STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157541	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLPOINTS HOME HEALTH CARE INC	**9801 PRAIRIE AVE , HIGHLAND, Indiana, 46322**

(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 The Indiana Department of Health conducted an Emergency Preparedness revisit survey, in accordance with 42 CFR 484.102, for a Home Health Provider. Survey Date: December 10, 2024 Census: 10 During this Emergency Preparedness survey, Allpoints Home Health Care Inc. was found to be in compliance with the Condition of Participation at 42 CFR §484.102: Emergency Preparedness Requirements for Medicare Participating Providers and Suppliers. A1 12/11/2024	E0000		
G0000	INITIAL COMMENTS A Post Condition Revisit survey for a home health recertification survey, conducted on 9/20/2024. Survey Dates: 10/29/2024 - 0/31/2024 Unduplicated Skilled Admissions for the last 12 Months: 71 During the Post Condition revisit survey, six Conditions of Participation were determined to be back into compliance at 42 CFR 484.55 Comprehensive Assessment of Patients, 484.58 Discharge Planning, 484.65 Quality Assessment /Performance Improvement, 484.70 Infection Prevention and Control, and 484.105 Organization and Administration of Services. Ten [10] standard level deficiencies were determined to be back in compliance, eight [8] standard level deficiencies were recited, and one [1] new standard level deficiency was determined to be non-compliant. Based on the Condition-level deficiencies during the 9/20/2024 recertification survey, Allpoints Home Health Care Inc. was subject to a fully extended survey, pursuant to section 1891(c)(2)(D) of the Social Security Act, on 9/20/2024. Therefore, and pursuant to section 1891(a)(3)(D)(iii) of the Act, your agency is precluded from operating a home health aide training,	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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157541	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/10/2024

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G0000	Continued from page 1 skills competency and/or competency evaluation program for a period of two years beginning 9/20/2024 and continuing through 9/19/2026.	G0000		