

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151501		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/14/2013	
NAME OF PROVIDER OR SUPPLIER CENTER FOR HOSPICE AND PALLIATIVE CARE INC, THE				STREET ADDRESS, CITY, STATE, ZIP CODE 111 SUNNYBROOK CT SOUTH BEND, IN 46637			
(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
S0000	<p>This was the 2013 ISDH Annual Compliance Survey based on the Retail Food Establishment Sanitation Requirements at 410 IAC 7-24.</p> <p>Facility Number: 005934</p> <p>Survey Dates: 1/14/2013</p> <p>Surveyors: Albert Daeger, CFM, SFPIO Medical Surveyor</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN January 15, 2013</p>			S0000			
S9999				S9999	The Hospice House Coordinator has in-serviced Hospice House staff on the requirement to wear hair restraints when entering the kitchen. Compliance will be monitored by the Hospice House Coordinator.		02/12/2013

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.