

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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151509	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/09/2011
NAME OF PROVIDER OR SUPPLIER INDIANA UNIVERSITY HEALTH HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 619 W 1ST ST BLOOMINGTON, IN 47403		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
L 000	<p>INITIAL COMMENTS</p> <p>This visit was for a hospice state relicensure and federal recertification survey.</p> <p>Survey Dates: December 6-9, 2011</p> <p>Facility #: 005811</p> <p>Medicaid Vendor #: 200141660</p> <p>Survey Team: Marty Coons, RN, PHNS</p> <p>Indiana University Health Hospice was in compliance with Conditions of Participation 42 CFR 418 and the Indiana requirements for licensure IC 16-25-3.</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN December 13, 2011</p>	L 000			
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE

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