

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 002605	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/14/2017
NAME OF PROVIDER OR SUPPLIER KINDRED HOSPITAL NORTHERN INDIANA		STREET ADDRESS, CITY, STATE, ZIP CODE 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	<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