

Indiana Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>005043</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C 12/06/2023</b>
NAME OF PROVIDER OR SUPPLIER  <b>LUTHERAN DOWNTOWN HOSPITAL</b>		STREET ADDRESS, CITY, STATE, ZIP CODE  <b>702 VAN BUREN STREET FORT WAYNE, IN 46802</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>INITIAL COMMENTS</p> <p>This visit was for investigation of a state licensure hospital complaint.</p> <p>Complaint Number: IN00301762</p> <p>Date of survey: 12/6/23</p> <p>Facility number: 005043</p> <p>Upon arrival at facility, it was found that the patient named in the complaint was not found as a patient at this facility.</p> <p>QA: 12/14/2023</p>	S 000		

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

TITLE

(X6) DATE