

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 005078	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/07/2012
NAME OF PROVIDER OR SUPPLIER ST VINCENT ANDERSON REGIONAL HOSPITAL INC		STREET ADDRESS, CITY, STATE, ZIP CODE 2015 JACKSON ST ANDERSON, IN 46016		
(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 one State hospital complaint.</p> <p>Complaint Number: IN00108458</p> <p>Unsubstantiated: Lack of Sufficient Evidence</p> <p>Date: 11/7/12</p> <p>Facility Number: 005078</p> <p>Surveyor: Linda Plummer, R.N., Public Health Nurse Surveyor</p> <p>Saint John's Health System is in compliance with 410 IAC 15-1.6.2, Emergency Services, Indiana Hospital Licensure Rules.</p> <p>QA: claughlin 11/13/12</p>	S 000		

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TITLE

(X6) DATE

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