Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	004390		02/14/2014

NAME OF PROVIDER OR SUPPLIER

OMNI HOME CARE

STREET ADDRESS, CITY, STATE, ZIP CODE

111 GARWOOD RD
RICHMOND, IN 47374

(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
N 000	Initial Comments This visit was a home health state licensure survey. Survey dates: February 11, 12, 13, and 14, 2014 Facility # 004390 Medicaid Vendor: # 200512710 Surveyor: Susan E. Sparks, RN, PH Nurse Surveyor Agency Census Skilled Patients 423 Home Health Aide Only Patients 0 Personal Service Only Patients 0 Total 423 Omni Home Care is incompliance with the Indiana rules for home health agencies 410 IAC Article 17 Quality Review: Joyce Elder, MSN, BSN, RN Febriary 18, 2014 .	N 000		

Indiana State Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE