

Indiana Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>006106</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C 09/14/2023</b>
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED HOSPITAL INDIANAPOLIS</b>		STREET ADDRESS, CITY, STATE, ZIP CODE  <b>1700 W 10TH ST INDIANAPOLIS, IN 46222</b>		
(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	<p>INITIAL COMMENTS</p> <p>This visit was for investigation of a state licensure hospital complaint.</p> <p>Complaint Number: IN00305909 - No deficiencies related to the allegations are cited.</p> <p>Survey Date: 9/14/2023</p> <p>Facility Number: 006106</p> <p>Kindred Hospital Indianapolis is in compliance with 410 IAC 15-1.5-6, Nursing Service, Hospital Licensure Rules, in regard to the investigation of complaint IN00305909.</p> <p>QA: 9/21/2023, 9/25/2023 &amp; 9/26/2023</p>	S 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE