

Indiana Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 002408	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 02/01/2024
NAME OF PROVIDER OR SUPPLIER DUPONT HOSPITAL LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 2520 E DUPONT RD FORT WAYNE, IN 46825		
(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 a state licensure hospital complaint.</p> <p>Complaint Number: IN00426721 - No deficiencies related to the allegations are cited.</p> <p>Date of Survey: 2/1/24</p> <p>Facility Number: 002408</p> <p>Dupont Hospital, LLC, is in compliance with 410 IAC 15-1.5-8, Physical Plant, Hospital Licensure Rules, in regard to the investigation of complaint IN00426721.</p> <p>QA: 2/13/2024</p>	S 000		

Indiana Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE