

Indiana 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>10/31/2024</b>
--	---	---	---

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>
--	--

(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 a State Licensure hospital complaint.</p> <p>Complaint Number: IN00404017 - No deficiencies related to the allegations are cited.</p> <p>Survey date: 10/31/2024</p> <p>Facility Number: 012908</p> <p>Community Health Network Rehabilitation Hospital was found in compliance with 410 IAC 15-1.5-6 Nursing Service, Hospital Licensure Rules in regard to the investigation of complaint IN00404017.</p> <p>QA: 01/08/25</p>	S 000		

Indiana Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
---	-------	-----------