Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	014118	A. BUILDING: _____ B. WING _____	R 03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADAPTIVE NURSING AND HEALTHCARE SERVICES,	**9840 WESTPOINT DRIVE, SUITE 400 INDIANAPOLIS, IN 46256**

(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) COMPLETE DATE
{N 000}	Initial Comments This visit was a second re-visit for Initial State Licensure survey. Facility #: 014118 Date of survey: 3-15-18 Census: 3 Active patients Skilled care: 0 Home Health Aide only: 3 Home Visits: 0 - No visits scheduled on 3-15-18 Record Review only: 3 15 patients since 1st provisional license granted Adaptive Nursing and Healthcare Services, Inc., was found to have been in compliance with the requirements of 410 IAC 17-9 through 410 IAC 17-16, for Home Health Agencies.	{N 000}		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE