STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005128	A. BUILDING: _____ B. WING _____	12/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INDIANA UNIVERSITY HEALTH HOSPICE	950 N MERIDIAN ST, SUITE 700 INDIANAPOLIS, IN 46204

(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 2020 IDOH Annual Compliance Survey based on the Retail Food Establishment Sanitation Requirements. Facility #: 005128 Survey Date(s): 12/16/20 This center for Hospice and Palliative Care was in compliance with 410 IAC 7-24 during its routine kitchen sanitation inspection. Quality Review completed on 12/28/2020 A4	S 000		