

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K097		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 09/23/2021	
NAME OF PROVIDER OR SUPPLIER 4U HOME HEALTH INC				STREET ADDRESS, CITY, STATE, ZIP CODE 8770 GUION ROAD SUITE K1 , INDIANAPOLIS, Indiana, 46268			
(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
G0000	<p>INITIAL COMMENTS</p> <p>This visit was for a Federal recertification survey of a home health provider.</p> <p>Survey Dates: 9-21-21, 9-22-21, and 9-23-21.</p> <p>Facility # 012906</p> <p>CNN # 15K097</p> <p>Census: 38</p> <p>During this visit, 4U Home Health was found to be in compliance with the 42 CFR 484 in regard to Recertification of a home health provider.</p> <p>Quality Review completed on 10/04/2021 by Area 3.</p>			G0000			

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 reverse for further 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.

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