STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K113	A. BUILDING B. WING	**05/26/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MISSION IN HOME HEALTH CARE, LLC	**1600 S STATE RD 135 PO BOX 36 , SALEM, Indiana, 47167**

(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
E0000	Initial Comments An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with Home Health 42 CFR 484.102. Survey Dates: 5/24/22, 5/25/22, and 5/26/22 Census: 15 At this Emergency Preparedness survey, Mission in Home Health care, LLC was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, Home Health 42 CFR 484.102. QR Completed 5/31/2022 A4	E0000		
G0000	INITIAL COMMENTS This visit was for Federal Recertification and State Relicensure of a Home Health Provider. Survey Dates: 5/24/22, 5/25/22, and 5/26/22. Active Census: 15 Unduplicated Admission for the last 12 months: 26 During this Federal Recertification Survey, Mission in Home Health Care, LLC was found to be in compliance with 42 CFR 484 and 410 IAC 17.	G0000		

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