STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 151589		r í	ILDING	onstruction 00	(X3) DATE (COMPL 04/20 /	ETED	
NAME OF PROVIDER OR SUPPLIER HERITAGE HOSPICE INC			1202 W	ADDRESS, CITY, STATE, ZIP COD BUENA VISTA RD STE 107 VILLE, IN 47710			
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
E 0000							
Bldg. 00	conducted by the In	paredness survey was diana Department of Health in CFR 418.113 Hospice Provider 2022 - 4/20/2022	E 00	000			
	Census: 231 undupl	icated last 12 months					
	Hospice Inc., was for Conditions of Partic Emergency Prepare Medicare Participat						
L 0000							'
Bldg. 00 L 0503	State Relicensure Solution Survey Dates: 4/18/ Census: 231 undupl 418.52(a)(2) NOTICE OF RIGH	icated in last 12 months	L 00	000			
Bldg. 00	requirements of su	ES ust comply with the ubpart I of part 489 of this advance directives. The					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

TITLE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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.

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 151589		(X2) MULTIPLE A. BUILDING B. WING	construction 00	(X3) DATE SURVEY COMPLETED 04/20/2022	
	PROVIDER OR SUPPLIER		1202	ET ADDRESS, CITY, STATE, ZIP COD P. W BUENA VISTA RD STE 107 NSVILLE, IN 47710	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	E COMPLETION
	information to the policies on advance description of app Based on record reversited to demonstrate directive changes by 1 of 1 home health a Findings include: An 8/04 policy title Compliance was considered to all state and the state and the state and the policy title compliance was considered to all state and the policy title compliance was considered to all state and the policy title compliance was considered to all state and the policy title compliance was considered to all state and the policy title compliance was considered to all state and the policies of the policies of the policy title compliance was considered to all state and the policies of the policy title compliance was considered to all state and the policies of the policies of the policy title compliance was considered to all state and the policies of t	d Heritage Hospice Corporate pied from the policy binder on .m. The policy indicated, but l'Heritage Hospice will strictly and federal regulations	L 0503	To correct the survey deficied Heritage Hospice has implemented that all hospice admission packets have been updated to include the most current advanced directive Form as of 4.21.22. Heritage hospice has joined IHPCO to keep informed of changes and updates as of 4.26.22.	een POST
	agency patient admi Advanced Directive 2013. At that time, he/she was aware of Directive information Director C indicated	of p.m. reviewed the current ission packet that included information dated July 1, RN Director C was asked if the updated Advance on dated July 1, 2021. RN In he/she was unaware of the ot know where to look to find		The Administrator and Admi Coordinator will be responsi ensuring correct form is use Administrator will be respon for overseeing this process ensure that the plan of corre is followed so that this defici is corrected and does not re	ble for d. The sible to ection ency
L 0658 Bldg. 00	and administrative delineated in the h structure and in pr	PLE LOCATIONS athority, and professional control must be clearly nospice's organizational cactice, and must be traced t issued the certification			
	Based on observation interview, the agence administrative contributions	on, record review, and by failed to ensure rol was clearly delineated in zational structure and in	L 0658	On 5.12.22 governing body member J submitted documentation thru IN.gov t newly appointed Vice Presidents	

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 151589			JILDING	onstruction <u>00</u>	(X3) DATE : COMPL 04/20/	ETED	
NAME OF P	PROVIDER OR SUPPLIER		•		ADDRESS, CITY, STATE, ZIP COD	•	
HERITAG	GE HOSPICE INC				BUENA VISTA RD STE 107 VILLE, IN 47710		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE.	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	and failed to ensure	officers for the hospice agency			Operations to the governing b	ody.	
		was separate and secured from			Heritage Hospice will		
		nsed Entities and failed to			ensure clear delineation of		
		es were secured for 1 of 1			the hospice organizational		
	hospice agency.	101 1 01 1			structure. Heritage Hospice a	s an	
	1 8 7				entity of Holiday Health Care		
	Findings include:				follow the policy titled "Holiday		
	_				Health Care Personnel File P		
	1. A revised 2/26/19	9 policy titled Heritage Hospice			implemented on 5.9.22 and is		
	Line of Authority w	vas copied from the policy			included in Heritage Hospice's	3	
	binder on 4/20/2022	2 at 2:30 p.m. The policy			policies under the same		
		not limited to, "Heritage			name. The steps we are takiı	ng to	
		onal structure delineates lines			prevent the deficiency from		
		ponsibility a. The			recurring in the future is we w		
		EO and CFO) appoints an			follow procedure as directed i	n the	
		rry out the day to day			policy Holiday Health Care		
		operation responsibilities of			Personnel File ensuring all ne	W	
	the program c. I	Exception: billing".			hires / appointees are clearly		
	2 4 : 12/20:	10 11 (2) 111 2			delineated in the hospice's		
		12 policy titled Heritage Body was copied from the			organization structure. The		
		20/2022 at 2:30 p.m. The policy			Heritage Hospice Administrate		
		not limited to, " shall			and the Governing Body will to responsible for ensuring the p		
		e with Centers of Medicare			procedures are followed. The	-	
	•	s of Participation assumes			for completion of this deficien		
		ility for determining,			was 5/12/22	-,	
		monitoring policies governing					
		peration appoints an					
		esponsible to the day-to-day					
	operation of the hos	spice program. This individual					
	will act as a liaison	between the governing body					
		ody will assure that all services					
	*	tent with accepted standards					
	-	dance with local, state, and					
	federal law"						
	3. On 4/18/2022 at	9:30 a.m. Person B indicated					
		acquired a corporate role and					
		cy practice At 10:36 a m					

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 151589	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 04/20/2022
	PROVIDER OR SUPPLIER	₹	1202 V	ADDRESS, CITY, STATE, ZIP CO V BUENA VISTA RD STE SVILLE, IN 47710	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE API DEFICIENCY)	ULD BE COMPLETION
	binder with Covid- the hospice along wand Entity 5 vaccin indicated human re entities' vaccination separated by tabs. It clear delineation of regarding the medicing files, which were nother licensed Entity. Review of the state Person B as an own body member. Revemployees did not a or contracted employees did not a or contracted employees did not a force of hospice bear to the governing Body matter agency was not officer of hospice bear to the governing member J indicated meeting minutes the communication occupated by and the Admit During exit confered Governing Body matter did not provide any Person B as a hosping governing body but to participate in exit 4. On 4/20/2022 at personnel files were within the building.	database did not identify her, manager, or governing liew of the agency list of indicate Person B was a direct byee for hospice. In on 4/20/2022 at 9:40 a.m. hember J did not indicate the otified of Person B's role as an out planned to appoint Person body. Governing Body here were no governing body at would identify that he here were the governing mistrator. In the on 4/20/2022 at 3:05 p.m. hember J and the Administrator of documentation that confirmed fice employee or part of the accontinued to allow Person B			

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/31/2022 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 151589	(X2) MUL' A. BUIL B. WINC	DING	NSTRUCTION 00	(X3) DATE : COMPL 04/20/	ETED
	PROVIDER OR SUPPLIER			1202 W	DDRESS, CITY, STATE, ZIP COD BUENA VISTA RD STE 107 VILLE, IN 47710		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	PR	ID EFIX ΓAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Έ	(X5) COMPLETION DATE
	Entity personnel file that was unlocked a failed to ensure hos secured and were m employees. During exit confere Person B indicated specific policy rega personnel files and B indicated the exp files were to be lock checked with human	g with other licensed affiliated es stored in 1 large file cabinet and unattended. The agency pice personnel files were saintained by hospice nce on 4/20/2022 at 3:05 p.m. the agency did not have a rding accessing and storage of delineation of services. Person ectation was that personnel aced and secured. Person B in resources regarding policies unable to produce any					
L 0769	documents or inform 418.112(c)(6)	nation.					
Bidg. 00	the following:] (6) A delineation of responsibilities, which is a delineation of responsibilities, which is a direction and mannursing; counseling dietary and bereat provision of medical equipment the palliation of parassociated with the related conditions services that are responsible.	of the hospice's hich include, but are not wing: providing medical agement of the patient; ig (including spiritual, wement); social work; cal supplies, durable at and drugs necessary for					
	Based on record rev failed to ensure a w hospice agency and	ritew and interview, the agency ritten contract between the a licensed nursing home was 6 contracts reviewed with the	L 076	9	Per policy number PC.H50 a written agreement will be in pla with all facilities that we serve 5.20.22.		05/20/2022

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Event ID:

C1M711 Facility ID: 004208

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/31/2022 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 151589		(X2) MUI A. BUI B. WIN	LDING	nstruction <u>00</u>	(X3) DATE : COMPL 04/20 /	ETED	
	PROVIDER OR SUPPLIER			1202 W	DDRESS, CITY, STATE, ZIP COD BUENA VISTA RD STE 107 VILLE, IN 47710		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	P	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	ΤE	(X5) COMPLETION
TAG		R LSC IDENTIFYING INFORMATION Il licensed nursing homes /		TAG	The Administrator will review		DATE
	assisted living faciliaffiliation.	ities regardless of agency			written agreements annually a upon any admission to a new facility.	nd	
	Nursing Facility Rewas copied from the 2:30 p.m. The policy of the provision of hospice services in [assisted living facility] of the provision of hospice facility] [skilled nurliving facility], or It provisions stated in hospice and the facility and the facility are responsible not limited to the form of the provision of hospice and the facility are responsible not limited to the form of the provision of hospice and the facility are responsible not limited to the form of the provision and manage counseling (including bereavement); social supplies, durable mecessary for the parassociated with the conditions; and all of necessary for the calliness and related of the responsibilities to provide bereaver. A revised 2/26/19 public of Authority with the provide of Authority with	2 policy titled Hospice Care for sidents - Written Agreements e policy binder on 4/20/2022 at y indicated, but was not limited nt: Prior to the provision of a LTCF/SNF/licensed lity] or ICF/MR, the hospice reement signed by authorized ne facility. Procedures: 1. The e care in a [long term care rsing facility]/licensed [assisted CF/MR in accordance with the the written contract between ility f. A delineation of the ilities, which include, but are ollowing: providing medical gement of the patient; nursing; and spiritual, dietary, and all work; provision of medical edical equipment and drugs alliation of pain and symptoms terminal illness and related other hospice services that are are of the resident's terminal conditions j. A delineation of of the hospice and the facility ment services to facility staff." solicy titled Heritage Hospice was copied from the policy 2 at 2:30 p.m. The policy			facility. The Administrator will be responsible for ensuring that whave written agreements with a facilities that we serve.		
	Hospice organization	not limited to, "Heritage onal structure delineates lines ponsibility a. The					

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Event ID:

C1M711 Facility ID: 004208

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 151589		 JILDING	00	COMPL 04/20/	ETED	
	ROVIDER OR SUPPLIER	1	1202 W	ADDRESS, CITY, STATE, ZIP COD BUENA VISTA RD STE 107 VILLE, IN 47710		
	SUMMARY: (EACH DEFICIEN REGULATORY OR governing body (CI Administrator to car administrative and of the program c. I A reviewed 3/2012 Governing Body wa binder on 4/20/2022 indicated, but was r maintain compliance Services Conditions full legal responsible implementing, and it the hospices total op body will assure that consistent with acce accordance with loc The Governing Bod Agreements for Con Procedures prior to Administrator may approval is obtained ". During an interview Administrator was a	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LESC IDENTIFYING INFORMATION EO and CFO) appoints an rry out the day to day operation responsibilities of Exception: billing". policy titled Heritage Hospice as copied from the policy out limited to, " shall with Centers of Medicare of Participation assumes dity for determining, monitoring policies governing operation The governing operation The governing at all services provided are expeted standards of practice in eal, state, and federal law by shall approve all intracted Services and Policy & implementation. The sign Agreements once verbal d by the Hospice President or on 4/19/2022 at 10:50 a.m. the asked to provide the contract diministrator indicated Entity 1	STREET A 1202 W	BUENA VISTA RD STE 107		(X5) COMPLETION DATE
	was a licensed nurs: 1's website identifie facility that provide health, and hospice. contract was mainta provides services, n supplies necessary t management on a 2	database indicated Entity 1 ing facility. Review of Entity ed it as an assisted living d 24/7 nursing care, home The agency failed to ensure a sined identifying how hospice nedications, equipment and for pain control and symptom 4-hour basis, and who may rders for patient care.				

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 151589	(X2) MUL' A. BUIL B. WINC	DING	nstruction 00	(X3) DATE S COMPL 04/20/	ETED
	PROVIDER OR SUPPLIER			1202 W	DDRESS, CITY, STATE, ZIP COD BUENA VISTA RD STE 107 /ILLE, IN 47710		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION nce on 4/20/2022 at 3:05 p.m.	PR	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
L 0772 Bldg. 00	the Administrator in 1 regarding a contra The Administrator in would not sign the in the past because comfortable signing. The Administrator in assisted living facility 1 as if going 418.112(c)(9) WRITTEN AGREE [The written agree the following:] (9) A delineation of hospice and the Sprovide bereavement ICF/MR staff. Based on record reversible and the series and the delined to ensure a whospice agency and regarding the delined bereavement service contracts reviewed licensed nursing hor regardless of agency. Findings include: A reviewed 2/2/201 Nursing Facility Rewas copied from the 2:30 p.m. The policity, "Policy Statement hospice services in [assisted living facility as written age obtains a written age of the significance of the sig	andicated he/she notified Entity and the Entity and the Entity as not anything involving Medicare. Indicated Entity 1 was not anything involving Medicare. Indicated Entity 1 was not an anything involving Medicare. Indicated Entity 1 was not an anything involving Medicare. Indicated Entity 1 was not an anything involving Medicare. Indicated Entity 1 was not an anything involving Medicare. Indicated Entity 1 was not an anything involving Medicare. Indicated Entity 1 was not an anything involving Medicare. Indicated Entity 1 was not an anything involving Medicare. Indicated Entity 1 was not an anything involving Medicare. Indicated Entity 1 was not an anything involving Medicare. Indicated Entity 1 was not an anything involving Medicare. Indicated Entity 1 was not an anything involving Medicare. Indicated Entity 1 was not an anything involving Medicare. Indicated Entity 1 was not an anything involving Medicare. Indicated Entity 1 was not an anything involving Medicare. Indicated Entity 1 was not an anything involving Medicare. Indicated Entity 1 was not an anything involving Medicare. Indicated Entity 1 was not an anything involving Medicare. Indicated Entity 1 was not an anything involving Medicare. Indicated Entity 1 was not anything involving	L 077	72	Per policy number PC.H50 a written agreement will be in pla with all facilities that we serve 5.20.22 including delineation of providing bereavement to staff. The Administrator will review written agreements annually a upon any admission to a new facility. The Administrator will be responsible for ensuring that whave written agreements with facilities that we serve.	by of f. and	05/20/2022

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 151589		(X2) MULTIPLE A. BUILDING B. WING	CONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 04/20/2022		
	PROVIDER OR SUPPLIEI	R	1202	TADDRESS, CITY, STATE, ZIP COD W BUENA VISTA RD STE 107 ISVILLE, IN 47710		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	COMP	(X5) PLETION ATE
	provision of hospic facility]/[skilled nu living facility], or I provisions stated in hospice and the face hospice's responsibe not limited to the form (including spiritual A delineation of the hospice and the face services to facility. A revised 2/26/19 provision of Authority with binder on 4/20/202 indicated, but was an Hospice organization of authority and resign governing body (C. Administrator to care administrative and the program c. 1. A reviewed 3/2012 Governing Body with binder on 4/20/202 indicated, but was a maintain compliant. Services Condition full legal responsibility implementing, and the hospices total of individual This between the governing Body will assure the consistent with accalled accordance with low The Governing Body Agreements for Co.	e care in a [long term care rsing facility]/licensed [assisted CF/MR in accordance with the the written contract between ility f. A delineation of the ilities , which include, but are ollowing: counseling , dietary, and bereavement) j. eresponsibilities of the ility to provide bereavement				

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	L HPLE CO.	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPLETED	
		151589	B. WI	B. WING		04/20/2022	
NAME OF PROVIDER OR SUPPLIER HERITAGE HOSPICE INC			1202 W	ADDRESS, CITY, STATE, ZIP COD BUENA VISTA RD STE 107 VILLE, IN 47710			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	1	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
IAG	Administrator may sapproval is obtained "." During an interview Administrator was a for Entity 1. The Addoes not require a contract was a licensed nursi 1's website identifie facility that provide health, and hospice. contract was maintaidelineation of respot the nursing facility services to nursing facility is services to nursing facility in the Administrator in 1 regarding a contract would not sign the comfortable signing The Administrator in the past because the Administrator in the past because the Administrator in the past because the Administrator in the Administrator in the Administrator in the past because the Administrator in the past because the Administrator in the past because the Administrator in the Administrator in the past because the Administrator in the Administrator in the past because the Administrator in the Administrator in the past because the Administrator in the Administrator in the past because the Administrator in	sign Agreements once verbal I by the Hospice President on 4/19/2022 at 10:50 a.m. the asked to provide the contract dministrator indicated Entity 1 ontract. database indicated Entity 1 ing facility. Review of Entity d it as an assisted living d 24 hour nursing care, home The agency failed to ensure a sined identifying the insibilities of the hospice and regarding bereavement facility staff. Ince on 4/20/2022 at 3:05 p.m. indicated he/she notified Entity act between both agencies. Indicated Entity 1's personnel contract and had never had to		IAG	DETCHACT		DATE
	Entity 1 as if going	into someone's home.					

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