

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 005939	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/13/2021
NAME OF PROVIDER OR SUPPLIER DEACONESS VNA		STREET ADDRESS, CITY, STATE, ZIP CODE 611 HARRIETT STREET P O BOX 3487 EVANSVILLE, IN 47734		
(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>INITIAL COMMENTS</p> <p>This was the 2021 IDOH Annual Compliance Survey based on the Retail Food Establishment Sanitation Requirements.</p> <p>Facility #: 005939</p> <p>Survey Date(s): 5/13/21</p> <p>_____</p> <p>This center for Hospice and Palliative Care was in compliance with 410 IAC 7-24 during their routine kitchen sanitation inspections.</p>	S 000		

Indiana State Department of Health

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

TITLE

(X6) DATE