

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 012395	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/11/2014
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NAME OF PROVIDER OR SUPPLIER LOVING CARE AGENCY INC	STREET ADDRESS, CITY, STATE, ZIP CODE 220 INSURANCE DR STE C FORT WAYNE, IN 46825
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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 state Home Health agency complaint investigation.</p> <p>Complaint #: IN00160033 - Unsubstantiated: Lack of sufficient evidence</p> <p>Facility #: 012395</p> <p>Survey Dates: December 11, 2014</p> <p>Medicaid vendor #: 201005960</p> <p>Surveyor: Miriam Bennett, RN, BSN, PHNS</p> <p>Loving Care Agency Inc. is in compliance with the Indiana rules for home health agencies 410 IAC Article 17 Rule 12(3) and Rule 14(1) as related to this complaint.</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN December 16, 2014</p>	N 000		

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