

Indiana State Department of Health

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                          |  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>002605</b>                       | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>03/14/2017</b> |
|--|--|--|--|--|
| NAME OF PROVIDER OR SUPPLIER<br><br><b>KINDRED HOSPITAL NORTHERN INDIANA</b> |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br><b>215 W 4TH ST STE 200<br/>MISHAWAKA, IN 46544</b> |  |  |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| S 000  | <p>INITIAL COMMENTS</p> <p>This visit was for a State hospital complaint investigation.</p> <p>Complaint Number: IN00223271</p> <p>Unsubstantiated: lack of sufficient evidence</p> <p>Date: 3/14/2017</p> <p>Facility Number: 002605</p> <p>Kindred Hospital Northern Indiana is in compliance with 410 IAC 15-1.5-6, Nursing service, Hospital Licensure Rules.</p> <p>QA: 03/28/18 LH</p> | S 000  |  |  |

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

TITLE

(X6) DATE