| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 011437 | A. BUILDING: _____ B. WING _____ | C 03/23/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COMMUNITY HOSPITAL NORTH | 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<br><br>This visit was for investigation of a State licensure hospital complaint.<br><br>Complaint Number: IN00346968<br><br>Substantiated: No deficiency related to the allegations is cited.<br><br>Survey Date: 3/23/21<br><br>Facility Number: 011437<br><br>Community Hospital North is in compliance with 410 IAC 15-1.5-6, Nursing Service, Hospital Licensure Rules.<br><br>QA: 03/24/2021 | S 000 | | |