

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 008899	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/29/2017
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NAME OF PROVIDER OR SUPPLIER KINDRED HOSPITAL NORTHWEST INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 5454 HOHMAN AVE 5TH FL HAMMOND, IN 46320
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(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 the investigation of two State complaints.</p> <p>Complaint Numbers: IN00202797 Unsubstantiated: lack of sufficient evidence</p> <p>IN00213454 Unsubstantiated: lack of sufficient evidence</p> <p>Dates: 12/28/17 and 12/29/17</p> <p>Facility Number: 008899</p> <p>Kindred Hospital Northwest Indiana is in compliance with 410 IAC 15-1.5-6, Nursing Services, 410 IAC 15-1.5-10 Utilization review and discharge planning services, Hospital Licensure Rules.</p> <p>QA: 4/2/18</p>	S 000		

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