STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	003868	A. BUILDING: _____ B. WING _____	01/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY HOWARD SPECIALTY HOSPITAL	829 N DIXON RD KOKOMO, IN 46901

(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 A complaint investigation was for one state hospital complaint. Complaint Number: IN00203931 Substantiated: No deficiencies related to allegation cited. Facility: 003868 Survey: 01/11/18 Community Howard Specialty Hospital is in compliance with 410 IAC 15-1.5-5, Medical Staff and 410 IAC 15-1.5-6, Nursing Services, Hospital Licensure Rules. QA: 4/04/18	S 000		