STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	009124	A. BUILDING: _____ B. WING _____	C 01/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAIN STREET HOSPICE, LLC	10 HIGHLAND AVENUE FRANKLIN, IN 46131

(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
S 000	INITIAL COMMENTS This visit was for a State Complaint Survey of a deemed Hospice Provider. Complaint #: IN 00292969; Substantiated; no deficiencies were cited. Date of survey: 01-08-20201 Facility #: 009124 CCN #: 151540 Current Active Census: 44 patients The Hospice provide is in compliance with IC 16 Article 25 et, sq	S 000		