STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	002605	A. BUILDING: _____ B. WING _____	C 01/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED HOSPITAL NORTHERN INDIANA	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	INITIAL COMMENTS This visit was for the investigation of a State hospital complaint. Complaint Number: IN00186294 Unsubstantiated; lack of sufficient evidence. Date: 01/23/2017 Facility Number: 002605 Kindred Hospital of Northern Indiana is in compliance with 410 IAC 15-1.5-6, Nursing Services, Hospital Licensure Rules. QA: 02/16/17 LH	S 000		