STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157081	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACME HEALTH SERVICE INC	6302 N RUCKER RD STE J , INDIANAPOLIS, Indiana, 46220

(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) COMPLETION DATE
G0000	INITIAL COMMENTS This was a second Post-Condition revisit for a home health agency recertification and re-licensure survey conducted on 02/12/2024. Survey Dates: 04-29-2024 and 04-30-2024. 12-Month Unduplicated Skilled Admissions: 2 During the post-condition revisit survey, Acme Home Health Services remained out of compliance with one previously cited condition and cited one new condition. One standard-level deficiency was corrected, one standard-level deficiency was re-cited, and one new standard was cited. The agency remained out of compliance with Cop 484.60, Care planning, coordination of services, and quality of care, and Cop 484.55, Reporting Outcome and Assessment Information Set (OASIS) information. Acme Home Health Services Incorporated continues to be precluded from providing its own home health aide training and competency evaluation program for a period of 2 years beginning February 12th, 2024, and continuing through February 11th, 2026. QR by Area 3 on 5-01-2024.	G0000		
G0370	Reporting OASIS information CFR(s): 484.45 Condition of participation: HHAs must electronically report all OASIS data collected in accordance with §484.55. This CONDITION is NOT MET as evidenced by: Based on record review and interview, the agency failed to transmit OASIS information for all skilled Medicaid patients utilizing federally funded health plans not meeting the transmittal requirements in 1 of 1 agency. The cumulative effect of this systemic problem resulted in the home health agency's inability to ensure the	G0370		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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G0370	Continued from page 1 provision of quality health care in a safe environment for the Condition of Participation of 42 CFR 484.45, Reporting of OASIS information. Findings include: 1. During the entrance conference on 04-29-2024 at 12:05 PM, the Alternate Administrator, Admin 2, indicated the agency had 2 skilled patients for skilled nursing medication setup. 2. A review of the agency's completed state document titled, "Facility Census" indicated ACME Health Services, Incorporated had 2 skilled patients, 5 home health aide-only patients, 9 personal service-only patients, and written in for other 51 patients received skilled nursing case management. 3. A review of an agency document titled " OASIS (The Outcome and Assessment Information Set) (a comprehensive assessment designed to collect information related to a home care recipient's demographic, clinical, functional, and service needs) Agency Final Validation." The document was for the reporting period of the year to date, which indicated Inactive Patient #5 and Active Patient #4 had a section titled "RFA (Reason For Assessment) listed as 04, indicating a recertification OASIS assessments were submitted on 10-17-2023 and 02-10-2024. The agency validations failed to report submissions for all of the 51 Medicaid patients the Alternative Administrator, Admin 2, indicated received skilled nursing case management utilizing federally funded health plans. On April 30th, 2024, at 12:30 PM, during an interview, Admin 2 stated ACME Health Services Incorporated staff had provided skilled nursing and social worker services to the 51 patients who received skilled nurse case management services. Admin 2 also confirmed they were responsible for submitting the OASIS for the agency but had not submitted the OASIS for the 51 patients who received skilled nursing case management.	G0370		
G0372	Encoding and transmitting OASIS CFR(s): 484.45(a) Standard: An HHA must encode and electronically transmit each completed OASIS assessment to the CMS system, regarding each beneficiary with respect to which information is required to be transmitted (as determined by the Secretary), within 30 days of completing the assessment of the beneficiary.	G0372		

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G0372	Continued from page 2 This STANDARD is NOT MET as evidenced by: Based on record review and interview, the agency failed to submit OASIS (Outcome Assessment Information Set) within 30 days of assessment completion for all 51 of 51 patients receiving skilled case management, and 3 of 3 active skilled records reviewed (Patients: #1, 2, and 3) Findings Include: 1. A review of an ACME Health Services Incorporated policy revision date April 2017, titled “OASIS Data Transmission” indicated, “…Policy: The organization will adhere to all OASIS data transmission requirements as outlined in the Medicare Conditions of Participation…1. The organization will encode and transmit completed OASIS data for each applicable patient within thirty (30) days of the M0090 date, date assessment completed…”. 2. A review of an agency document titled “ OASIS (The Outcome and Assessment Information Set) (a comprehensive assessment designed to collect information related to a home care recipient’s demographic, clinical, functional, and service needs) Agency Final Validation.” The document was for the reporting period of the year to date, which indicated Inactive Patient #5 and Active Patient #4 had a section titled “RFA (Reason For Assessment) listed as 04, indicating a recertification OASIS assessments were submitted on 10-17-2023 and 02-10-2024. The agency validations failed to report submissions for all of the 51 Medicaid patients the Alternative Administrator, Admin 2, indicated received skilled nursing case management utilizing federally funded health plans. 3. A review of the active clinical record for Patient #1, with a start of care date of 04-05-2023 and a recertification assessment dated 03-25-2024, indicated the status of the assessment was in progress. The recertification assessment was to be submitted by 04-25-2024. The record failed to evidence that an OASIS submission occurred within 30 days of completion and failed to evidence the start of care assessment was submitted from the start of care date 04-05-2023. 4. A review of the active clinical record for Patient #2, with a start of care date of 12-01-2023 and a start of care assessment dated 12-01-2023. The recertification assessment due date 03-25-2024, failed to be completed for submission. The record failed to evidence the recertification assessment OASIS submission occurred within 30 days of completion and	G0372		

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G0372	Continued from page 3 failed to evidence the start of care assessment was submitted from the start of care date 12-01-2023. 5. A review of the active clinical record for Patient #3, with a start of care date of 03-06-2023, contained 2 recertification assessments dated 02-27-2024 and 04-26-2024. The recertification assessments were to be submitted by 03-27-2024. The record failed to evidence an OASIS submission occurred within 30 days of completion of their dates, and failed to evidence the start of care assessment was submitted from the start of care date 03-06-2023. During an interview on 04-30-2024 at 12:20 PM, the Alternate Administrator, Admin 2, confirmed the OASIS for Patients #1, 2, and 3 and all 51 patients who had received skilled nursing case management had not been submitted.	G0372		
G0570	Care planning, coordination, quality of care CFR(s): 484.60 Condition of participation: Care planning, coordination of services, and quality of care. Patients are accepted for treatment on the reasonable expectation that an HHA can meet the patient's medical, nursing, rehabilitative, and social needs in his or her place of residence. Each patient must receive an individualized written plan of care, including any revisions or additions. The individualized plan of care must specify the care and services necessary to meet the patient-specific needs as identified in the comprehensive assessment, including identification of the responsible discipline(s), and the measurable outcomes that the HHA anticipates will occur as a result of implementing and coordinating the plan of care. The individualized plan of care must also specify the patient and caregiver education and training. Services must be furnished in accordance with accepted standards of practice. This CONDITION is NOT MET as evidenced by: Based on record review and interview, the agency failed to ensure services were provided per the plan of care and failed to ensure each patient received an individualized plan of care that identified patient-specific and measurable outcomes and goals that were periodically reviewed and signed by a physician (see G572); failed to ensure all Durable Medical Equipment (DME) and Supplies, specific frequency and duration of visits and treatments, all safety measures	G0570		04/25/2024

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G0570	Continued from page 4 to protect against injury, patient-specific interventions, measurable outcomes and goals identified by the home health agency and patient (see G574); failed to ensure the plan of care was reviewed and revised every 60 days (see G588); and failed to ensure they coordinated care delivery with other agencies providing care to ensure they meet the patient's needs (see G608). These practices affected 3 of 3 active clinical records reviewed. (Patients: #1, 2, and 3) The cumulative effect of these problems resulted in the home health agency's inability to ensure the provision of quality health care in a safe environment for the Condition of Participation 42 CFR 484.60 Care Planning, Coordination, Quality of Care. *	G0570		
G0572	Plan of care CFR(s): 484.60(a)(1) Each patient must receive the home health services that are written in an individualized plan of care that identifies patient-specific measurable outcomes and goals, and which is established, periodically reviewed, and signed by a doctor of medicine, osteopathy, or podiatry acting within the scope of his or her state license, certification, or registration. If a physician or allowed practitioner refers a patient under a plan of care that cannot be completed until after an evaluation visit, the physician or allowed practitioner is consulted to approve additions or modifications to the original plan. This STANDARD is NOT MET as evidenced by: Based on record review and interview, the agency failed to ensure each patient received an individualized plan of care, and identified patient-specific, measurable outcomes and goals for 2 of 3 active records reviewed. (Patients: #1 and 2) Findings include: 1. An agency policy with a revision date of October 2016, titled “Care Planning Process” indicated but was not limited to, “Purpose: To provide clinical direction to the clinicians providing patient care … A written plan of care will be initiated within five (5) days of start of care and updated at least every 60 days or as patient’s condition warrants … The patient and family/caregiver will participate in decisions regarding the plan of care … The care planning process	G0572		04/25/2024

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G0572	Continued from page 5 will be documented on the plan of care, individualized discipline-specific care plans … The plan of care includes: … G. Goals/outcomes to be achieved … ” 2. A review of the active clinical record for Patient #1, with a start of care date of 04-05-2023, contained a recertification comprehensive assessment dated 03-25-2024. The recertification comprehensive assessment dated 03-25-2024 indicated the Alternate Clinical Manager, Admin 4’s visit time of 9:00 AM to 10:00 AM. The assessment's status was in progress and failed to list individualized goals and measurable outcomes and progress toward those goals. The clinical record failed to evidence a current plan of care with goals and measurable outcomes. During an interview on 04-30-2024 at 10:45 AM, when questioned regarding the plan of care goals and measurable outcomes, Admin 4 indicated they had until the next day to submit their comprehensive assessments and updated plan of care. Admin 4 further confirmed the revised plan of care was not completed. 3. A review of the active clinical record for Patient #2, with a start of care date of 12-01-2023, contained a plan of care for the recertification period of 01-30-2024 to 03-29-2024 but failed to evidence a plan of care for the current recertification period of 03-30-2024 to 05-27-2024. The clinical record indicated a visit for the recertification comprehensive was to be completed by the Clinical Manager, Admin 3. The clinical record failed to provide evidence a comprehensive reassessment had been completed. During an interview on 04-30-3024 at 11:00 AM, when queried about the location of the current plan of care and comprehensive reassessment for Patient #2, Admin 3 indicated they could not locate them in the clinical record. Admin 3 further indicated they completed the skilled nurse revisit but failed to complete the comprehensive reassessment and plan of care. 410 IAC 17-13-1(a)	G0572		
G0574	Plan of care must include the following CFR(s): 484.60(a)(2)(i-xvi) The individualized plan of care must include the following: (i) All pertinent diagnoses; (ii) The patient's mental, psychosocial, and cognitive	G0574		04/25/2024

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G0574	Continued from page 6 status; (iii) The types of services, supplies, and equipment required; (iv) The frequency and duration of visits to be made; (v) Prognosis; (vi) Rehabilitation potential; (vii) Functional limitations; (viii) Activities permitted; (ix) Nutritional requirements; (x) All medications and treatments; (xi) Safety measures to protect against injury; (xii) A description of the patient's risk for emergency department visits and hospital re-admission, and all necessary interventions to address the underlying risk factors. (xiii) Patient and caregiver education and training to facilitate timely discharge; (xiv) Patient-specific interventions and education; measurable outcomes and goals identified by the HHA and the patient; (xv) Information related to any advanced directives; and (xvi) Any additional items the HHA or physician or allowed practitioner may choose to include. This ELEMENT is NOT MET as evidenced by: Based on record review and interview, the agency failed to ensure the Plan of Care was individualized and included all the required elements for 3 of 3 active clinical records reviewed (Patients #1, 2, and 3). Findings Include: 1. An agency policy revised October 2016 and titled “Care Planning Process”, Policy No. 4-001.1, indicated but was not, “ … Policy … the patient plan of care will be developed or revised within five (5) working days of initiation of each service or of the reassessment of the patient … 1. Plan of Care … includes: … D.	G0574		

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G0574	Continued from page 7 Pertinent primary and secondary diagnoses, E. Food or drug allergies, F. Homebound status, G. Goals/outcomes to be achieved, H. Patient's mental status, I. Functional limitations, J. Activities permitted, K. Safety measures, L. Nutritional requirements, M. Medications including dose/frequency/route, N. orders for specific home health services and disciplines, treatments and procedures, including amount/frequency/duration, O. Supplies and equipment required, P. Discharge or referral plans, Q. Discharge teaching, R. Frequency and duration of visits, S. Prognosis, T. Rehabilitation potential …" 2. A review of the clinical record for Patient #1 contained a plan of care for the recertification period 01-30-2024 to 03-29-2024. The plan of care indicated but was not limited to diagnoses, Chronic kidney disease (the failure of the kidney to filter wastes and excess fluid from your blood), Dependence on supplemental oxygen, Diabetes mellitus with diabetic neuropathy (a condition caused by long-term elevated blood sugars causing nerve damage) and Anemia in chronic kidney disease (a condition where the red blood cell count is low due to impaired kidney function). The section Medications/Dose/Route/Frequency indicated but was not limited to, Humalog (medication to lower blood sugar) Pen Injector 100 units/milliliter (ml)/100 units/1ml subcutaneous once a day, and Insulin Glargine (a medication used to lower blood sugar) 100units/ml subcutaneous/give 77 units once a day; (Durable Medical Equipment) DME and Supplies evidenced cane, walker, shower bench, bath safety bars, hazardous waste container, oxygen, and electric wheelchair; Orders for Disciplines and Treatments (Specify Amount/Frequency/Duration) evidenced Attendant 65-69 hours weekly for 1 certification period, and Home Health Aide (HHA) Hourly 91 hours weekly for 1 certification period; Problems and Interventions evidenced Patient #3's main goal is to be able to remain in their apartment and not go to an assisted living; Goals/Rehabilitation Potential/Discharge Plans evidenced no goals, fair rehabilitation potential, and discharge plans indicated when services are no longer authorized by payer. The plan of care failed to include all DME and medical supplies including, insulin pen needles, glucometer, lancets, and glucometer strips; failed to include specific HHA and Attendant frequency, treatments, and duration; failed to include HHA and Attendant care interventions; patient-specific problems, and risk factors to include diabetes and renal function; failed to include measurable goals; failed to include Patient #1's risk for emergency room visits and hospital admissions; failed to address specific education and training provided. The record	G0574		

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G0574	Continued from page 8 evidence a plan of care for the current recertification period 03-30-2024 to 05-28-2024. During an interview on 04-30-2024 at 10:45 AM, when queried about the plan of care, the Alternate Clinical Manager, Admin 4, indicated they completed the reassessment visit on 03-25-2024. Admin 4 further indicated they found out yesterday the reassessment and plan of care were incomplete. Admin 4 confirmed they were to submit the completed comprehensive reassessments and plan of care revisions to the office the next day. 3. A review of the clinical record for Patient #2, contained a plan of care for the recertification period 01-30-2024 to 03-29-2024. The plan of care indicated the principal diagnosis of Cerebral infarction due to an embolism of unspecified artery (a stroke caused by a blood clot that traveled to the brain), and other diagnoses included but were not limited to: Hemiplegia left non-dominant side (severe or complete loss of strength affecting one side of the body), Anxiety disorder, and Hypoxic Ischemic Encephalopathy (brain damage caused by lack of oxygen to the brain). The section for Orders for Disciplines and Treatments (Specify Amount/Frequency/Duration) evidenced IHCC (Integrated Health Care Coordination) 16 hours monthly for 1 certification period, and Registered Nurse for recertification 1 visit for the certification period; Problems and Interventions where blank; Goals/Discharge Plans were blank. The record failed to evidence a current plan of care for the recertification period 03-30-2024 to 05-28-2024. During an interview on During an interview on 04-30-3024 at 11:00 AM, when queried about the location of the current plan of care for Patient #2, Admin 3 indicated they could not locate them in the clinical record. Admin 3 further indicated they completed the skilled nurse revisit but failed to complete the plan of care. 4. A review of the clinical record for Patient #3, contained a plan of care for the recertification period 02-29-2024 to 04-28-2024. The plan of care indicated the principal diagnosis of Unspecified Dementia without behavioral disturbance (a condition characterized by a decline in cognitive abilities without exhibiting any behavioral disturbances), and Acquired absence of limb (a condition missing either a leg or arm). The section for Orders for Disciplines and Treatments (Specify Amount/Frequency/Duration) evidenced Attendant 56-62 hours weekly for 1 certification period, IHCC 16 hours weekly for 1 certification period, and Registered Nurse	G0574		

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G0574	Continued from page 9 (RN) 1 visit for the certification period. The plan of care failed to have specific individualized visit frequency. During an interview on 04-30-2024 at 11:15, when queried about the frequency and corrections per the agency plan of correction of the plan of care being individualized and patient-specific, the Alternate Administrator, Admin 2, indicated they were responsible for the audited the plan of care to ensure specific and individualized frequencies. 410 IAC 17-13-1(a)(1)(D)(i, ii, iii, iv, v, vi, vii, viii, ix, x, xi, xii, xiii xiv)	G0574		
G0588	Reviewed, revised by physician every 60 days CFR(s): 484.60(c)(1) The individualized plan of care must be reviewed and revised by the physician or allowed practitioner who is responsible for the home health plan of care and the HHA as frequently as the patient's condition or needs require, but no less frequently than once every 60 days, beginning with the start of care date. This ELEMENT is NOT MET as evidenced by: Based on record review and interview, the agency failed to evidence a recertification plan of care had been reviewed by a physician every 60 days in 2 of 3 clinical records reviewed. (Patients: #1 and 2) Findings Include: 1. An agency policy revised October 2016 and titled “Care Planning Process”, Policy No. 4-001.1, indicated but was not, “ … The plan of care will be based upon the physician’s (or other authorized licensed independent practitioner's) orders … The clinicians will be responsible to revise the plan of care or update the plan at least every 60 days … ” 2. A review of the clinical record for Patient #1, with a start of care date of 04-05-2023, the record evidenced a physician signed and dated 04-10-2024, order for a revision to the plan of care for the recertification period of 01-30-2024 to 03-29-2024, but failed to contain a plan of care for the current recertification period 03-30-2024 to 05-28-2024. The record contained a comprehensive reassessment dated 03-25-2024, with the time at 9:00 AM to 10:00 AM, by the Alternate Clinical Manager, Admin 4, that indicated the assessment was still in progress. The clinical	G0588		04/25/2024

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G0588	Continued from page 10 record failed to contain a plan of care or order for Patient #1 to receive continued treatment. During an interview on 04-30-2024 at 10:45 AM, Admin 4 confirmed Patient #1's clinical record did not contain a current plan of care for the recertification period 03-30-2024 to 05-28-2024 or orders for care. 3. A review of the active clinical record for Patient #2, with a start of care date of 12-01-2023, contained a physician-signed plan of care for the recertification period of 01-30-2024 to 03-29-2024 but failed to evidence a plan of care or physician order for the current recertification period of 03-30-2024 to 05-27-2024. The clinical record indicated a visit for the recertification comprehensive was to be completed by the Clinical Manager, Admin 3. During an interview on 04-30-3024 at 11:00 AM, when queried about the location of the current plan of care or orders for the current certification period for Patient #2, Admin 3 indicated they could not locate them in the clinical record. Admin 3 further indicated they completed the skilled nurse revisit but failed to complete the plan of care. IAC 17-13-1(a)(2)	G0588		
G0608	Coordinate care delivery CFR(s): 484.60(d)(4) Coordinate care delivery to meet the patient's needs, and involve the patient, representative (if any), and caregiver(s), as appropriate, in the coordination of care activities. This ELEMENT is NOT MET as evidenced by: Based on record review and interview, the agency failed to ensure the patient's clinical records included information about the services the patient received from other health providers and failed to ensure they coordinated care delivery to meet the patient's needs for 2 of 3 active patient records reviewed. (Patients: #1 and 3) Findings Include: 1. An agency policy with a revision date of October 2016, titled "Coordination of Services with Other Providers" indicated but was not limited to, " … A Case Manager will be assigned to be responsible for coordinating services provided to the patient by the	G0608		04/25/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157081	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACME HEALTH SERVICE INC	6302 N RUCKER RD STE J , INDIANAPOLIS, Indiana, 46220

(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) COMPLETION DATE
G0608	Continued from page 11 organization, including services provided directly and through contract. The Case Manager will act as a liaison with other organizations or individuals also providing care to the patient to assure effective coordination of related services … ” 2. On 04-29-2024 at 12:05 PM, during the Entrance Conference, when queried about how care is coordinated with other agencies, the Alternate Administrator, Admin 2, indicated the nurses and social worker address coordination of care in the section of their electronic medical record titled “Client Logging and Case Communication.” 3. A review of the clinical record for Patient #1, the start of care of 04-05-2023, contained a plan of care for the recertification period of 01-30-2024 to 03-29-2024. The plan of care indicated Patient #1 goes to Entity 1, an in-center dialysis treatment facility, three times a week. A review of agency documents titled “Client Logging Report” dated 03-25-2024 to 04-29-2024, failed to evidence documentation of coordination of care with Entity 1. During an interview on 04-29-2024 at 3:28 PM, Patient #1 confirmed they go to Entity 1, for dialysis treatments. 4. A review of an Entity 1 document titled, “Current Order” indicated Patient #1 had a Central Venous Catheter (CVC) (a large tube inserted into the central jugular vein) used for their dialysis treatments, and orders for in-center dialysis every Tuesday, Thursday, and Saturday for a 5-hour duration of treatment time. During an interview on 04-30-2024 at 9:49 AM, Person 2, the Director of Operations for Entity 1, confirmed Patient #1 received dialysis treatment every Tuesday, Thursday, and Saturday for 5 hours at Entity 1. Person 2 further confirmed the home health agency had not contacted them to coordinate care regarding Patient #1. 5. During an interview on 04-30-2024 at 10:49 AM, the Alternate Clinical Manager, Admin 4, the Registered Nurse (RN) who saw Patient #1, confirmed they had not spoken to any staff at Entity 1. 6. A review of the clinical record for Patient #3, who started care on 03-06-2023, indicated an agency document titled, “Intake/Referral.” The referral form indicated Patient #3’s referral was from Entity 3, a not-for-profit agency that manages people with	G0608		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157081	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACME HEALTH SERVICE INC	6302 N RUCKER RD STE J , INDIANAPOLIS, Indiana, 46220

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G0608	Continued from page 12 disabilities to remain safe at home and out of institutional care. Person 4 was listed as Patient #3's case manager from Entity 3. On 04-30-2024 at 11:37 AM, Person 3 indicated they had not heard from anyone about any of their clients at ACME Health Services. 410 IAC 17-14-1(a)(1)(F)	G0608		