STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K093	A. BUILDING B. WING	**02/29/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Adaptive Nursing And Healthcare Services LLC	**50 WASHINGTON STREET , COLUMBUS, Indiana, 47201**

(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: 02/26/2024-02/29/2024 Active Census: 232 At this Emergency Preparedness survey, Adaptive Nursing and Healthcare Services was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 484.102.	E0000		
G0000	INITIAL COMMENTS This visit was for a Federal Recertification and State Re-Licensure survey of a Home Health Agency Provider. Survey Dates: 02/26/2024-02/29/2024 12-Month Unduplicated Skilled Admissions: 2 Adaptive Nursing and Healthcare Services was found to be in compliance with 42 CFR 484 and 410 IAC 17 of a home health survey.	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