

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 011437	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 09/22/2021
NAME OF PROVIDER OR SUPPLIER COMMUNITY HOSPITAL NORTH		STREET ADDRESS, CITY, STATE, ZIP CODE 7150 CLEARVISTA DR INDIANAPOLIS, IN 46256		
(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: IN00249507 Unsubstantiated: Lack of sufficient evidence. Survey Date: 9/22/2021 Facility Number: 011437 Community Hospital North is in compliance with 410 IAC 15-1.5-6, Nursing Service, Hospital Licensure Rules. QA: 10/5/2021	S 000		

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

TITLE

(X6) DATE