STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005809	A. BUILDING: _____ B. WING _____	11/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOSPICE FRANCISCAN COMMUNITIES	1225 E COOLSPRING AVE STE 1E MICHIGAN CITY, IN 46360

(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 was the 2017 ISDH Annual Compliance Survey based on the Retail Food Establishment Sanitation Requirements. Facility Number: 005809 Survey Date(s): 11-20-2017 Quality Review: KH Hospice Franciscan Communities was in compliance with 410 IAC 7-24 during their routine kitchen sanitation inspection.	S 000		