

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>012908</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/17/2021</b>
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NAME OF PROVIDER OR SUPPLIER  <b>COMMUNITY HEALTH NETWORK REHABILITATION H</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>7343 CLEARVISTA DRIVE</b> <b>INDIANAPOLIS, IN 46256</b>
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(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 investigation of a state licensure hospital complaint.</p> <p>Complaint Number: IN00228260</p> <p>Unsubstantiated: Lack of sufficient evidence.</p> <p>Survey Date: 6/17/2021</p> <p>Facility Number: 012908</p> <p>Community Health Network Rehabilitation Hospital is in compliance with 410 IAC 15-1.5-6 Nursing Service, Hospital Licensure Rules.</p> <p>QA: 6/23/2021</p>	S 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_