

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

<b>STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS</b>		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: <b>15K128</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED <b>12/05/2024</b>
NAME OF PROVIDER OR SUPPLIER <b>TEAM SELECT HOME CARE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>8275 ALLISON POINTE TRAIL STE 350, INDIANAPOLIS, Indiana, 46250</b>		
(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 visit was for a Federal/State complaint survey of a HHA Provider.</p> <p>Survey Dates: 12/04/2024 and 12/05/2024</p> <p>Complaint: IN111086 No deficiencies cited.</p> <p>12-Month Unduplicated Skilled Admissions: 68</p> <p>Team Select Home Health is in compliance with 42 CFR 484.50, 42 CFR 484.60, and 42 CFR 484.80 as related to this complaint.</p> <p>QR by Area 3 on 12/10/2024.</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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