STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	006218	A. BUILDING: _____ B. WING _____	C 01/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED HOSPITAL- INDIANAPOLIS SOUTH	607 GREENWOOD SPRINGS DRIVE GREENWOOD, IN 46143

(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 This visit was for the investigation of one (1) State complaint. Complaint Number: IN00190583 Unsubstantiated; lack of sufficient evidence Date of survey: 1/27/16 Facility number: 006218 Kindred Hospital-Indianapolis South is in compliance with 410 IAC 15-1.5-6, Nursing Services, Hospital Licensure Rules. QA: cjl 02/03/16	S 000		