| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 006218 | A. BUILDING: _____ B. WING _____ | 08/17/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| KINDRED HOSPITAL- INDIANAPOLIS SOUTH | 607 GREENWOOD SPRINGS DRIVE GREENWOOD, IN 46143 |

| (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 |
|---|---|---|---|---|
| S 000 | INITIAL COMMENTS<br><br>This visit was for one State hospital complaint investigation.<br><br>Complaint number: IN00183041<br>Unsubstantiated: lack of sufficient evidence.<br><br>Survey date: 08-17-16<br><br>Facility Number: 006218<br><br>Kindred Hospital - Indianapolis South is in compliance with 410 IAC 15-1.5-6, Nursing Services, Indiana Hospital Licensure Rules.<br><br>QA: 10/4/16 jlh | S 000 | | |