

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>006218</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/24/2012</b>
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED HOSPITAL- INDIANAPOLIS SOUTH</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>607 S GREENWOOD SPRINGS DR GREENWOOD, IN 46143</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><b>INITIAL COMMENTS</b></p> <p>This visit was for the investigation of one hospital State complaint.</p> <p>Complaint Number: IN00094058 Unsubstantiated; lack of sufficient evidence</p> <p>Survey Dates: 4-24-2012</p> <p>Facility Number: 006218</p> <p>Surveyor: Deborah Franco, RN Public Health Nurse Surveyor</p> <p>Kindred Hospital-Indianapolis South is in compliance with 410 IAC 15-1.5-6, Nursing services, Hospital Licensure Rules.</p> <p>QA: cloughlin 05/16/12</p>	S 000		

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TITLE

(X6) DATE

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