| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 004386 | A. BUILDING: _____ B. WING _____ | 02/18/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ASERACARE HOSPICE | 8401 NORTH KENTUCKY AVENUE, SUITE G EVANSVILLE, IN 47725 |

| (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) COMPLETE DATE |
|---|---|---|---|---|
| S 000 | INITIAL COMMENTS<br><br>This visit was for a State Re-Licensure of a deemed hospice agency.<br><br>Dates of survey: March 12 & March 16-18 of 2021<br><br>Facility ID: 004386<br><br>Unduplicated census for the last 12 months: 227<br>Census: 29<br><br>At this survey, AseraCare Hospice was found to be in compliance with IC 16-25-3 in regards to State Licensure of a Hospice Agency.<br><br>Quality Review completed on 3/29/2021 A4 | S 000 | | |