

HOSPICE SURVEY AND DEFICIENCIES REPORT

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CERTIFICATION NUMBER	NAME OF FACILITY	SURVEY DATE
1. Was this hospice surveyed for compliance with 42 CFR 418.110? <input type="checkbox"/> Yes <input type="checkbox"/> No		L50
2. If this hospice provides inpatient care directly, is the inpatient care provided on the premises? <input type="checkbox"/> Yes <input type="checkbox"/> No		L51
3. Has a waiver of core nursing services been granted? <input type="checkbox"/> Yes <input type="checkbox"/> No	L52	4. If "Yes" indicate date L53
5. Indicate type of setting(s) in which the hospice provides routine home care. <input type="checkbox"/> Private residence <input type="checkbox"/> SNF <input type="checkbox"/> NF <input type="checkbox"/> Other (specify)		L54
6. Number of hospice patients residing in a SNF, NF or other residential facility who receive routine home care from the hospice.		L55
7. Number of hospice patients admitted during recent 12 month period.		L56
8. Number of records reviewed during survey.		L57
9. Number of home visits conducted to patients in a private residence.		L58
10. Number of home visits conducted to patients in residential facilities.		L59
11. Does this hospice operate under the same certification number at more than one location? <input type="checkbox"/> Yes <input type="checkbox"/> No	L60	12. If "Yes" enter number of locations. L61
13. Does this hospice operate as part of another entity that participates in the Medicare program? <input type="checkbox"/> Yes <input type="checkbox"/> No	L62	14. If "Yes" enter the Medicare certification number of the entity. L63
SURVEYOR SIGNATURE	TITLE	DATE

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0379. The time required to complete this information collection is estimated to average 1 hour per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, Attn: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.

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DEFICIENCIES

DATA TAG NUMBER	COP/STND. NO.	COMMENTS
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I certify that I have reviewed each hospice Condition of Participation and related standards and except as indicated on this form the facility was found to be in compliance with the standards and/or the Conditions of Participation.

SURVEYOR SIGNATURE	TITLE	DATE
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