

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 005007	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/15/2021
NAME OF PROVIDER OR SUPPLIER COMMUNITY HOWARD REGIONAL HEALTH INC		STREET ADDRESS, CITY, STATE, ZIP CODE 3500 S LAFOUNTAIN ST KOKOMO, IN 46902		
(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 investigation of a state licensure hospital complaint.</p> <p>Complaint Number: IN00363958</p> <p>Unsubstantiated: Lack of sufficient evidence.</p> <p>Survey Date: 11/15/2021</p> <p>Facility Number: 005007</p> <p>Community Howard Regional Health, Inc. is in compliance with 410 IAC 15-1.5-10, Utilization Review and Discharge Planning Services, Hospital Licensure Rules.</p> <p>QA: 11/19/2021</p>	S 000		

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

TITLE

(X6) DATE