| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 002605 | A. BUILDING: _____ B. WING _____ | 05/04/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| KINDRED HOSPITAL NORTHERN INDIANA | 215 W 4TH ST STE 200 MISHAWAKA, IN 46544 |

| (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>Facility Number: 002605<br><br>Type of Survey: State Licensure Off Site Joint Commission Accreditation Survey<br><br>Date of Joint Commission On Site Survey - Hospital full survey 4/25/2017-5/4/2017<br><br>Date of ISDH off site review - 02/12/2018<br><br>Based on review of the 7/20/2017 Joint Commission Accreditation Survey Report, it has been determined that Kindred Hospital Northern Indiana meets the requirements for Hospital Licensure in Indiana for 2017. | S 000 | | |