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
	012444		C 03/17/2015

NAME OF PROVIDER OR SUPPLIER

HOPE HOME HEALTH CARE INC

STREET ADDRESS, CITY, STATE, ZIP CODE

3800 W 80TH LN
MERRILLVILLE, IN 46410

(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 was a State home health complaint survey. Complaint ID# IN00162286 - Unsubstantiated:Lack of sufficient evidence. Survey Date: March 17, 2015 Facility #: 012444 Medicaid Vendor #: N/A Surveyor: Tameka Warren, RN, BSN, PHNS Unduplicated 12 month census: 155 Active Patients: 64 Quality Review: Joyce Elder, MSN, BSN, RN March 23, 2015	N 000		

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