

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 008899	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/17/2013
NAME OF PROVIDER OR SUPPLIER KINDRED HOSPITAL NORTHWEST INDIANA		STREET ADDRESS, CITY, STATE, ZIP CODE 5454 HOHMAN AVE 5TH FL HAMMOND, IN 46320		
(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 was for investigation of two State hospital complaints.</p> <p>Complaint Numbers: IN00122386 Unsubstantiated: lack of sufficient evidence</p> <p>IN00126445 Unsubstantiated: lack of sufficient evidence</p> <p>Date: 4/17/13</p> <p>Facility Number: 008899</p> <p>Surveyor: Jacqueline Brown, R.N., Public Health Nurse Surveyor</p> <p>Kindred Hospital Northwest Indiana is in compliance with 410 IAC 15-1.5-6, Nursing service, 410 IAC 15-1.5-5, Medical staff and 410 IAC 15-1.6-7, Respiratory care services, Indiana Hospital Licensure Rules.</p> <p>QA: cloughlin 04/26/13</p>	S 000		

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TITLE

(X6) DATE

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