

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>005128</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>11/22/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>INDIANA UNIVERSITY HEALTH HOSPICE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>950 N MERIDIAN ST, SUITE 700 INDIANAPOLIS, IN 46204</b>		
(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	<p><b>INITIAL COMMENTS</b></p> <p>This was the 2021 IDOH Annual Compliance survey based on the Retail Food Establishment Sanitation Requirements</p> <p>Facility Number: 005128 Survey Dates: 11/22/2021</p> <p>Quality Review: 4/26/2022 A4</p> <p>Indiana University Health Hospice was in compliance with 410 IAC 7-24 during their routine kitchen sanitation inspection.</p>	S 000		

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

TITLE

(X6) DATE