

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 014339	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 09/04/2018
NAME OF PROVIDER OR SUPPLIER ADAPTIVE NURSING AND HEALTHCARE SERVICES -			STREET ADDRESS, CITY, STATE, ZIP CODE 938 MEZZANINE DRIVE, SUITE A LAFAYETTE, IN 47905		
(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}	<p>Initial Comments</p> <p>This was a re-visit for the Initial state licensure survey of a home health agency completed on 7/25/18.</p> <p>Re-visit date: 9/4/18</p> <p>Facility ID: 14339</p> <p>Census: 4</p> <p>Adaptive Nursing and Healthcare Services of Lafayette was found to be in compliance with 410 IAC Article 17.</p>	{N 000}			

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE