STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005971	A. BUILDING: _____ B. WING _____	C 06/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REHABILITATION HOSPITAL OF INDIANA INC	4141 SHORE DR INDIANAPOLIS, IN 46254

(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 a state licensure hospital complaints. Complaint Number: IN00305927 Unsubstantiated: Lack of sufficient evidence. Date of Survey: 06/14/21 Facility Number: 005071 Rehabilitation Hospital of Indiana, INC is in compliance with 410 IAC 15-1.5-1 Dietetic Services, 410 IAC 15-1.5-6 Nursing Service and 410 IAC 15-1.5-10 Utilization Review and Discharge Planning Services, Hospital Licensure Rules. QA: 6/22/21	S 000		