

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K163	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/08/2024
NAME OF PROVIDER OR SUPPLIER Elite Home Healthcare, Llc		STREET ADDRESS, CITY, STATE, ZIP CODE 1009 14TH STREET, BEDFORD, Indiana, 47421		
(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	<p>INITIAL COMMENTS</p> <p>This was a Post-Condition revisit for the Home Health Agency Recertification survey conducted on 01/26/2024.</p> <p>Survey Dates: 03/07/2024 – 03/08/2024</p> <p>One previously cited condition was corrected and 2 standard level deficiencies were corrected.</p> <p>Elite Home Healthcare, LLC was found to be back into compliance with 42 CFR 484 for Home Health Agency Providers.</p> <p>Elite Home Healthcare, LLC continues to be precluded from providing its own home health aide training and competency evaluation program for a period of 2 years beginning 01/26/2024 to 01/25/2026.</p> <p>QR Completed on 03/12/2024 by A4.</p>	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
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