

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 005007	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/06/2013
NAME OF PROVIDER OR SUPPLIER COMMUNITY HOWARD REGIONAL HEALTH INC			STREET ADDRESS, CITY, STATE, ZIP CODE 3500 S LAFOUNTAIN ST KOKOMO, IN 46902		
(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>INITIAL COMMENTS</p> <p>This visit is for a State hospital complaint investigation.</p> <p>Complaint: #IN00125639 Unsubstantiated; lack of sufficient evidence.</p> <p>Survey Date: 05/06/13</p> <p>Facility # 005007</p> <p>Surveyor: Linda Dubak, R.N. Public Health Nurse Surveyor</p> <p>Community Howard Regional Health, Inc. is in compliance with 410 IAC 15-1.6-5, Psychiatric services and 410 IAC 15-1.5-6, Nursing services, Hospital Licensure Rules.</p> <p>QA: cloughlin 05/23/13</p>	S 000			

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TITLE

(X6) DATE

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