

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 013349	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/10/2015
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NAME OF PROVIDER OR SUPPLIER HOMETOWN HOME HEALTHCARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 302 E NORTH B STREET GAS CITY, IN 46933
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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
N 000	<p>Initial Comments</p> <p>This was a Home Health State Relicensure survey.</p> <p>Survey Dates: June 8, 9, and 10, 2015</p> <p>Facility #: 013349</p> <p>Medicaid Vendor #: 2012113550</p> <p>Skilled Patients: 10 Home Health Aide Only Patients: 14 Personal Service Only Patients: 0 Total number of Home Health Aide Patients: 23 Total Census: 24</p> <p>Home visits with record review: 3 Record review, no home visit: 3 Total Record Review: 6 Total home visits: 3</p> <p>Hometown Home Healthcare Inc. is in compliance with the Indiana Rules for Home Health Agency licensure 410 IAC Article 17.</p> <p>QR: JE 6/22/15</p>	N 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____