STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K107	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTSTAR HEALTHCARE	**9102 N MERIDIAN STREET STE 100 , INDIANAPOLIS, Indiana, 46260**

(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 42 CFR 484.102. Survey Dates: 1/24/23, 1/25/23, and 1/26/23 At this Emergency Preparedness survey, Brightstar Healthcare was found to have been in compliance with the Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, including staffing and the implementation of staffing during a pandemic at 42 CFR 484.102. QR by Area 3 on 2-1-2023	E0000		
G0000	INITIAL COMMENTS This visit was for a Federal Recertification and State Re-licensure Survey of a Home Health Provider. Survey Dates: 1/24/23, 1/25/23, and 1/26/23 Brightstar Healthcare was found to have been in compliance with 42 CFR 184 in regards to the Federal Recertification survey and was found in compliance with the rules for home health agencies at 410 IAC 17-12-1 et seq. QR by Area 3 on 2-1-2023	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