

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 014743	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/25/2021
NAME OF PROVIDER OR SUPPLIER INDIANAPOLIS REHABILITATION HOSPITAL, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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	<p>INITIAL COMMENTS</p> <p>This visit was for an initial hospital licensure survey.</p> <p>Facility Number: 014743</p> <p>Survey Date: 2/22-24/2021</p> <p>Indianapolis Rehabilitation Hospital is in compliance with 410 IAC 15.1, Hospital Licensure Rules.</p> <p>QA: 2/25/21</p>	S 000		

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

TITLE

(X6) DATE