

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

PRINTED: 07/25/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151559	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/22/2019
NAME OF PROVIDER OR SUPPLIER DEKALB HEALTH HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 1700 E. 7TH ST AUBURN, IN 46706		
(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 on 7/22/19 by the Indiana State Department of Health in accordance with 42 CFR 418.113 Hospice. Survey dates: July 18, 19 and 22, 2019 Facility Number: IN009702 Medicaid Number: 200139550 At this Emergency Preparedness survey, DeKalb Health Hospice was found to be in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 418.113 Hospice.	E 000			
L 000	INITIAL COMMENTS This was a federal hospice recertification and state re-licensure survey. Survey dates: July 18, 19 and 22, 2019 Facility Number: IN009702 Medicaid Number: 200139550 Census: 5 active patients 56 admissions in past year 51 discharges in past year Sample = 11 DeKalb Health Hospice is in compliance with the Indiana rules for hospice IC 16-25-3 and the	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 Conditions of Participation 42 CFR Part 418.	L 000			