STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005008	A. BUILDING: _____ B. WING _____	C 11/18/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CATHERINE HOSPITAL INC	4321 FIR STREET EAST CHICAGO, IN 46312

(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	INITIAL COMMENTS This visit was for investigation of a State licensure hospital complaint. Complaint Number: IN00307753 Unsubstantiated: Lack of sufficient evidence. Date of Survey: 11/18/2021 Facility Number: 005008 St. Catherine Hospital, Inc. is in compliance with 410 IAC 15-1.5-5, Medical Staff and 410 IAC 15-1.5-6, Nursing Service, Hospital Licensure Rules. QA: 11/24/2021	S 000		