

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

PRINTED: 05/25/2012
FORM APPROVED
OMB NO. 0938-0391

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|---|---|---|---|----------------------|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157551 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 05/24/2012 |
| NAME OF PROVIDER OR SUPPLIER INTERIM HEALTHCARE OF SE INDIANA INC | | | STREET ADDRESS, CITY, STATE, ZIP CODE 500 W EADS PKWY LAWRENCEBURG, IN 47025 | | |
| (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 | |
| G 000 | <p>INITIAL COMMENTS</p> <p>This visit was a home health agency federal complaint survey.</p> <p>Intake #: IN00105894 - Substantiated: No deficiencies are cited.</p> <p>Survey date: May 24, 2012</p> <p>Facility #: 003257</p> <p>Medicaid Vendor #: 200424030</p> <p>Surveyor: Susan E. Sparks, RN, PH Nurse Surveyor</p> <p>Interim Healthcare of SE Indiana is in compliance with the Conditions of Participation of home health agencies 42 CFR Part 484.36 as related to this complaint.</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN May 25, 2012</p> | G 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.