

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 006218	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 08/04/2015
NAME OF PROVIDER OR SUPPLIER KINDRED HOSPITAL- INDIANAPOLIS SOUTH		STREET ADDRESS, CITY, STATE, ZIP CODE 607 GREENWOOD SPRINGS DRIVE GREENWOOD, IN 46143		
(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 complaint. Complaint: #IN00176954 Substantiated; no deficiencies cited. Facility Number: 006218 Survey Date: 08/04/2015 Kindred Hospital-Indianapolis South is in compliance with 410 IAC 15-1.5-6, Nursing Service, Hospital Licensure Rules. QA: cjl 08/07/15	S 000		

Indiana State Department of Health

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

TITLE

(X6) DATE