STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	151603	A. BUILDING 00 B. WING	01/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SEASONS HOSPICE & PALLIATIVE CARE OF INDIANA LLC	2629 WATERFRONT PARKWAY EAST DRIVE, SUITE 3 INDIANAPOLIS, IN 46214

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
S 0000 Bldg. 00	This visit was for a State Re-licensure Survey in conjunction with 4 complaints of a Deemed Hospice Provider. Visit Dates: January 20, 21, 22, 25 and 26, 2021 Complaint #: IN00219332: Unsubstantiated IN00259335: Unsubstantiated IN00310951: Substantiated. No State Deficiencies were cited. IN00222082: Substantiated. No State Deficiencies were cited. Facility #: 011779 Quality Review completed on 2/3/2021 A4	S 0000		
S 0545 Bldg. 00	418.56(c) CONTENT OF PLAN OF CARE The hospice must develop an individualized written plan of care for each patient. The plan of care must reflect patient and family goals and interventions based on the problems identified in the initial, comprehensive, and updated comprehensive assessments. The plan of care must include all services necessary for the palliation and management of the terminal illness and related conditions, including the following: Based on record review and interview, the Interdisciplinary Team failed to ensure a plan of care included services being provided by an outside home health provider and the delineation of duties between the hospice and home health agency in 1 of 1 record reviewed of a pediatric	S 0545	**Action** All RN Case Managers were assigned education on 2/10/2021 in Seasons University to be completed by 2/19/21. The education assigned covered the following:	05/19/2021

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	151603	A. BUILDING 00 B. WING	01/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SEASONS HOSPICE & PALLIATIVE CARE OF INDIANA LLC	2629 WATERFRONT PARKWAY EAST DRIVE, SUITE 3 INDIANAPOLIS, IN 46214

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	patient receiving services from a home health provider in a sample of 17. (Patient #1) Findings include: Review of an undated agency policy titled "Hospice Care To Residents in a Facility" indicated " .... 4. A written hospice plan of care must be established and maintained in consultation with the facility representatives ... a. The hospice plan of care must identify the care and services that are needed and specifically identify which provider is responsible for performing the respective functions that have been agreed upon and included in the hospice plan of care .... " Review of an undated agency policy titled "Plan of Care" indicated " ... Procedures: ... 2. ... h) Plans for instructing and educating the patient/ family and the designated caregiver as appropriate to their responsibilities for the care and services identified in the POC .... " [plan of care] Review of an undated agency policy titled "Medical Records" indicated " ... Procedures: 4. The medical record will include documentation of all care and services whether furnished directly or under arrangements." The clinical record for patient #1, Election Date 11/2/2018, was reviewed and included a SN visit note dated 11/12/20 which revealed in the visit narrative that there was collaboration of care with Person C from Entity G (a home health agency), but failed to include specifically what that collaboration was. Review of a SN visit note dated 11/19/20, revealed in the visit narrative that the patient's family		1. Facility Integration PowerPoint slides 2. Facility Integration Form 3. Protocol 2076 4. Policy 233: Hospice Care to Residents in a Facility 5. Policy 214: Plan of Care 6. Policy 901: Medical Records 7. Protocol 9008: Medical Records 8. Nursing manual – Wound section: Pages 162-167 9. Protocol 2005: Wound Care 10. Protocol 2063: IDG Meeting Process **Monitoring** Supervisory visits by Executive Director/Clinical Director/Team Director with each full time RNCM to ensure a complete and accurate assessment, documentation of measurable goals related to assessment findings and interventions within the plan of care, clear delineation of duties, and facility collaboration utilizing full name and credentials Immediate feedback will be provided to staff and follow up visits will be made if goals not met.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	151603	A. BUILDING 00 B. WING	01/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SEASONS HOSPICE & PALLIATIVE CARE OF INDIANA LLC	2629 WATERFRONT PARKWAY EAST DRIVE, SUITE 3 INDIANAPOLIS, IN 46214

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	member is a contracted primary caregiver for the patient. Review of two plans of care for the benefit period of 10/22/2020 to 12/20/2020 and 12/21/2020 to 2/18/2021, revealed that the hospice was providing skilled nursing and home health aide services. The plan of care failed to evidence the specific home health services the patient was receiving and failed to evidence any delineation of duties between both providers.		Supervisory visit audits will meet a threshold of 85% compliance or above for 3 consecutive months **Reporting** Leadership meetings are held every 2 weeks and results/trends of B2B visits, chart reviews, facility chart audits will be discussed, and action steps determined based on the data. Quarterly QAPI meetings will also review the trends and any follow up action steps implemented to ensure that compliance is maintained. **Responsible person** Executive Director	
S 0553 Bldg. 00	418.56(d) REVIEW OF THE PLAN OF CARE A revised plan of care must include information from the patient's updated comprehensive assessment and must note the patient's progress toward outcomes and goals specified in the plan of care. Based on record review and interview, the agency failed to ensure the Interdisciplinary Team updated the plan of care when there were changes in a patients feeding schedule for 1 of 1 records reviewed of a pediatric patient receiving gastric feedings (Patient #1) and failed to ensure patient goals were updated, measurable, and pertinent/specific to the patient's ongoing care needs in 2 of 7 active records reviewed from a sample of 17. (Patients #7 and #14)	S 0553	**Action** All RN Case Managers were assigned education on 2/10/2021 in Seasons University to be completed by 2/19/21. The education assigned covered the following: 1. Facility Integration PowerPoint slides 2. Facility Integration Form 3. Protocol 2076 4. Policy 233: Hospice Care	05/19/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	151603	A. BUILDING 00 B. WING	01/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SEASONS HOSPICE & PALLIATIVE CARE OF INDIANA LLC	2629 WATERFRONT PARKWAY EAST DRIVE, SUITE 3 INDIANAPOLIS, IN 46214

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Findings include: 1. Review of an agency policy titled "Interdisciplinary Group [IDG] Meeting Process" indicated " ... Protocol: ... 2. Prior to IDG meeting, all IDG members will complete the following: a. All care plans will be updated to include: 1) New problems, interventions and goals; 2) ... Discontinued problems, interventions or goals that are no longer current; .... " 2. The clinical record for patient #1, Election Date 11/2/2018, was reviewed and included a plan of care for the benefit periods of 10/22/2020 to 12/20/2020 and 12/21/2020 to 2/18/2021, in which orders included gastric tube [g-tube] feedings of "2 cans of Nestle Pediatric Complete Regular and 2 cans of Nestle Pediatric Complete Reduced Calorie @ 58 ml/hr [milliliters per hour] over 24 hours ... on 4L 02 via NC [4 liters of oxygen by nasal cannula]." The Interdisciplinary Team failed to update both plans of care as evidenced by the following: Review of skilled nursing visit notes dated 11/5/20 and 11/12/20 revealed g-tube feedings were infusing from 5:00 p.m. to 10:00 a.m., not the 24 hours per the plan of care. Review of skilled nursing visit notes dated 11/19/20, revealed the patient was on 5.0 liters of oxygen and g-tube feedings were infusing from 5:00 p.m. to 10:00 a.m., not the 24 hours per the plan of care. Review of a "Physician Interim Order Report" dated 12/3/2020, revealed an order for oxygen 5 - 6 liters per nasal cannula. On 12/7/2020, the 4 liters was discontinued		to Residents in a Facility 5. Policy 214: Plan of Care 6. Policy 901: Medical Records 7. Protocol 9008: Medical Records 8. Nursing manual – Wound section: Pages 162-167 9. Protocol 2005: Wound Care 10. Protocol 2063: IDG Meeting Process **Monitoring** Supervisory visits by Executive Director/Clinical Director/Team Director/Director of Business Operations with each full time RNCM to ensure a complete and accurate assessment, documentation of measurable goals related to assessment findings and interventions within the plan of care, clear delineation of duties , and facility collaboration utilizing full name and credentials Immediate feedback will be provided to staff and follow up visits will be made if goals not met. Supervisory visit audits will meet a threshold of 85% compliance or above for 3 consecutive months	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	151603	A. BUILDING 00 B. WING	01/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SEASONS HOSPICE & PALLIATIVE CARE OF INDIANA LLC	2629 WATERFRONT PARKWAY EAST DRIVE, SUITE 3 INDIANAPOLIS, IN 46214

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Review of skilled nursing visit notes dated 12/3/20, 12/10/20, 12/17/20, and 12/31/20, revealed the patient was on 5.0 liters of oxygen and g-tube feedings were infusing from 5:00 p.m. to 10:00 a.m., not the 24 hours per the plan of care. Review of skilled nursing visit notes dated 1/7/21 and 1/14/21 revealed the patient was on 5.5 liters of oxygen and g-tube feedings were infusing from 5:00 p.m. to 10:00 a.m., not the 24 hours per the plan of care. Review of a "Patient Chart Report" dated 10/1/2020 to 1/20/2021, revealed "Problem O-002 Orders: Nutrition/Diet Updated 9/2/20 Interventions IN02" indicating the patient's g-tube feedings were infusing over 24 hours and "Problem R-002 Orders: Respiratory/ Dyspnea Updated 9/2/2020 Interventions IN03" indicating the patient was on 4 liters of oxygen. The chart report also included the "IDG Scribe" dated 11/18/20, which revealed the patient was on 4.5 liters of oxygen and g-tube feedings were infusing from 5:00 p.m. to 10:00 a.m. and the scribes for 12/2/20, 12/16/20, and 12/30/20, revealed the patient was on 5 liters of oxygen and g-tube feedings were infusing from 5:00 p.m. to 10:00 a.m. Review of an "IDT Care Plan" dated 12/21/2020 to 1/22/2021, revealed an update on 1/15/2021 indicating the patient's g-tube feedings were infusing over 24 hours and the last update on the patients oxygen nursing interventions was on 9/2/20, indicating the patient was on 4 liters of oxygen. The findings were reviewed on 1/26/2021 at 11:00 a.m., in which Employee M stated the plan of care should have been updated and it was the responsibility of the case manager to do so.		**Reporting** Leadership meetings are held every 2 weeks and results/trends of B2B visits, chart reviews, facility chart audits will be discussed, and action steps determined based on the data. Quarterly QAPI meetings will also review the trends and any follow up action steps implemented to ensure that compliance is maintained. **Responsible person** Executive Director	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	151603	A. BUILDING 00 B. WING	01/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SEASONS HOSPICE & PALLIATIVE CARE OF INDIANA LLC	2629 WATERFRONT PARKWAY EAST DRIVE, SUITE 3 INDIANAPOLIS, IN 46214

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	3. A review of a document for Patient #7 titled "Hospice Certification and Plan of Treatment" for benefit period 11/23/20-1/21/21 revealed a clinical summary, updated 11/22/20, showing a stage 2 pressure ulcer requiring daily dressing changes. No goal was included to address the patient's wound. 4. A review of a document for Patient #14 titled "Patient Chart Report" revealed a neurological assessment from 1/21/21 that stated the patient was alert and oriented to person, place, and time, could make her needs known, appeared more relaxed, and her daughter was anxious the patient would be exposed to Covid 19. The goal stated, "Patient will continue to participate in activities." The same document revealed the patient often complained of nausea and stated she was going to vomit, but would belch and have relief. She had hyperactive bowel sounds, and had no changes or concerns with oral intake. The goal stated, "Patient will maintain bowel functions." Further review of the document revealed the patient had oxygen ordered, however her daughter declined to allow oxygen use. The goal stated, "Patient will maintain comfortable respiratory status." The clinical record lacked patient goals that were specific to the patient's ongoing care needs. 5. During an interview on 1/26/21 at 11:49 a.m., the Team Director agreed that goals were not updated, measurable, patient specific, or pertinent to either patients current care needs at the time.			
S 0558 Bldg. 00	418.56(e)(5) COORDINATION OF SERVICES [The hospice must develop and maintain a system of communication and integration, in accordance with the hospice's own policies and procedures, to-]			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	151603	A. BUILDING 00 B. WING	01/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SEASONS HOSPICE & PALLIATIVE CARE OF INDIANA LLC	2629 WATERFRONT PARKWAY EAST DRIVE, SUITE 3 INDIANAPOLIS, IN 46214

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	(5) Provide for an ongoing sharing of information with other non-hospice healthcare providers furnishing services unrelated to the terminal illness and related conditions. Based on record review and interview, the agency failed to ensure all collaboration with outside providers was documented in 1 of 1 record reviewed of a pediatric patient receiving services from a home health provider in a sample of 17. (Patient #1) Findings include: Review of an undated agency policy titled "Medical Records" indicated " ... 2. the medical record will contain at least the following documents: ... Evidence of coordination of services through the interdisciplinary group and the attending physician .... " Review of an undated agency policy titled "Plan of Care" indicated " ... Procedures: ... 6. The IDG will maintain and document a system of communication to: a) Ensure that the IDG maintains responsibility for directing, coordinating and supervising the care and services provided; ... d) Provide for and ensure the ongoing sharing of information between all disciplines providing care and services in all settings, whether the care and services are provided directly or under arrangements; e) Provide for an ongoing sharing of information with other non-hospice healthcare providers furnishing unrelated to the terminal illness and related conditions. All communications will be documented in the patient's medical record .... " The clinical record for patient #1, Election Date 11/2/2018, was reviewed. On 1/20/2020, the	S 0558	**Action** All RN Case Managers were assigned education on 2/10/2021 in Seasons University to be completed by 2/19/21. The education assigned covered the following: 1. Facility Integration PowerPoint slides (Attached) 2. Facility Integration Form 3. Protocol 2076 4. Policy 233: Hospice Care to Residents in a Facility 5. Policy 214: Plan of Care 6. Policy 901: Medical Records 7. Protocol 9008: Medical Records 8. Nursing manual – Wound section: Pages 162-167 9. Protocol 2005: Wound Care 10. Protocol 2063: IDG Meeting Process **Monitoring** Supervisory visits by Executive Director/Clinical Director/Team Director/Director of Business Operations with each full time RNCM to ensure a complete and accurate assessment, documentation of measurable goals related to assessment findings and interventions within the plan of care, clear delineation of duties, and facility collaboration utilizing full name and credentials	05/19/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	151603	A. BUILDING 00 B. WING	01/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SEASONS HOSPICE & PALLIATIVE CARE OF INDIANA LLC	2629 WATERFRONT PARKWAY EAST DRIVE, SUITE 3 INDIANAPOLIS, IN 46214

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	agency was provided a list of documents to provide, which included but not limited to, skilled nursing (SN) visit notes, any coordination notes, plans of care, and Interdisciplinary Team notes from 10/29/20 to 01/21/21. Review of a SN visit note dated 11/12/20 which revealed in the visit narrative that there was collaboration of care with Person C from Entity G (home health agency), but failed to include specifically what that collaboration was. Review of a SN visit note dated 11/19/20, revealed in the visit narrative that the patient's family member was a contracted primary caregiver for the patient. A review of the agency's last 12 weeks (10/29/2020 to 01/21/21) of coordination notes failed to evidence that any collaboration took place. A review of the plans of care for the benefit period of 10/22/2020 to 12/20/2020 and 12/21/2020 to 2/18/2021, failed to evidence any interventions for collaboration. Interdisciplinary Team notes from 10/29/20 to 01/21/21, failed to evidence any collaboration the hospice agency may have had with Entity G. During the exit conference on 1/26/21 at 1:00 p.m., Employee K, Executive Director, stated they have been sending Entity G updated plans of care to the agency and when queried if she could provide evidence of them sending information, was not able to provide that evidence.		Immediate feedback will be provided to staff and follow up visits will be made if goals not met. Supervisory visit audits will meet a threshold of 85% compliance or above for 3 consecutive months **Reporting** Leadership meetings are held every 2 weeks and results/trends of B2B visits, chart reviews, facility chart audits will be discussed, and action steps determined based on the data. Quarterly QAPI meetings will also review the trends and any follow up action steps implemented to ensure that compliance is maintained. **Responsible person** Executive Director	
S 0774 Bldg. 00	418.112(d)(1) HOSPICE PLAN OF CARE The hospice plan of care must identify the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	151603	A. BUILDING 00 B. WING	01/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SEASONS HOSPICE & PALLIATIVE CARE OF INDIANA LLC	2629 WATERFRONT PARKWAY EAST DRIVE, SUITE 3 INDIANAPOLIS, IN 46214

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	care and services that are needed and specifically identify which provider is responsible for performing the respective functions that have been agreed upon and included in the hospice plan of care. Based on record review and interview, the agency failed to follow their documented protocol for wound assessment and coordination of care and failed to identify which provider was responsible for performing the weekly wound measurements/assessments and daily dressing changes for 1 of 1 records reviewed of patients residing in a skilled nursing facility, in a sample of 17. (Patient #7) Findings Included: A review of an agency protocol titled "Wound Care Protocol 2005", last revised 5/11/17 indicated, but was not limited to, "#4 The nurse will assess wounds at least every 7 days ... in coordination with the facility nurse or other caregivers." A review of a document for patient #7, a resident of a skilled nursing facility, titled "IDT (Interdisciplinary Team) Care Plan" for benefit period 11/23/20-1/21/21 revealed updated entries on 11/22/20, 11/25/20, 1/12/21, and 1/20/21 which evidenced a Stage 2 open coccyx wound. The document failed to evidence who was responsible for providing the wound treatment in 4 of 4 entries. A review of a document titled "Hospice Certification and Plan of Treatment", start of care date 6/7/18 for benefit period 11/23/20-1/21/21 evidenced a wound labeled as Wound #1 and skilled nurse orders to wash with wound cleanser, dry, apply medihoney, and cover with foam.	S 0774	**Action** All RN Case Managers were assigned education on 2/10/2021 in Seasons University to be completed by 2/19/21. The education assigned covered the following: 1. Facility Integration PowerPoint slides (Attached) 2. Facility Integration Form 3. Protocol 2076 4. Policy 233: Hospice Care to Residents in a Facility 5. Policy 214: Plan of Care 6. Policy 901: Medical Records 7. Protocol 9008: Medical Records 8. Nursing manual – Wound section: Pages 162-167 9. Protocol 2005: Wound Care 10. Protocol 2063: IDG Meeting Process **Monitoring** Supervisory visits by Executive Director/Clinical Director/Team Director/Director of Business Operations with each full time RNCM to ensure a complete and accurate assessment, documentation of measurable goals related to assessment findings and interventions within the plan of care, clear delineation of duties , and facility collaboration	05/19/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	151603	A. BUILDING 00 B. WING	01/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SEASONS HOSPICE & PALLIATIVE CARE OF INDIANA LLC	2629 WATERFRONT PARKWAY EAST DRIVE, SUITE 3 INDIANAPOLIS, IN 46214

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Change every day and prn (as needed) for soiling. The document failed to designate who was responsible for wound measurements and completion of daily wound care. A review of documents titled "Nurse Visit Note", dated 12/8/20, 12/22/20, 12/29/20, 1/5/21, and 1/19/21 revealed a coccyx wound but failed to identify who assessed the wound, who provided the measurements, and who provided the daily dressing changes. A review of a document for patient #7 titled "Nurse Visit Notes" dated 1/21/21 at 12:40 PM revealed a goal, last updated 4/6/20, which stated "Seasons Hospice will work with facility/provider to ensure collaborative integrated plan of care documenting which services will be provided, by whom, and at what frequency on the facility integration form at admit, when changes are made, and at recert. (recertification)." The record failed to evidence any contact with the skilled facility. On 1/25/21 at 2:54 PM, an interview with the Director of Nursing (Person D) for Entity E revealed Patient #7 was a resident at the facility and was receiving hospice services. Person D stated the patient had a 1.5cm x 2cm, stage 2 coccyx wound treated daily and prn (as needed) for soiling by cleansing with sterile water, applying medihoney, and covering with foam. She stated there was usually a notebook where the hospice nurse left information for the facility, but the notebook was with the patient who was in isolation for Covid 19 and it could not be accessed for confirmation. When queried if she knew when the hospice nurse visits the patient she stated, "At least weekly but I don't know a specific date." She denied receiving updates every 2 weeks after IDT and denied any other		utilizing full name and credentials Immediate feedback will be provided to staff and follow up visits will be made if goals not met. Supervisory visit audits will meet a threshold of 85% compliance or above for 3 consecutive months **Reporting** Leadership meetings are held every 2 weeks and results/trends of B2B visits, chart reviews, facility chart audits will be discussed, and action steps determined based on the data. Quarterly QAPI meetings will also review the trends and any follow up action steps implemented to ensure that compliance is maintained. **Responsible person** Executive Director	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	151603	A. BUILDING 00 B. WING	01/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SEASONS HOSPICE & PALLIATIVE CARE OF INDIANA LLC	2629 WATERFRONT PARKWAY EAST DRIVE, SUITE 3 INDIANAPOLIS, IN 46214

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	communication with the hospice staff or agency. Person D confirmed the nurses from Entity E were providing daily wound care but was unable to confirm communication with the hospice agency that identified who was responsible for providing the wound treatments. During an interview on 1/26/21 at 11:49 AM the Team Director stated that nursing was expected to coordinate care with the assisted living facility after every IDT meeting and as needed to determine care needs of the patient and specify who would provide them, and agreed that there is no evidence in the clinical record of patient #7 identifying which provider was responsible to provide wound assessment and ongoing daily dressing changes.			
S 0778 Bldg. 00	418.112(e)(1)(i) COORDINATION OF SERVICES [The designated interdisciplinary group member is responsible for:] (i) Providing overall coordination of the hospice care of the SNF/NF or ICF/MR resident with SNF/NF or ICF/MR representatives; Based on record review and interview, the agency failed to evidence coordination of care with the patient's skilled nursing facility for 1 of 1 records reviewed of a patient who was receiving hospice services in a skilled nursing facility, in a sample of 17. (Patient #7) Findings Included: Review of an undated agency policy titled "Hospice Care To Residents in a Facility" indicated " .... 5. Seasons Hospice will coordinate services by: ... a. ... ii. Communicating with the	S 0778	**Action** All RN Case Managers were assigned education on 2/10/2021 in Seasons University to be completed by 2/19/21. The education assigned covered the following: 1. Facility Integration PowerPoint slides (Attached) 2. Facility Integration Form 3. Protocol 2076 4. Policy 233: Hospice Care to Residents in a Facility 5. Policy 214: Plan of Care	05/19/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	151603	A. BUILDING 00 B. WING	01/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SEASONS HOSPICE & PALLIATIVE CARE OF INDIANA LLC	2629 WATERFRONT PARKWAY EAST DRIVE, SUITE 3 INDIANAPOLIS, IN 46214

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	facility representatives and other health care providers participating in the provision of care for the terminal illness and related conditions and other conditions to ensure quality of care for the patient and family.... " A review of a document for patient #7, a resident of a skilled nursing facility, titled "IDT (Interdisciplinary Team) Care Plan" for benefit period 11/23/20-1/21/21 revealed updated entries on 11/22/20, 11/25/20, 1/12/21, and 1/20/21 which evidenced a Stage 2 open coccyx wound. The document failed to identify who was responsible for providing the wound treatment and failed to evidence any case coordination with the patient's caregiver or family, or the skilled nursing facility. A review of a document titled "IDT (Interdisciplinary Team) Care Plan", updated 1/20/21, revealed Patient #7 had a stage 2 pressure wound to the coccyx. It failed to identify any coordination of care between the hospice team, the patient's caregiver or family, or the skilled nursing facility. A review of a document titled "Hospice Certification and Plan of Treatment", start of care date 6/7/18 for benefit period 11/23/20-1/21/21 evidenced a wound labeled as Wound #1 and skilled nurse orders to wash with wound cleanser, dry, apply medihoney, and cover with foam. Change every day and prn (as needed) for soiling. The document failed to evidence case coordination with the skilled facility or the patient's caregiver/family to determine who was responsible for wound measurements and completing the daily wound care. A review of documents titled "Nurse Visit Note", dated 12/8/20, 12/22/20, 12/29/20, 1/5/21, and		6. Policy 901: Medical Records 7. Protocol 9008: Medical Records 8. Nursing manual – Wound section: Pages 162-167 9. Protocol 2005: Wound Care 10. Protocol 2063: IDG Meeting Process **Monitoring** Supervisory visits by Executive Director/Clinical Director/Team Director/Director of Business Operations with each full time RNCM to ensure a complete and accurate assessment, documentation of measurable goals related to assessment findings and interventions within the plan of care, clear delineation of duties , and facility collaboration utilizing full name and credentials Immediate feedback will be provided to staff and follow up visits will be made if goals not met. Supervisory visit audits will meet a threshold of 85% compliance or above for 3 consecutive months	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	151603	A. BUILDING 00 B. WING	01/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SEASONS HOSPICE & PALLIATIVE CARE OF INDIANA LLC	2629 WATERFRONT PARKWAY EAST DRIVE, SUITE 3 INDIANAPOLIS, IN 46214

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	1/19/21 revealed a coccyx wound but failed to identify the provider responsible for performing wound assessments/measurements for Patient #7 and failed to identify the provider responsible for performing the daily dressing changes. A review of a document for patient #7 titled "Nurse Visit Notes" dated 1/21/21 at 12:40 PM revealed a goal, last updated 4/6/20, which stated "Seasons Hospice will work with facility/provider to ensure collaborative integrated plan of care documenting which services will be provided, by whom, and at what frequency ...," The record failed to evidence any contact with the skilled facility or with the patient's caregiver or family to determine who was responsible to provide wound care. On 1/25/21 at 2:54 PM, an interview with the Director of Nursing (Person D) for Entity E revealed Patient #7 was a resident at the facility and was receiving hospice services. Person D stated wound care included (as needed) for soiling by cleansing with sterile water, applying medihoney, and covering with foam. She stated there was usually a notebook where the hospice nurse left information for the facility, but the notebook was with the patient who was in isolation for Covid 19 and it could not be accessed for confirmation. When queried if she knew when the hospice nurse visits the patient she stated, "At least weekly but I don't know a specific date." She denied receiving updates every 2 weeks after IDT and denied any other communication with the hospice staff or agency. Person D confirmed the nurses from Entity E were providing daily wound care but was unable to confirm communication with the hospice agency that identified who was responsible for providing the wound treatments		**Reporting** Leadership meetings are held every 2 weeks and results/trends of B2B visits, chart reviews, facility chart audits will be discussed, and action steps determined based on the data. Quarterly QAPI meetings will also review the trends and any follow up action steps implemented to ensure that compliance is maintained. **Responsible person** Executive Director	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	151603	A. BUILDING 00 B. WING	01/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SEASONS HOSPICE & PALLIATIVE CARE OF INDIANA LLC	2629 WATERFRONT PARKWAY EAST DRIVE, SUITE 3 INDIANAPOLIS, IN 46214

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	During an interview on 1/26/21 at 11:49 AM the Team Director stated that nursing was expected to coordinate care with the facility after every IDT meeting and as needed to determine care needs of the patient and specify who would provide them, and agreed that there is no evidence in the clinical record of patient #7 identifying which provider was responsible to provide wound assessment and ongoing daily dressing changes.			