		uzuiuiii.			of care.	~	
	D. The same				3.Random chart audit via	ì	
	_	ncy's document titled			clinical record review will be		
	_	Oncall/Unscheduled visit			conducted to monitor for		
		," indicated "pt [patient]			compliance with HOSPICE CA	ARE	
	became comfort	able once bladder was			FOR NURSING FACILITY RESIDENTS – COORDINATION	ON	
	drained and alpr	azalam dose 6 mg."			OF CARE PFC.H20	ON	
					·How the actions will improv	'e	
	C. The ager	ncy's document titled			the processes: Anticipated	-	
	"Medication Sta	-			outcome of this education, an	d	
		mouth tablet 2 MG. 1			chart audits is that hospice sta		
		ours as needed PO [as			will be fully aware and mainta		
	1	_			compliance with the policy and	d	
	needed] for anxi	ety.			expectations.	na	
					<ul> <li>Procedures for implementir the plan of correction for this</li> </ul>	ıy	
	_	an interview on 7/5/17 at			deficiency:		
	1:30 PM, the ad	ministrator stated			1.This education, provide	ed	
	agreement to me	edication error.			via written educational materia		
					and interactive discussion of t	he	

PRINTED: 08/08/2017 FORM APPROVED OMB NO. 0938-0391

	TOF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA			ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		UILDING	00	COMPL	
		151511	B. W	'ING		07/05/	2017
NAME OF I	DROVIDED OD GLIDDI IEI			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF			950 NO	RTH MERIDIAN STREET, SUI	TE 700	
INDIANA	UNIVERSITY HEA	LTH HOSPICE		INDIAN	APOLIS, IN 46204		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	2. The agencies	policy titled "HOSPICE			materials with clinical team		
	CARE FOR NU	RSING FACILITY			members, is scheduled for		
	RESIDENTS-CO	OORDINATION OF			completion by 8-5-17.  2.Education and discuss	ion	
	CARE," Policy #	#: PFC.H20 revised			provided at each region locati		
	February 2015 s	tated "POLICY			staff meeting and completed I		
	1	: [Agency] ensures that			August 5th.		
		in place to provide for			·The Clinical Director will be		
		all hospice services			responsible for monitoring the corrective actions to ensure the		
		ents residing in facilities.			this deficiency is corrected an		
	1 * *	ES: C. The following			will not recur.		
		ovided to the facility: 1.			·A quarterly clinical record		
		hospice plan of care			review tool has been develop		
		patient; 2. Hospice			for hospice and will begin now with these audits for second	/	
		d any advance directives			quarter 2017. Results of the		
		patient; Physician			Clinical Record Reviews will be	e	
		recertification of the			documented and shared with		
					clinical leaders to pass on to staff. Will also be reviewed in	tho	
		specific to each patient;			Agency's QAPI monthly	uie	
		act information for			meetings.		
		el involved in hospice					
		ent; 5. Instructions on					
		e hospice's 24 hour					
		6. Hospice medication					
		eific to each patient; and					
	1 1 1	cian and attending					
		y) orders specific to each					
	patient."						
		Job description titled					
		vide Clinical Home					
	_	pice," dated April 14,					
	2016 stated, "Inc	cumbent is responsible					
	for maintaining	compliance in process,					
	policy and service	ce for all Statewide					
	Homecare and H	lospice activities Acts					

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

Event ID:

URIR11

Facility ID: 005128

If continuation sheet

Page 33 of 60

PRINTED: 08/08/2017 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151511	,	LDING	nstruction <u>00</u>	(X3) DATE : COMPL 07/05/	ETED	
	PROVIDER OR SUPPLIER  UNIVERSITY HEA		STREET ADDRESS, CITY, STATE, ZIP CODE  950 NORTH MERIDIAN STREET, SUITE 700 INDIANAPOLIS, IN 46204					
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	F	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE	
	Medicare] Admi Health and Hosp	iters for Medicaid and nistrator for Home ice." Job description titled						
	May 28, 2013 staclinical competer twenty four accorpatient care Mobest practices in organizational reunit compliance national regulator	al Operations," dated ated, "Assures the ace of staff Maintains untability for quality faintains knowledge of areas of clinical and sponsibility Assures with all state and ry standards daily unit operations.						
L 0653 Bldg. 00	drugs and biologic §418.106) must be on a 24-hour basis covered services r 24-hour basis when ecessary to meet and family.  Based on record and interview the that nursing services for services r 24-hour basis when ecessary to meet and family.	review, policy review, e agency failed to ensure iced were made available is for 2 of 10 records	L 06	53	Summary statement: The age ensures that nursing is availab on a 24 hour basis.  Action planned:  1.Clinical leaders reviewe pertinent policy: PFC.A65, no changes were recommended f	ed	08/05/2017	

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

Event ID:

URIR11

Facility ID: 005128

If continuation sheet

Page 34 of 60

NAME OF PROVIDER OR SUPPLIER  INDIANA UNIVERSITY HEALTH HOSPICE  (X4) ID PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  1. The clinical record of patient #1 was reviewed and indicated a start of care date of 2/2/17. The record contained a plan of care dated 2/2/17-5/2/17, which indicated "SN [Skilled Nurse] 1-2 x    STREET ADDRESS, CITY, STATE, ZIP CODE 950 NORTH MERIDIAN STREET, SUITE 700 INDIANAPOLIS, IN 46204    STREET ADDRESS, CITY, STATE, ZIP CODE 950 NORTH MERIDIAN STREET, SUITE 700 INDIANAPOLIS, IN 46204    STREET ADDRESS, CITY, STATE, ZIP CODE 950 NORTH MERIDIAN STREET, SUITE 700 INDIANAPOLIS, IN 46204    STREET ADDRESS, CITY, STATE, ZIP CODE 950 NORTH MERIDIAN STREET, SUITE 700 INDIANAPOLIS, IN 46204    STREET ADDRESS, CITY, STATE, ZIP CODE 950 NORTH MERIDIAN STREET, SUITE 700 INDIANAPOLIS, IN 46204    STREET ADDRESS, CITY, STATE, ZIP CODE 950 NORTH MERIDIAN STREET, SUITE 700 INDIANAPOLIS, IN 46204    STREET ADDRESS, CITY, STATE, ZIP CODE 950 NORTH MERIDIAN STREET, SUITE 700 INDIANAPOLIS, IN 46204    STREET ADDRESS, CITY, STATE, ZIP CODE 950 NORTH MERIDIAN STREET, SUITE 700 INDIANAPOLIS, IN 46204    STREET ADDRESS, CITY, STATE, ZIP CODE 950 NORTH MERIDIAN STREET, SUITE 700 INDIANAPOLIS, IN 46204    STREET ADDRESS, CITY, STATE, ZIP CODE 950 NORTH MERIDIAN STREET, SUITE 700 INDIANAPOLIS, IN 46204    STREET ADDRESS, CITY, STATE, ZIP CODE 950 NORTH MERIDIAN STREET, SUITE 700 INDIANAPOLIS, IN 46204    STREET ADDRESS, CITY, STATE, ZIP CODE 950 NORTH MERIDIAN STREET, SUITE 700 INDIANAPOLIS, IN 46204    STREET ADDRESS, CITY, STATE, ZIP CODE 950 NORTH MERIDIAN STREET, SUITE 700 INDIANAPOLIS, IN 46204    STREET ADDRESS, CITY, STATE, ZIP CODE 950 NORTH MERIDIAN STREET, SUITE 700 INDIANAPOLIS, IN 46204    STREET ADDRESS, CITY, STATE, ZIP CODE 950 NORTH MERIDIAN STREET, SUITE 700 INDIANAPOLIS, IN 46204    STREET ADDRESS, CITY, STATE, ZIP CODE 950 NORTH MERIDIAN STREET, SUITE 700 INDIANAPOLIS, IN 46204    STREET ADDRESS, CITY, STATE, ZIP CODE 950 NORTH MERIDIAN STREET, SUITE 700 INDIANAPOLIS, IN 46204    STR	f ´		l í	(X2) MULTIPLE CONSTRUCTION			URVEY
NAME OF PROVIDER OR SUPPLIER  INDIANA UNIVERSITY HEALTH HOSPICE  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  1. The clinical record of patient #1 was reviewed and indicated a start of care date of 2/2/17. The record contained a plan of care dated 2/2/17-5/2/17, which indicated "SN [Skilled Nurse] 1-2 x  STREET ADDRESS, CITY, STATE, ZIP CODE (950 NORTH MERIDIAN STREET, SUITE 700 INDIANAPOLIS, IN 46204  ID PROVIDERS PLAN OF CORRECTION (CACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  TAG 1. The clinical record of patient #1 was reviewed and indicated a start of care dated 2/2/17-5/2/17, which indicated "SN [Skilled Nurse] 1-2 x	AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:			00		
INDIANA UNIVERSITY HEALTH HOSPICE  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  1. The clinical record of patient #1 was reviewed and indicated a start of care date of 2/2/17. The record contained a plan of care dated 2/2/17-5/2/17, which indicated "SN [Skilled Nurse] 1-2 x  950 NORTH MERIDIAN STREET, SUITE 700 INDIANAPOLIS, IN 46204  (X5) PREFIX (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  1. The clinical record of patient #1 was developed February 2009, last reviewed and updated on March 2015, and was designed to communicate guidelines for availability 24/7.  2 Clinical leaders		151511	B. W.	ING		07/05/2	2017
INDIANA UNIVERSITY HEALTH HOSPICE  (X4) ID  PREFIX  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  TAG  1. The clinical record of patient #1 was reviewed and indicated a start of care date of 2/2/17. The record contained a plan of care dated 2/2/17-5/2/17, which indicated "SN [Skilled Nurse] 1-2 x  [X5]  10  PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  TAG  PREFIX  (EACH DEFICIENCY)  TAG  PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  TAG  This policy.  1. Policy PPFC.A65 was developed February 2009, last reviewed and updated on March 2015, and was designed to communicate guidelines for availability 24/7.  2. Clinical leaders	NAME OF PROVIDER OR SUPPLIE	LIER					
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  1. The clinical record of patient #1 was reviewed and indicated a start of care date of 2/2/17. The record contained a plan of care dated 2/2/17-5/2/17, which indicated "SN [Skilled Nurse] 1-2 x  ID PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  TAG  PREFIX TAG  PREFIX TAG  PREFIX TAG  PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  DATE  This policy.  1. Policy PPFC.A65 was developed February 2009, last reviewed and updated on March 2015, and was designed to communicate guidelines for availability 24/7.  2. Clinical leaders						ΓE 700	
PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  1. The clinical record of patient #1 was reviewed and indicated a start of care date of 2/2/17. The record contained a plan of care dated 2/2/17-5/2/17, which indicated "SN [Skilled Nurse] 1-2 x  PREFIX TAG  PREFIX TAG  PREFIX (EACH DEFICIENCY)  PREFIX TAG  PREFIX TAG  PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  This policy.  1. Policy PPFC.A65 was developed February 2009, last reviewed and updated on March 2015, and was designed to communicate guidelines for availability 24/7.  2. Clinical leaders	INDIANA UNIVERSITY HEA	IEALTH HOSPICE		INDIAN	APOLIS, IN 46204		
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  1. The clinical record of patient #1 was reviewed and indicated a start of care date of 2/2/17. The record contained a plan of care dated 2/2/17-5/2/17, which indicated "SN [Skilled Nurse] 1-2 x  PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED to THE APPROPRIATE DEFICIENCY)  TAG  PREFIX  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED to THE APPROPRIATE DEFICIENCY)  DATE  This policy.  1. Policy PPFC.A65 was developed February 2009, last reviewed and updated on March 2015, and was designed to communicate guidelines for availability 24/7.  2. Clinical leaders	(X4) ID SUMMARY S	RY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
1. The clinical record of patient #1 was reviewed and indicated a start of care date of 2/2/17. The record contained a plan of care dated 2/2/17-5/2/17, which indicated "SN [Skilled Nurse] 1-2 x  this policy.  1. Policy PPFC.A65 was developed February 2009, last reviewed and updated on March 2015, and was designed to communicate guidelines for availability 24/7.  2. Clinical leaders	`				CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
1. The clinical record of patient #1 was reviewed and indicated a start of care date of 2/2/17. The record contained a plan of care dated 2/2/17-5/2/17, which indicated "SN [Skilled Nurse] 1-2 x  1. Policy PPFC.A65 was developed February 2009, last reviewed and updated on March 2015, and was designed to communicate guidelines for availability 24/7.	TAG REGULATORY OR	OR LSC IDENTIFYING INFORMATION)		TAG			DATE
[times] week x 13 weeks SN 5 PRN [as needed]: symptom management, patient comfort, family request. Instruct patient/caregiver on around the clock medication administration and maintenance of pain medication log, Assess/instruct patient/caregiver on medication administration, side effects, actions, and effectiveness Aid 1-2 x week x 13 weeks Provide personal care and assistance with ADL's [Activities of daily living] SC [Spiritual Counselor] 8 PRN: Provide relation-based spiritual care SC 1 x day x 1 day."  A. The SNF Resident Progress Note from the Registered Nurse (RN) on duty dated 2/10/17 at 12:37 AM indicated "At 9 PM resident daughter asked me to come in to assess her mother. Resident RR [Respiration Rate] increased to 32 and frothy bile colored secretions coming from resident mouth. Writer completed mouth care and administered another PRN Hyoscyamine and morphine 0.25 ml [milliliter]. Meds were ineffective.  Writer called [hospice staff on the policy and guidelines of on call and after hour nursing 24 hour availability.  How the actions will improve the processes: Anticipated outcome of this education is that the hospice staff will be fully aware of the policy and expectations.  Procedures for implementing the plan of correction for this deficiency:  1.Provide education to all Hospice staff on the policy and after hour nursing 24 hour availability.  How the actions will improve the processes: Anticipated outcome of this education is that the hospice staff will be fully aware of the policy and expectations.  Procedures for implementing the plan of correction for this deficiency:  1.Provide education to all Hospice Staff will be fully aware of the policy and expectations.  Procedures for implementing the plan of correction for this deficiency:  1.Provide aducation stations with the hospice staff will be fully aware of the policy and expectations.  Procedures for implementing the plan of correction for this deficiency:  2.Educations and iscussion will take place at each region location's	reviewed and indate of 2/2/17. In plan of care date indicated "SN [S [times] week x 1 [as needed]: syn patient comfort, patient/caregiver medication administerance of patient and actions, and effer week x 13 week care and assistant [Activities of da [Spiritual Counstrelation-based spiday x 1 day."  A. The SNI from the Register dated 2/10/17 at 9 PM resident dated 2/10/1	I indicated a start of care 7. The record contained a lated 2/2/17-5/2/17, which N [Skilled Nurse] 1-2 x x 13 weeks SN 5 PRN symptom management, ort, family request. Instruct iver on around the clock dministration and of pain medication log, ct patient/caregiver on dministration, side effects, effectiveness Aid 1-2 x eeks Provide personal stance with ADL's Fdaily living] SC unselor] 8 PRN: Provide d spiritual care SC 1 x  SNF Resident Progress Note istered Nurse (RN) on duty 7 at 12:37 AM indicated "At at daughter asked me to seess her mother. Resident ion Rate] increased to 32 le colored secretions coming a mouth. Writer completed and administered another amine and morphine 0.25 ml Meds were ineffective.			1.Policy PPFC.A65 was developed February 2009, lass reviewed and updated on Mar 2015, and was designed to communicate guidelines for availability 24/7.  2.Clinical leaders re-educated all Hospice staff of the policy and guidelines of on call and after hour nursing 24 hour availability.  How the actions will improve the processes: Anticipated outcome of this education is the hospice staff will be fully aware of the policy and expectations.  Procedures for implementing the plan of correction for this deficiency:  1.Provide education to all Hospice Staff, provided via written educational materials a interactive discussion of the materials with clinical team members, is scheduled for completion by 8-5-17.  2.Education and discussion will take place at each region location's staff meeting and completed by August 5th.  The Clinical Director will be responsible for monitoring thes corrective actions to ensure the this deficiency is corrected and	et rich en e e e e e e e e e e e e e e e e e e	

PRINTED: 08/08/2017 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA	ľ í		NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	B. W	UILDING	00	COMPL	
		151511	D. W			07/05/	2017
NAME OF P	PROVIDER OR SUPPLIEF	<b>t</b>			DDRESS, CITY, STATE, ZIP CODE		
INIDIANIA		LTILLIOODIOE			RTH MERIDIAN STREET, SUI	TE 700	
INDIANA	UNIVERSITY HEA	LTH HOSPICE		INDIANA	APOLIS, IN 46204		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG				TAG	DEFICIENCI)		DATE
	•	ated that it sounds like re					
	_	n be done. Writer					
	-	idents daughter would					
	-	eone from the hospice to					
	- 1	ce nurse] replied I will					
		urse and see if she can					
		hospice nurse ever					
	•	vriter never received a					
		ospice." The record					
		e that symptoms were					
		ospice failed to make a					
	visit to assist wit	th symptom management.					
		ecord of patient #3 was					
	reviewed and inc	dicated a start of care					
	date of 2/28/17.	The record contained a					
	plan of care date	ed 2/28/17-5/28/17, which					
	indicated "SN 1-	-2 x week x 13 weeks					
	MSS [Medical S	ocial Services] 1 x week					
	x 1 week, 4 PRN	V: Assess, changes and					
	requests. Provide	e counseling, emotional					
	support, uncond	itional positive regard					
	AID 1 x week x	1 week, 3-4 x week x 12					
	weeks. SC 4 PR	N: assessments, changes,					
	requests." The r	ecord failed to evidence					
	that a SN was re	adily available to meet					
	the patient/famil	y needs.					
	A. The age	ncy's document titled					
	_	Notes," dated 3/5/17 and					
		3:13 PM indicated "Call					
		g [sister] has not heard					
	_	plained with another					
	-	urinate. Advised will					
	_						

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

Event ID:

URIR11

Facility ID: 005128

If continuation sheet

Page 36 of 60

PRINTED: 08/08/2017 FORM APPROVED OMB NO. 0938-0391

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151511	(X2) MULTIPLE A. BUILDING B. WING	E CONSTRUCTION  OO	COMI	E SURVEY PLETED 5/2017		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE  950 NORTH MERIDIAN STREET, SUITE 700 INDIANAPOLIS, IN 46204					
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE		
	come see them a resolved. Not ha wait."	s soon as that is appy about having to						
	"Chart/Clinical I signed by RN at from brother-inso log for nurse [nurse] was with come as soon as [patient] visit. It so long. Explain to all of out patient they need, and a some families to provide the care provide them. Simeeting [families]	notes," dated 3/5/17 and 3:40 PM indicated "Call law upset that it is taking to get there. Explained another family, and will she has finished with Disputed the need to take the lagency] have a duty ents to give them the time at times we have to ask be patient to allow us to they would want us to aid [agency] is not so needs [Caller] said gotten better care with						
	"Chart/Clinical I the on call nurse states being unhal experience and prevocation forms contacted another Sister states that AM [morning] the contact other hose Documentation of	acy's document titled Notes," dated 3/5/17 from visit indicated, "Family appy with hospice vatients sister asks for s as [sister] has already or hospice company. if pt [patient] alive in nat will revoke and spice company." of note is signed 3/8/17 is not evidenced what						

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

Event ID:

URIR11

Facility ID: 005128

If continuation sheet

Page 37 of 60

PRINTED: 08/08/2017 FORM APPROVED OMB NO. 0938-0391

	COMPLETED 07/05/2017			
STREET ADDRESS, CITY, STATE, ZIP CODE  950 NORTH MERIDIAN STREET, SUITE 700 INDIANAPOLIS, IN 46204				
ID PROVIDER'S PLAN OF PREFIX (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TION DEFICIENCY)	N SHOULD BE HE APPROPRIATE  COMPLETION			
	950 NORTH MERIDIAN STR INDIANAPOLIS, IN 46204  ID PROVIDER'S PLAN OF (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TO			

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

Event ID:

URIR11

Facility ID: 005128

If continuation sheet

Page 38 of 60

PRINTED: 08/08/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA  AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		ľ í		NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		UILDING	00	COMPL	
		151511	B. W	ING		07/05/	2017
NAME OF F	ROVIDER OR SUPPLIER	}		STREET A	DDRESS, CITY, STATE, ZIP CODE		
					RTH MERIDIAN STREET, SUI	TE 700	
INDIANA	UNIVERSITY HEA	LTH HOSPICE		INDIAN	APOLIS, IN 46204		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	-	nters for Medicaid and					
	Medicare] Administrator for Home						
	Health and Hosp	pice."					
	5. The agencies	Job description titled					
	"Manager-Clinic	cal Operations," dated					
	May 28, 2013 st	ated, "Assures the					
	clinical compete	nce of staff Maintains					
	•	ountability for quality					
		Maintains knowledge of					
	best practices in areas of clinical and						
	organizational responsibility Assures						
	_	with all state and					
	national regulato						
	_	daily unit operations.					
	Accountable for	daily unit operations.					
	6 The agencies	Job description titled					
	_	dated September 15, 2014					
		s responsibility for					
	•	per Hospice policies and					
	_	ntains up to date patient					
	_	roblems, plans, actions					
	_	curately and clearly					
	-	ges are reflected as they					
		es communication with					
		ians Demonstrates					
		policies of the agency					
		gulations of state and					
		hich relate to the					
		ice services Assumes					
	-	r evening and weekend					
	-	cheduled and consistent					
	with services po	licies."					

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

Event ID:

URIR11

Facility ID: 005128

If continuation sheet

Page 39 of 60

PRINTED: 08/08/2017 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	ULTIPLE CO JILDING	ONSTRUCTION	(X3) DATE SURVEY  COMPLETED		
AND PLAN	OF CORRECTION	151511	B. W		00	. 07/05/2017	
		101011	D		DDDDGG GYMY GWAME GIP GODE	01/03/	2017
NAME OF F	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE  950 NORTH MERIDIAN STREET, SUITE 700				
INDIANA	UNIVERSITY HEA	LTH HOSPICE	INDIANAPOLIS, IN 46204				
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		CY MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION DATE
	3:27 PM the adm clinical manager for on call nurse administrator if noncall needs. 8. During an into 3:28 PM the adm	erview on 6/28/17 at aninistrator stated that a or team leader is backup and ultimately the needed for patient/family erview on 6/28/17 at aninistrator stated that it is practice to deny a visit if					
L 0661 Bldg. 00	the hospice philos contracted staff who contact.  Based on docume the agency failed employees work were on the empreceived orientate philosophy for 4 I, J).  Findings include 1. On 6/28/17 at	t provide orientation about ophy to all employees and no have patient and family ent review and interview to ensure that all ing in the hospice house loyee register and ion to the hospice active employees (G, H, ::  2:50 PM, the agency or with employee lists for	L 00	561	Summary statement: The agency ensures the all employees, contract staff, and volunteers, everyone who has patient and family contact will receive orientation about the hospice philosophy.  Action planned:  1.An active employee list including all volunteers, contrastaff and management, will be maintained and updated with each new hire or termination of employment.  2.Clinical leaders reviewed pertinent policy: Competency Assessment for Staff HR.115 awas reviewed and revised, to	, act of ed	08/05/2017

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

Event ID:

URIR11

Facility ID: 005128

If continuation sheet

Page 40 of 60

STATEMENT OF DEFICIENCIES X3) DATE SURVEY X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING AND PLAN OF CORRECTION 00 COMPLETED 151511 B. WING 07/05/2017 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 950 NORTH MERIDIAN STREET, SUITE 700 INDIANA UNIVERSITY HEALTH HOSPICE INDIANAPOLIS, IN 46204 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE apply to all employees, volunteers 2. The employee list for Bloomington and contracted staff, anyone that Hospice House indicated 8 Registered has patient and family contact. Nurses, 3 Licensed Practical Nurses, and All employees, contracted staff, 5 Home Health Aides. The employee list volunteers who have patient and indicated no other staff or management at family contact, will be required to receive orientation to the hospice the hospice house. philosophy at hire. ·How the actions will improve 3. During interview on 6/29/17 at 11:20 the processes: Anticipated outcome- all hospice staff all AM, Employee H, Regional Director (including: employees, volunteers stated that employees at the hospice and contract staff, anyone with house have the same competencies as the patient or family contact) will hospital. receive education on the hospice philosophy as part of our onboarding education, records of 4. During interview on 6/29/17 at 12:30 education will be maintained in PM, Employee H stated that the dietician each employee record. comes from another office. ·Procedures for implementing the plan of correction for this deficiency: 5. During interview on 6/29/17, at 10:20 1.Leadership has been AM Employee G, the maintenance tech notified of the requirement to stated that his records are stored at the maintain an updated list of active employees, including anyone with hospital. patient or family contact, contract staff, volunteers. List is to be 6. The agencies Job description titled updated with each new hire and "Director-Statewide Clinical Home termination of employment and Health and Hospice," dated April 14, include all employees, volunteers and contract staff. 2016 stated, "Incumbent is responsible 2. This education, provided for maintaining compliance in process, via written educational materials policy and service for all Statewide and interactive discussion of the Homecare and Hospice activities ... Acts materials with clinical team members, is scheduled for as the CMS [Centers for Medicaid and completion by 8-5-17. Medicare] Administrator for Home 3.Education and discussion Health and Hospice." will take place at each region location's staff meeting and completed by August 5th.

PRINTED: 08/08/2017 FORM APPROVED OMB NO. 0938-0391

		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CC		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED		
		151511	B. WING		07/05/2017		
	PROVIDER OR SUPPLIER	TH HOSPICE	STREET ADDRESS, CITY, STATE, ZIP CODE  950 NORTH MERIDIAN STREET, SUITE 700 INDIANAPOLIS, IN 46204				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE		
				4.Clinical staff will be required to sign a statement indicating he/she has reviewed the educational materials and understands the expectation of completing all the components. Hospice Philosophy education of The Clinical Director will be responsible for maintaining a current list of active employees contract staff, and volunteers, ensuring they have received education on the hospice philosophy as part of their orientation. The Clinical Direct will be responsible for monitoring these corrective actions to ensure this deficiency is corrected and will not recur.	f s of		
L 0678 Bldg. 00	following:] (7) Physician order Based on record r agency failed to e order for medicat records reviewed Findings include:  1. The clinical re reviewed and indi date of 2/28/17.	review and interview the evidence a physicians ions given for 1 of 10 (#3).	L 0678	Summary statement: The agency ensures physician order are obtained as needed and received from the physician withe time frame required by law and regulations. The physician orders are for the following but not limited to: admit the patien hospice services and to initially certify the patient's terminal illness, new medications, char in medications, discontinuation medication, change in visit frequency if not within the range	thin ys t t t t to y age		

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

Event ID:

URIR11

Facility ID: 005128

If continuation sheet

Page 42 of 60

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING <u>00</u>			COMPLETED		
		151511	B. W	B. WING			07/05/2017	
				STREET /	ADDRESS CITY STATE ZIP CODE			
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  950 NORTH MERIDIAN STREET, SUITE 700				
INIDIANA		LTULIOSDICE			•	E 700		
INDIANA	UNIVERSITY HEA	LTH HOSPICE		INDIAN	APOLIS, IN 46204			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	re I	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
	indicated "SN [S	killed Nursing] 1-2 x			specified in the patient's plan of	of		
	[times] week x 1	3 weeks MSS			care, dressing changes, wound			
		Services] 1 x week x 1			care, and/or added disciplines			
	-	•			services or equipment to meet			
	· ·	ssess, changes and			the needs of the patient.			
	requests. Provide	e counseling, emotional			Documentation of receipt of the			
	* *	tional positive regard			verbal order and of the written sent to the physician for signat			
	AID 1 x week x	1 week, 3-4 x week x 12			are maintained in patient's	.ure		
		tual Counselor] 4 PRN			medical record per current poli	<sub>CV</sub>		
	- 1	essments, changes,			Physician Orders WE.P30.			
					·Action planned:			
	•	ecord failed to evidence			1.Clinical leaders reviewe	ed		
		g of alprazalam as well			pertinent policy: Physician			
	as notification to	the physician that			Orders WE.P30, no changes			
	patient received	more alprazalam than			were recommended for this			
	physician ordere	d.			policy.			
	F 32 - 11 - 11 - 1				2.Policy WE.P30 was			
	A The ease	and do assessed titled			developed February 2009, last			
		ncy's document titled			reviewed and updated on			
		Notes," dated 3/3/17			February 2015 and was design	nea		
	indicated, "CG [	caregiver] gave 6 mg			to communicate guidelines for physician orders.			
	[milligram] alpra	azalam."			3.Clinical leaders plan to			
					educate hospice staff on the			
	B The ager	cy's document titled			procedure for physician orders	.		
	_	Oncall/Unscheduled visit			4.The Agency's Statewide			
	•				Medical Director plan to educa			
		" indicated "pt [patient]			medical director staff on the			
		able once bladder was			procedures for physician order			
	drained and alpra	azalam dose 6 mg."			5.Random chart audits wi	ill		
					be conducted to monitor			
	C. The ager	ncy's document titled			compliance with policy WE.P3	υ		
	"Medication Star	_			including the documentation within the EMR.			
		mouth tablet 2 MG. 1			·How the actions will improve	_		
	-				the processes: Anticipated	_		
		urs as needed PO [as			outcome of this education, and	,		
	needed] for anxi	ety."			chart audits is that hospice sta			
					will be fully aware and complia			
	2. The agencies	Job description titled			with the policy and expectation			
	_	al Operations," dated			Procedures for implementin			
	1	r, www.						

PRINTED: 08/08/2017 FORM APPROVED OMB NO. 0938-0391

	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CC		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION IDENTIFICATION NUMBER:	A. BUILDING B. WING	00	COMPLETED		
	151511	B. WING		07/05/2017		
INDIANA	UNIVERSITY HEALTH HOSPICE	STREET ADDRESS, CITY, STATE, ZIP CODE  950 NORTH MERIDIAN STREET, SUITE 700 INDIANAPOLIS, IN 46204				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
	May 28, 2013 stated, "Assures the clinical competence of staff Maintains twenty four accountability for quality patient care Maintains knowledge of best practices in areas of clinical and organizational responsibility Assures unit compliance with all state and national regulatory standards Accountable for daily unit operations.		the plan of correction for this deficiency:  1.This education, provide via written educational materia and interactive discussion of the materials with clinical team members, is scheduled for completion by 8-5-17.  2.Education and discussi will take place at each region location's staff meeting and completed by August 5th.  The Clinical Director will be responsible for monitoring the corrective actions to ensure the this deficiency is corrected and will not recur.  A quarterly clinical record review and shared visit tool had been developed for hospice and will begin now with these audit for second quarter 2017.  Results of the Clinical Record Reviews will be documented as shared with clinical leaders to share with staff. Data and trem will be reviewed in the Agency QAPI meetings.	on  see at d  ss and d  ss		
L 0680 Bldg. 00	418.104(c) PROTECTION OF INFORMATION The clinical record, its contents and the information contained therein must be safeguarded against loss or unauthorized use. The hospice must be in compliance with the Department's rules regarding personal health information as set out at 45 CFR parts 160 and 164.					
	Based on record review, policy review,	L 0680	Summary Statement: The	08/05/2017		

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

Event ID:

URIR11

Facility ID: 005128

If continuation sheet

Page 44 of 60

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SI	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	A. BUILDING <u>00</u>		COMPLETED	
		151511	B. WI	ING		07/05/2	2017
				STREET A	ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIEF	<b>{</b>	950 NORTH MERIDIAN STREET, SUITE 700				
INDIANA	UNIVERSITY HEA	LTH HOSPICE	INDIANAPOLIS, IN 46204				
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	· · · · · · · · · · · · · · · · · · ·		DATE
		e agency failed to protect			agency will protect and safeguard records against loss. (1 or 10 records reviewd)		
	_	ecords against loss for 1					
	of 10 records rev	viewed (#1).					
	Findings include	·					
					Action Planned:		
		record of patient #1 was			·The agency Leadership		
		eviewed and indicated a start of care			reviewed policies CES.C15		
	date of $2/2/17$ . The record contained a				Clinical Records, and PFC.H	20	
	plan of care date			Hospice Care For Nursing			
	indicated "SN [S			Facility			
	[times] week x 13 weeks SN 5 PRN				Residents-Coordination of		
	[as needed]: symptom management,				Care, No suggestions for revisions were made for		
	patient comfort,	family request. Instruct			CES.C15. Suggestions mad	e	
	_	r on around the clock			to revise policy PFC.H20 to	<b>"</b>	
	medication admi				include provision that writte	n	
		pain medication log,			documentation left in facility	/ is	
		patient/caregiver on			considered to be part of		
	_	inistration, side effects,			hospice Clinical Record and		
		ctiveness Aid 1-2 x			will be picked up by Hospice	9	
	· ·	s Provide personal			Agency Staff upon death or discharge of patient and tha	,	
	care and assistar	•			this documentation will be	`	
					scanned into the Hospice		
	-	ily living] SC			Agency's EMR.		
	[Spiritual Care]				Policy CES.C15 was	.	
		piritual care SC 1 x			developed February 2009, las		
		he hospice failed to			reviewed and updated April 2 and was designed to	015,	
	1	rotect hospice records			communicate guidelines for		
	,	n facility where patient			clinical records.		
	_	tient passed away. The			PRC.H20 was develope		
	_	ospice could locate			February 2009, last reviewed		
	patients hospice	records from hospice			updated on February 2015 an was designed to communicate		
	binder.				guidelines for coordination of		
					care, including Hospice medic		
	A. During a	nn interview on 6/28/17 at			records in a facility. Policy rev		

CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING 00 COMPLETED 151511 B. WING 07/05/2017 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 950 NORTH MERIDIAN STREET, SUITE 700 INDIANA UNIVERSITY HEALTH HOSPICE INDIANAPOLIS, IN 46204 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE  $\mathsf{TAG}$ to include provision that written 11:00 AM, Employee A, the documentation left in the facility is administrator, stated that the hospice considered part of the Hospice records within the binders at facilities are Clinical Record and will be picked the property of the facility since it is on up by Hospice Agency Staff at discharge of or death of patient site at the facility. and will be scanned into the EMR. ·Provide Staff education before B. During an interview on 6/27/17 at August 5, 2017, around the facility 12:12 PM, Employee AA, the Director of record considered part of the Hospice Clinical Record and will Nursing at the facility where patient be picked up by Hospice Agency resided, stated that the facility medical staff upon death or discharge of records department called the hospice the patient, then scanned into the inquiring where the hospice Hospice Agency's EMR. documentation was from the hospice ·Random shared visits will be binder. Stated the hospice instructed that conducted with leadership visiting after patient death that the binder is patients in facilities at each picked up and the records are shredded. location to assess and monitor compliance with policy CES.C15 Clinical Records and PFC.H20 C. During an interview on 6/28/17 at Hospice Care for Nursing Facility 12:06 PM, the administrator stated that Residents, including the when facility called hospice in regards to documentation within the EMR. records employee K told facility that the ·How the actions will improve the processes: Anticipated binder is picked up after death. outcome of this education, shared visits and chart audits is that D. During an interview on 6/28/17 at hospice staff will be fully aware of 12:07 PM, the administrator stated that the policy and expectations. ·Procedures for implementing the hospice gives the facility the option to the plan of correction for this keep the records from the hospice binder. deficiency: If facility does not want the records then 1.Clinical Leaders will it will be scanned into the hospice provide education via written educational materials and records. Also stated that there is no interactive discussion of the records from the facility scanned into materials with clinical team patients hospice record. members, is scheduled for completion by 8-5-17.

E. During interview on 6/27/17 at

2.Education and discussion

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. Bl	UILDING	00	COMPLETED		
		151511	B. W	ING		07/05/2017		
NAME OF I	PROVIDER OR SUPPLIE	R	-	STREET A	ADDRESS, CITY, STATE, ZIP CODE			
				950 NORTH MERIDIAN STREET, SUITE 700				
INDIANA	UNIVERSITY HEA	ALTH HOSPICE		INDIANAPOLIS, IN 46204				
(X4) ID		STATEMENT OF DEFICIENCIES		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 DEFICIENCY)		ION	
TAG		R LSC IDENTIFYING INFORMATION)		TAG	will take place at each region	DATE		
	-	ployee AA stated that			location's staff meeting and			
	hospice documentation is usually sent to facilities medical records and then				completed by August 5th.			
					·The Clinical Director will be			
	scanned into the	e patients chart.			responsible for monitoring the			
	F. During interview on 6/27/17 at 12:13 PM, Employee AA stated that				corrective actions to ensure the this deficiency is corrected an			
					will not recur.			
					·A quarterly clinical record			
	_	ice documentation in the			review tool has been develop			
	facilities records for this patient.				for hospice and will include th information for second quarte			
		41 - 23 - 4			2017.	·		
	2. The agencies	_			·Results of the Clinical Reco			
		N/STORAGE/DESTRUC			Reviews will be documented			
		NT RECORDS," Policy			shared with clinical leaders to			
		ed March 2017 stated			discuss with staff. Data and trends will be reviewed in the			
	_	policy applies to all paper			Agency's QAPI meetings.			
		lient records POLICY						
	STATEMENTS	S: [Agency] is responsible						
	for the protection	on of client records and						
	the storage of th	iose records once the						
	_	discharged or is no						
		g services from [agency].						
	Client record							
		inst loss All records						
		ned for ten (10) years						
		of service or record						
	creation."							
		***						
	_	S Job description titled						
		wide Clinical Home						
		pice," dated April 14,						
		cumbent is responsible						
	_	compliance in process,						
		ce for all Statewide						
	Homecare and I	Hospice activities Acts						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING <u>00</u>		00	COMPLETED	
		151511	B. WI	NG		07/05/	2017
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE  950 NORTH MERIDIAN STREET, SUITE 700 INDIANAPOLIS, IN 46204				
(X4) ID	SUMMARY S	FATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	re .	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	as the CMS [Centers for Medicaid and Medicare] Administrator for Home Health and Hospice."						
L 0681	418.104(d)						
Bldg. 00	RETENTION OF RECORDS Patient clinical records must be retained for 6 years after the death or discharge of the patient, unless State law stipulates a longer period of time. If the hospice discontinues operation, hospice policies must provide for retention and storage of clinical records. The hospice must inform its State agency and its CMS Regional office where such clinical records will be stored and how they may be accessed.		L 06	581	Summary Statement: The		08/05/2017
			2 0001		agency will retain written hosp records from a skilled nursing facility. (1 or 10 records reviewed)	ice	
	Findings include	:			Action Planned:  The agency Leadership		
	reviewed and inc date of 2/2/17. T plan of care date indicated "SN [S [times] week x 1 [as needed]: sym patient comfort,	cecord of patient #1 was dicated a start of care The record contained a d 2/2/17-5/2/17, which killed Nurse] 1-2 x 3 weeks SN 5 PRN aptom management, family request. Instruct on around the clock nistration and			reviewed policies CES.C15 Clinical Records, and PFC.H2t Hospice Care For Nursing Fac Residents-Coordination of Car No suggestions for revisions w made for CES.C15. Suggestic made to revise policy PFC.H2t include provision that written documentation left in facility is considered to be part of hospic Clinical Record and will be pict up by Hospice Agency Staff up death or discharge of patient a	e, vere ons O to  ce ked	

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

Event ID:

URIR11

Facility ID: 005128

If continuation sheet

Page 48 of 60

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00		00	COMPLETED	
		151511	B. W	B. WING		07/05/2017	
				CTREET	ADDRESS CITY STATE ZID CODE		
NAME OF F	PROVIDER OR SUPPLIEF	2			ADDRESS, CITY, STATE, ZIP CODE	FF 700	
INIDIANIA		1 TI I I I O O DI O E		950 NORTH MERIDIAN STREET, SUITE 700		E 700	
INDIANA	UNIVERSITY HEA	ALTH HOSPICE		INDIAN	APOLIS, IN 46204		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	re C	OMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	maintenance of	pain medication log,			that this documentation will be		
		patient/caregiver on			scanned into the Hospice		
	_	inistration, side effects,			Agency's EMR. Hospice staff		
		ectiveness Aid 1-2 x			discontinue the practice of lear		
					their written documentation (in	tne	
		s Provide personal			form of communication notes, progress notes, etc.,)		
	care and assistan				Policy CES.C15 was		
	[Activities of da	ily living] SC			developed February 2009, last		
	[Spiritual Care]	8 PRN: Provide			reviewed and updated April 20		
	relation-based sp	oiritual care SC 1 x			and was designed to		
	dav x 1 dav." Tl	he hospice failed to retain			communicate guidelines for		
	1 -	from facility where			clinical records.		
	_				PRC.H20 was developed		
		after patient passed away.			February 2009, last reviewed a		
		the hospice could locate			updated on February 2015 and was designed to communicate		
		records from hospice			guidelines for coordination of		
	binder.				care, including Hospice medic	al I	
					records in a facility.Policy revis		
	A. During a	an interview on 6/28/17 at			to include provision that written		
	11:00 AM, Emp				documentation left in the facilit	y is	
		ated that the hospice			considered part of the Hospice	;	
	· ·	•			Clinical Record and will be pic		
		ne binders at facilities are			up by Hospice Agency Staff at		
		he facility since it is on			discharge of or death of patier		
	site at the facility	y.			and will be scanned into the E Provide Staff education before		
					August 5, 2017, around the fac		
	B. During a	in interview on 6/27/17 at			record considered part of the	Jiiity	
		loyee AA, the Director of			Hospice Clinical Record and w	rill	
		acility where patient			be picked up by Hospice Ager		
		-			staff upon death or discharge		
	· ·	nat the facility medical			the patient, then scanned into	the	
		ent called the hospice			Hospice Agency's EMR.		
	inquiring where	*					
	documentation v	vas from the hospice			·Clinical Leaders will perform		
	binder. Stated th	e hospice instructed that			random shared visits will be		
		th that the binder is			conducted with staff visiting		
	-	ne records are shredded.			patients in facilities at each		
	picked up and in	ic records are sineducu.			location to assess and	,	
					monitorcompliance with policy	'	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	A. BUILDING <u>00</u>		COMPLETED	
		151511	B. W	ING		07/05/2017	
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	t .		950 NO	RTH MERIDIAN STREET, SUI	E 700	
	UNIVERSITY HEA	LTH HOSPICE		INDIAN	APOLIS, IN 46204		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)		ON
TAG		LSC IDENTIFYING INFORMATION)		TAG	CES.C15 Clinical Records and	DATE	
	_	n interview on 6/28/17 at			PFC.H20 Hospice Care for	1	
	-	dministrator stated that			Nursing Facility Residents,		
	1	lled hospice in regards to			including the documentation		
	records employe	e K told facility that the			within the EMR.		
	binder is picked	up after death.			·How the actions will improve	9	
					the processes: Anticipated outcome of this education, sha	red	
	D. During an interview on 6/28/17 at				visits and chart audits is that		
	12:07 PM, the ac	dministrator stated that			hospice staff will be fully aware	e of	
	the hospice give	s the facility the option to			the policy and expectations.		
	keep the records from the hospice binder.  If facility does not want the records then				·Procedures for implementin	g	
					the plan of correction for this deficiency:		
	_	d into the hospice			1.Clinical Leaders will		
		ated that there is no			provide education via written		
	records from the	facility scanned into			educational materials and		
	patients hospice				interactive discussion of the		
	patronis nespies	100014.			materials with clinical team members, is scheduled for		
	F During i	nterview on 6/27/17 at			completion by 8-5-17.		
	1	loyee AA stated that			2.Education and discussi	on	
	_	ntation is usually sent to			will take place at each region		
	_	l records and then			location's staff meeting and		
					completed by August 5th.  •The Clinical Director will be		
	scanned into the	patients chart.			responsible for monitoring the	se	
	F 5	(107/17)			corrective actions to ensure th		
	_	nterview on 6/27/17 at			this deficiency is corrected and	i	
	-	oyee AA stated that			will not recur.		
		ce documentation in the			·A quarterly clinical record	d	
	facilities records	for this patient.			review tool has been develope for hospice and will include thi		
					information for second quarter		
	_	Job description titled			2017.		
	"Director-Statew	vide Clinical Home			Results of the Clinical Reco		
	Health and Hosp	pice," dated April 14,			Reviews will be documented a	nd	
	2016 stated, "Inc	cumbent is responsible			shared with clinical leaders to discuss with staff. Data and		
	for maintaining	compliance in process,			trends will be reviewed in the		
	policy and service	ce for all Statewide			Agency's QAPI meetings.		
		Iospice activities Acts					

PRINTED: 08/08/2017 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  151511		A. BUILDING B. WING	00	COMPLETED 07/05/2017	
NAME OF PROVIDI		LTH HOSPICE	950 NO	ADDRESS, CITY, STATE, ZIP CODE ORTH MERIDIAN STREET, SUI NAPOLIS, IN 46204	TE 700
`	EACH DEFICIEN	TATEMENT OF DEFICIENCIES  CY MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
Med	_	ters for Medicaid and nistrator for Home ice."			
Bldg. 00  Bldg. 00  (3) T requirement for requirement for requirement for requirement for for requirement for requirement for requirement for for requirement for for requirement for requirement for for requirement for requ	the hospice di ired by (e)(1) it include- summary of the ments, sympto agement; he patient's can be called to ested by the activing facility, and on recording facility are done of a commary was commation for 1 december of 2/2/17. The of care date cated "SN [Sizes] week x 1 december of the called to cate and the cate and the cate of the called "SN [Sizes] week x 1 december	arrent plan of care; attest physician orders; and amentation that will assist continuity of care or that is attending physician or review and interview the ensure that the discharge mplete with all required of 10 records reviewed	L 0684	Summary statement: The age ensures that the discharge summary is complete with all required information.  Action planned:  1.Clinical leaders review pertinent policy: CES.D15 Discharge from Hospice Care and no changes were recommended for this policy.  1.Policy CES.D15 Discharge from Hospice Care was developed February 2008 last reviewed and updated on February 2015, and was design to communicate guidelines for	ed 9,

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

Event ID:

URIR11

Facility ID: 005128

If continuation sheet

Page 51 of 60

PRINTED: 08/08/2017 FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING AND PLAN OF CORRECTION 00 COMPLETED 151511 B. WING 07/05/2017 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 950 NORTH MERIDIAN STREET, SUITE 700 INDIANA UNIVERSITY HEALTH HOSPICE INDIANAPOLIS, IN 46204 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE  $\mathsf{TAG}$ discharging a hospice patient, patient comfort, family request. Instruct including required information for patient/caregiver on around the clock the discharge summary. medication administration and 2.Clinical leaders maintenance of pain medication log, re-educated all Hospice staff on Assess/instruct patient/caregiver on the policy and guidelines of required information for a medication administration, side effects, discharge summary. actions, and effectiveness ... Aid 1-2 x ·How the actions will improve week x 13 weeks ... Provide personal the processes: Anticipated outcome of this education is that care and assistance with ADL's the hospice staff will be fully [Activities of daily living] ... SC aware and compliant with the [Spiritual Care] 8 PRN: Provide policy and expectations. relation-based spiritual care ... SC 1 x ·Procedures for implementing the plan of correction for this day x 1 day." The record failed to deficiency: evidence a complete and accurate 1.Provide education to all discharge summary. Hospice Staff, provided via written educational materials and A. The agency's document titled interactive discussion of the materials with clinical team "Agency Discharge summary as of members, is scheduled for 7/5/2017," indicated "Services Provided, completion by 8-5-17. Goals/Expected Health Status 2.Education and discussion Evaluation." The record failed to will take place at each region location's staff meeting and evidence a summary of the patient's stay completed by August 5th. including treatments, symptoms and pain ·The Clinical Director will be management; the patients current plan of responsible for monitoring these care; and the patient's latest physician corrective actions to ensure that this deficiency is corrected and orders. will not recur. ·A quarterly clinical record 2. The agencies Job description titled review tool has been developed "Director-Statewide Clinical Home for hospice and will include this information for second quarter Health and Hospice," dated April 14,

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

2016 stated, "Incumbent is responsible

for maintaining compliance in process,

Homecare and Hospice activities ... Acts

policy and service for all Statewide

Event ID:

URIR11

Facility ID: 005128

2017.

·Results of the Clinical Record

Reviews will be documented and

shared with clinical leaders to discuss with staff. Data and

If continuation sheet

Page 52 of 60

PRINTED: 08/08/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA  AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MUI A. BUII		NSTRUCTION	(X3) DATE S COMPL		
151511		B. WIN		00	07/05/		
101011						017007	2017
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE  950 NORTH MERIDIAN STREET, SUITE 700				
INDIANA	UNIVERSITY HEA	LTH HOSPICE	INDIANAPOLIS, IN 46204				
(X4) ID		FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL	P	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	trends will be reviewed in the		DATE
	-	iters for Medicaid and			Agency's QAPI meetings.		
	-	nistrator for Home					
	Health and Hosp	ice.					
	2 During on inte	erview on 7/5/17 at					
		Iministrator stated that					
	· ·	narge summary is the					
	0 ,	sent to the physician					
	upon discharge o	1 3					
	upon disentinge o	r patient death.					
L 0778	418.112(e)(1)(i)						
20770	COORDINATION	OF SERVICES					
Bldg. 00		terdisciplinary group					
	member is respons						
		Il coordination of the eSNF/NF or ICF/MR					
	resident with SNF/						
	representatives;						
	Based on record	review, policy review,	L 077	78	·Summary statement: The		08/05/2017
	and interview the	e agency failed to ensure			agency ensures the staff is	,	
	that coordination	of care was established			providing the following for each specific patient: most recent	1	
	with facility staff	f with every nursing visit			hospice plan of care, hospice		
	for 4 of 9 record	s reviewed receiving			election form, any advance		
	hospice in Skille	d Nursing Facilities			directives, physician certification		
	(SNF) (1, 4, 5, 6)	).			and recertification of the termir illness, names and contact	ıdı	
					information for hospice person	nel	
	Findings include	·			involved in the care, instructior	าร	
					on how to access the hospice's		
	1. The clinical re	ecord of patient #1 was			24 hour on call system, hospic medication information, and	E	
					caroadori imorridatori, aria		

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

Event ID:

URIR11

Facility ID: 005128

If continuation sheet

Page 53 of 60

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUF			(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING <u>00</u> COMPLETED			COMPLETED		
151511			B. W	ING		07/05/2017	
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	₹			ORTH MERIDIAN STREET, SUI	TE 700	
INDIANA UNIVERSITY HEALTH HOSPICE					IAPOLIS, IN 46204	12 700	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	ION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	
	reviewed and in	dicated a start of care			hospice physician and attendi	-	
	date of 2/2/17.	The record contained a			physician (if any) orders speci	fic	
	plan of care date	ed 2/2/17-5/2/17, which			to the patient. In addition,	oro	
	1 *	Skilled Nurse] 1-2 x			documenting coordination of countries in the patient record all of this		
	_	3 weeks SN 5 PRN			current policy Coordination of	PCI	
	1				Care PRC.H20.		
	1 -	nptom management,			·Action planned:		
	1 *	family request. Instruct			1.Clinical leaders reviewe		
		r on around the clock			pertinent policy: Hospice Care	e for	
	medication adm	inistration and			Nursing Facility Residents –	_	
	maintenance of	pain medication log,			Coordination of Care PRC.H2		
	Assess/instruct p	patient/caregiver on			no changes were recommend for this policy.	eu	
	medication adm	inistration, side effects,			1.Policy PRC.H20 wa	s	
		ectiveness Aid 1-2 x			developed February 2009, las		
	· ·	s Provide personal			reviewed and updated on		
	care and assistar	•			February 2015 and was desig	ned	
					to communicate guidelines for		
	-	ily living] SC			coordination of care in a facilit	y.	
		elor] 8 PRN: Provide			2.Clinical leaders	an	
	relation-based sp	piritual care SC 1 x			Re-education of Hospice staff the procedure for providing the		
	day x 1 day."				facility with the aforementione		
					documents and correctly		
	A. In the ag	gency's document titled			documenting coordination of c	are	
	_	Initial Visit- on 02-02-			within the assessment.		
		nanagement section of			3.Random Shared visits		
	I	cated "Case Coordination:			be conducted with staff visiting	]	
		ication with other			patients in facilities at each location to assess and monito	.	
					compliance with policy	' <u> </u>	
		ncies and vendors today."			Coordination of Care PRC.H2	0	
		ord failed to evidence any			including the documentation		
	care coordinatio	n between the hospice			within the EMR.		
	nurse and the fa	cility staff or family.			·How the actions will improv	e	
					the processes: Anticipated	. [	
	B. In the ag	gency's document titled			outcome of this education, sha	ared	
	1	Routine Visit- on 02-04-			visits and chart audits is that		
	_	ment contains no			hospice staff will be fully awar	e or	
	· ·				the policy and expectations.  Procedures for implementing		
	mention of care	coordination. The record			1-10cedures for implementin	9	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		IDENTIFICATION NUMBER:	A. BUILDING <u>00</u> COMPI			ETED	
151511			B. WING 07/05/2017				2017
		<u> </u>		CTDEET /	ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF P	ROVIDER OR SUPPLIE	R				TE 700	
INIDIANA	UNIVERSITY HEA	N TH HOSPICE			RTH MERIDIAN STREET, SUI APOLIS, IN 46204	IE /00	
	UNIVERSIIT HEF	ALIII HUOFIUE		INDIAN	AFOLIO, IN 40204		
(X4) ID		STATEMENT OF DEFICIENCIES		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
		ce any care coordination			the plan of correction for this		
	between the hos	pice nurse and the facility			deficiency: 1.This education, provide	ad	
	staff or family.				via written educational materia		
					and interactive discussion of t		
	2 The clinical i	record of patient #4 was			materials with clinical team	<del></del>	
		dicated a start of care			members, is scheduled for		
		5. The record contained a			completion by 8-5-17.		
					2.Education and discuss	ion	
	•	ed 5/14/17-7/12/17, which			will take place at each region		
		x week x 9 weeks			location's staff meeting and		
	MSS [Medical S	Social Services] 4 PRN:			completed by August 5th.  3.Clinical staff will be		
	Counseling, fina	ancial concerns, resource			required to sign a statement		
	referrals, AID 2	x week x 9 weeks, SC			indicating he/she has reviewe	d	
	1-2 x month."	•			the educational materials and		
					understands the expectation of		
	Δ In the or	gency's document titled			completing all the component	s of	
	_	-			care coordination.		
	•	Routine Visit- on 05-15-			·The Clinical Director will be		
	•	nanagement section of			responsible for monitoring the corrective actions to ensure the		
		cated "Case Coordination:			this deficiency is corrected an		
	List all commun	nication with other			will not recur.	<u> </u>	
	disciplines, ager	ncies and vendors today."			·A quarterly clinical record		
	None." The rec	ord failed to evidence any			review tool has been develop		
		on between the hospice			for hospice and will include th		
		cility staff or family.			information for second quarte	r	
		,			2017.  Results of the Clinical Reco	ard	
	R In the oc	gency's document titled			Reviews will be documented a		
	_	•			shared with clinical leaders to		
	•	Routine Visit- on 05-22-			discuss with staff. Data and		
	-	nanagement section of			trends will be reviewed in the		
		cated "Case Coordination:			Agency's QAPI meetings.		
	List all commun	ication with other					
	disciplines, ager	ncies and vendors today."					
	None." The rec	ord failed to evidence any					
		n between the hospice					
		cility staff or family.					
	naise and me in	one, our or mining.					

PRINTED: 08/08/2017 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151511	(X2) MULTIPLE A. BUILDING B. WING	E CONSTRUCTION  G 00	СОМЕ	E SURVEY PLETED 5/2017		
NAME OF PROVIDER OR SUPPLIER INDIANA UNIVERSITY HEALTH HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE  950 NORTH MERIDIAN STREET, SUITE 700 INDIANAPOLIS, IN 46204					
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE		
	C. In the ag "Hospice v16.3 I 2017, the care m assessment indic List all commun disciplines, agen None." The reco care coordination nurse and the fac  D. In the ag "Hospice v16.3 I 2017, the care m assessment indic List all commun disciplines, agen None." The reco care coordination nurse and the fac  3. The clinical r reviewed and inc date of 9/30/16. plan of care date indicated "SN 1- Instruct patient/c clock medication maintenance of p Instruct patient/c poorly controlled Assess/Instruct/r	ency's document titled Routine Visit- on 06-12- anagement section of ated "Case Coordination: ication with other cies and vendors today." ord failed to evidence any a between the hospice cility staff or family.  ency's document titled Routine Visit- on 06-19- anagement section of ated "Case Coordination: ication with other cies and vendors today." ord failed to evidence any a between the hospice cility staff or family.  ecord of patient #5 was dicated a start of care The record contained a d 5/28/17-7/26/17, which 3 x week x 9 weeks. caregiver on around the a administration and bain medication log, caregiver on reporting d pain to Hospice, monitor patient/caregiver mistration, side effects,						
	medication dose	for comfort per						

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

Event ID:

URIR11

Facility ID: 005128

If continuation sheet

Page 56 of 60

PRINTED: 08/08/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  151511			(X2) MUL A. BUII B. WIN	DING	STRUCTION  00	(X3) DATE : COMPL 07/05/	ETED
NAME OF PROVIDER OR SUPPLIER INDIANA UNIVERSITY HEALTH HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE  950 NORTH MERIDIAN STREET, SUITE 700 INDIANAPOLIS, IN 46204				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	weeks Provide p	AID 1-2 x week x 9 bersonal care and ADL's, Companionship."					
	"Hospice v16.3 2017, the care massessment indicated List all commun disciplines, agen None." The recordination	gency's document titled Routine Visit- on 06-01- nanagement section of cated "Case Coordination: ication with other ncies and vendors today." ord failed to evidence any n between the hospice cility staff or family.					
	6/27/17 at 9:45 A observed that the contained no conterminal illness of hospice staff contained to the contained the contained no conterminal illness of the contained the	risit to the facility on AM, the surveyor e Hospice Binder nsents, certificate of or recertifications, ntact information, 24 hour ation list, or physicians					
	reviewed and ind date of 2/9/17. The plan of care date indicated "SN 1 AID 2 x week x	record of patient #6 was dicated a start of care The record contained a start 5/10/17-8/7/17, which a week x 13 weeks 13 weeks provide d assistance with ADL's."					
	"Hospice v16.3	gency's document titled Routine Visit- on 06-13- nanagement section of					

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

Event ID:

URIR11

Facility ID: 005128

If continuation sheet

Page 57 of 60

PRINTED: 08/08/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  151511		(X2) MULT A. BUILI B. WING		NSTRUCTION  00	(X3) DATE COMPL <b>07/05</b> /	ETED	
NAME OF PROVIDER OR SUPPLIER  INDIANA UNIVERSITY HEALTH HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE  950 NORTH MERIDIAN STREET, SUITE 700 INDIANAPOLIS, IN 46204				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES  NCY MUST BE PRECEDED BY FULL  R LSC IDENTIFYING INFORMATION)	PRI	D EFIX 'AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	List all commundisciplines, ager None." The recordination nurse and the factor B. In the age "Hospice v16.3 2017, the care massessment indiction List all commundisciplines, ager None." The recordination nurse and the factor care coordination nurse and the factor facto	cated "Case Coordination: nication with other ncies and vendors today." ord failed to evidence any in between the hospice cility staff or family.  gency's document titled Routine Visit- on 06-20-nanagement section of cated "Case Coordination: nication with other ncies and vendors today." ord failed to evidence any in between the hospice cility staff or family.  record of patient #8 was dicated a start of care  The record contained a red 3/31/17-6/28/17, which -2 x week x 14 weeks."  visit to the facility on AM, the surveyor red Hospice Binder nisents, certificate of or recertifications, or res.  record of patient #9 was dicated a start of care  The record contained a red 6/19/17-9/16/17, which					

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

Event ID:

URIR11

Facility ID: 005128

If continuation sheet Page 58 of 60

PRINTED: 08/08/2017 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION  AND PLAN OF CORRECTION  IDENTIFICATION NUMBER:  151511		ì	UILDING	00	COMPL 07/05/	ETED		
NAME OF PROVIDER OR SUPPLIER INDIANA UNIVERSITY HEALTH HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE  950 NORTH MERIDIAN STREET, SUITE 700 INDIANAPOLIS, IN 46204					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE	
	[times] week x 1 month x 3 month week SC 1-3	Skilled Nurse] 1-2 x 3 weeks MSS 1-3 x ns AID 2 x week x 1 x month x 3 months."						
	6/28/17 at 8:57 A observed that the was not present. present that cont	AM, the surveyor Hospice Binder which There was a folder ained only progress note The folder contained no						
	terminal illness of hospice staff cor	f care, certificate of or recertifications, ntact information, 24 hour ation list, or physicians						
	"Director-Statew Health and Hosp 2016 stated, "Ind for maintaining policy and service Homecare and H as the CMS [Cer	Job description titled vide Clinical Home vice," dated April 14, cumbent is responsible compliance in process, ce for all Statewide Iospice activities Acts inters for Medicaid and inistrator for Home vice."						
	"Manager-Clinic May 28, 2013 st clinical compete twenty four acco	Job description titled cal Operations," dated ated, "Assures the nee of staff Maintains ountability for quality Maintains knowledge of						

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

Event ID:

URIR11

Facility ID: 005128

If continuation sheet

Page 59 of 60

PRINTED: 08/08/2017 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER  INDIANA UNIVERSITY HEALTH HOSPICE  (X4) ID  PREFIX  (EACH DEFICIENCY MUST BE PRECEDED BY FULL)  STREET ADDRESS, CITY, STATE, ZIP CODE  950 NORTH MERIDIAN STREET, SUITE 700  INDIANAPOLIS, IN 46204  ID  PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PROVIDER'S PLAN OF CORRECTION	` ′
PREFIX   CEACH DEFICIENCY MUST BE PRECEDED BY FULL   PREFIX   REGULATORY OR LSC IDENTIFYING INFORMATION)	COMPLETION DATE

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

Event ID:

URIR11

Facility ID: 005128

If continuation sheet Page 60 of 60