

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 005120	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/03/2014
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NAME OF PROVIDER OR SUPPLIER VISITING NURSE & HOSPICE HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 5910 HOMESTEAD RD FORT WAYNE, IN 46814
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(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	<p>INITIAL COMMENTS</p> <p>This was a state Hospice complaint survey.</p> <p>Complaint # IN00149803 - Unsubstantiated: Lack of sufficient evidence.</p> <p>Survey Date: June 3, 2014</p> <p>Facility Number: 005120</p> <p>Medicaid Number: 200141410A</p> <p>Surveyor: Miriam Bennett, RN, BSN, PHNS</p> <p>Visiting Nurse and Hospice Home is in compliance with IC 16-25-3 and the Conditions of Participation 42 CFR 418.52: Patient Rights and 418.56: Interdisciplinary Group, Care Planning, and Coordination of Services.</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN June 6, 2014</p>	S 000		

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