| 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 01/16/2018 |

| 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<br><br>This visit was for the investigation of one State hospital complaint.<br><br>Complaint Number: IN00207417<br>Unsubstantiated; lack of sufficient evidence.<br><br>Date: 01/16/2018<br><br>Facility Number: 002605<br><br>Kindred Hospital of Northern Indiana is in compliance with Infection Control, 410 IAC 15-1.5-2, Hospital Licensure Rules.<br><br>QA: 4/11/18 | S 000 | | |