

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

PRINTED: 10/20/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151537	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/16/2020
NAME OF PROVIDER OR SUPPLIER ASERACARE HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 252 W MAIN STREET CARMEL, IN 46032		
(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 the investigation of a federal complaint at a deemed Hospice agency.</p> <p>Complaint #: IN 00337419: Unsubstantiated.</p> <p>Survey dates: 10-15, 10-16, and 10-19-2020</p> <p>Facility #: 008883</p> <p>CCN: 151537</p> <p>Medicaid #: 200141740 A</p> <p>Census: 81</p> <p>Clinical records reviewed: 3 Home visits: 1</p> <p>At this complaint investigation survey, Aseracare Hospice was found to have been in compliance in relation to the complaint allegations in Patient Rights, 42 CFR 418.52 and Core Services (Skilled Nursing), 42 CFR 418.64.</p> <p>Quality Review Completed on 10/20/2020 by Area 3</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.