STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K064	A. BUILDING _____ B. WING _____	C 03/06/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AT HOME HEALTH SERVICES LLC	7202 NORTH SHADELAND AVE STE 119 INDIANAPOLIS, IN 46250

(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
G 000	INITIAL COMMENTS This visit was for a recertification and state relicensure survey of a Medicaid home health agency. This was a standard survey. A federal and state complaint was investigated in conjunction with this survey. Complaint #: IN 00238519; unsubstantiated; no findings. Facility #: 012383 Medicaid #: 201005950 Dates of survey, 3-2, 3-3, 3-4, 3-5, and 3-6-2020 Unduplicated skilled admissions in prior 12 months: 1 Current Census: 41 Skilled: 4 Home Health Aide only : 37 Personal Services only: 0 Home Visits: 3 Clinical Record Review: 7 Active with home visit: 3 Active without home visit: 2 Closed records: 2	G 000		

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

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 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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G 000	Continued From page 1 At this Medicaid recertification and state re-licensure survey, At Home Health Services, LLC, was found to have been in compliance with the requirements of 42 CFR 484.40 et seq., and 410 IAC 17-9-1 et seq., for home health agencies.	G 000		