

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K183	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/26/2022
NAME OF PROVIDER OR SUPPLIER Lovability Home Health Care Llc			STREET ADDRESS, CITY, STATE, ZIP CODE 410 N MONROE STREET, SUITE 19A , MOORESVILLE, Indiana, 46158	
(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, State Re-licensure, and Complaint investigation survey of a home health provider.</p> <p>Survey Dates: 10-24, 10-25 and 10-26-2022</p> <p>Complaint #: 93982; Substantiated; no deficiencies were cited.</p> <p>Home Care Census: 26</p> <p>Lovability Home Health Care, LLC, was found to have been in compliance with the requirements of 42 CFR 484 et seq. and 410 IAC 17 et seq.</p> <p>QR by Area 3 on 10-28-2022</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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