| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 012908 | A. BUILDING: _____ B. WING _____ | C 10/07/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COMMUNITY HEALTH NETWORK REHABILITATION H | 7343 CLEARVISTA DRIVE INDIANAPOLIS, IN 46256 |

| (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 a state licensure hospital complaint.<br><br>Complaint Number: IN00274041<br><br>Unsubstantiated: Lack of sufficient evidence.<br><br>Date of Survey: 10/07/21<br><br>Facility Number: 012908<br><br>Community Health Network Rehabilitation Hospital is in compliance with 410 IAC 15-1.6-6 Rehabilitation Services, Hospital Licensure Rules.<br><br>QA: 10/12/21 | S 000 | | |