STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	008900	A. BUILDING: _____ B. WING _____	C 07/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED HOSPITAL INDIANAPOLIS NORTH	8060 KNUE ROAD INDIANAPOLIS, IN 46250

(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 investigation of two state licensure hospital complaints. Complaint Number: IN00272412 Unsubstantiated: Lack of sufficient evidence. Complaint Number: IN00299341 Unsubstantiated: Lack of sufficient evidence. Survey Date: 7/1/2021 Facility Number: 008900 Kindred Hospital Indianapolis North is in compliance with 410 IAC 15-1.5-6, Nursing Services, Hospital Licensure Rules. QA: 7/21/2021	S 000		