STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	014743	A. BUILDING: _____ B. WING _____	C 06/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INDIANAPOLIS REHABILITATION HOSPITAL, LLC	1260 CITY CENTER DRIVE CARMEL, IN 46032

(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 This visit was for the investigation of a state licensure hospital complaint. Complaint Number: IN00382972 Unsubstantiated: Lack of sufficient evidence. Date of Survey: 06/28/22 Facility Number: 014743 Indianapolis Rehabilitation Hospital, LLC is in compliance with 410 IAC 15-1.5-6, Nursing Service and 410 IAC 15-1.6-7, Respiratory Care Services, Hospital Licensure Rules. QA: 7/5/2022	S 000		