

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

PRINTED: 06/14/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151582	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/26/2022
NAME OF PROVIDER OR SUPPLIER SOUTHERNCARE SOUTH BEND			STREET ADDRESS, CITY, STATE, ZIP CODE 1626 E DAY RD MISHAWAKA, IN 46545		
(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
E 000	Initial Comments An Emergency Preparedness survey was conducted by the Indiana Department of Health in accordance with 42 CFR 484.113 for a Hospice Provider and Suppliers. Survey Date: 05-23, 05-24, 05-25 and 05-26-2022 At this Emergency Preparedness survey, Southerncare South Bend was found to have been in compliance with Condition of Participation 42 CFR 484.113, Emergency Preparedness requirements for Medicare Participating Providers and Suppliers.	E 000			
L 000	QR by Area 3 INITIAL COMMENTS This visit was for a Federal and State investigation of 11 complaints with a State Relicensure Survey of a Deemed Hospice provider. Survey Date: 05-23, 05-24, 05-25 and 05-26-2022 Census: 139 Complaint #: IN 00310263 - Unsubstantiated, unrelated findings IN 00238625 - Unsubstantiated, unrelated findings IN 00238227 - Unsubstantiated, unrelated findings IN 00233175 - Unsubstantiated, unrelated findings	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.

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L 000	Continued From page 1 IN 00225238 - Unsubstantiated, unrelated findings IN 00203255 - Unsubstantiated, unrelated findings IN 00197943 - Unsubstantiated, unrelated findings QR by Area 3	L 000			