Indiana Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	008900	A. BUILDING: ____ B. WING ____	C **09/18/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED HOSPITAL INDIANAPOLIS NORTH	**8060 KNUE ROAD** **INDIANAPOLIS, IN 46250**

(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 2 state licensure hospital complaints. Complaint Number: IN00375213 - No deficiencies related to the allegations cited. Complaint Number: IN00389033 - No deficiencies related to the allegations cited . Date of Survey: 09/18/23 Facility Number: 008900 Kindred Hospital Indianapolis North is in compliance with Hospital Licensure rules 410 IAC 15-1.5-6, Nursing Service and 410 IAC 15-1.6.7, Respiratory Care Services, in regard to the investigation of complaints IN00375213 and IN00389033. QA: 9/26/2023	S 000		

Indiana Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE