

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>005615</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/30/2011</b>
NAME OF PROVIDER OR SUPPLIER  <b>FRANCISCAN PHYSICIANS HOSPITAL LLC</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>701 SUPERIOR AVE MUNSTER, IN 46321</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 investigation of a State hospital complaint.</p> <p>Complaint Number: IN00091596</p> <p>Unsubstantiated: lack of sufficient evidence</p> <p>Date: 6/30/11</p> <p>Facility Number: 005615</p> <p>Surveyor: ReBecca Lair, LCSW Medical Surveyor</p> <p>Franciscan Physician Hospital is in compliance with 410 IAC 15-1.5-2, Infection control and 410 IAC 15-1.5-8, Physical plant, Hospital Licensure Rules.</p> <p>QA: cloughlin 09/01/11</p>	S 000		

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TITLE

(X6) DATE

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