PRINTED: 05/25/2021 FORM APPROVED

Indiana State Department of Health

NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE 400 8TH AVE TERRE HAUTE, IN 47804  PREPER TAGO  INITIAL COMMENTS  Source Based on the Retail Food Establishment of 410 IAC 7-24. Facility #: 001277  Survey Date: 5/19/21  This facility was in compliance with all requirements with 410 IAC 7-24 for Food Establishment Sanitation Requirements.	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
HOSPICE OF THE WABASH VALLEY INC    CX4) ID   SUMMARY STATEMENT OF DEFICIENCIES   ID   PREFIX   CEACH DEFICIENCY MUST BE PRECEDED BY FULL   TAG     TAG   REGULATORY OR LSC IDENTIFYING INFORMATION)   S 000     S 000   INITIAL COMMENTS   S 000     This was the 2020 IDOH Annual Compliance   Survey   Based on the Retail Food Establishment   Sanitation Requirements   of 410 IAC 7-24.     Facility #: 005127   Survey Date: 5/19/21   This facility was in compliance with all requirements with 410 IAC 7-24 for			005127	B. WING		05/19/2021	
TERRE HAUTE, IN 47804    X4) ID   PREFIX TAGS   SUMMARY STATEMENT OF DEFICIENCIES   ID   PROVIDER'S PLAN OF CORRECTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX TAGS   TAGS   PREFIX TAGS   PRE	400 8TH AVE						
PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  S 000  INITIAL COMMENTS  This was the 2020 IDOH Annual Compliance Survey Based on the Retail Food Establishment Sanitation Requirements of 410 IAC 7-24.  Facility #: 005127  Survey Date: 5/19/21  This facility was in compliance with all requirements with 410 IAC 7-24 for	HOSPICE OF THE WABASH VALLEY INC						
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Survey Based on the Retail Food Establishment Sanitation Requirements of 410 IAC 7-24.  Facility #: 005127  Survey Date: 5/19/21  This facility was in compliance with all requirements with 410 IAC 7-24 for	S 000	000 INITIAL COMMENTS					
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Indiana State Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE