

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 005017	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 03/15/2023
NAME OF PROVIDER OR SUPPLIER ELKHART GENERAL HOSPITAL		STREET ADDRESS, CITY, STATE, ZIP CODE 600 E BLVD ELKHART, IN 46514		
(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: IN00363219 Unsubstantiated: Lack of sufficient evidence. Date of Survey: 3/15/23 Facility Number: 005017 Elkhart General Hospital is in compliance with 410 IAC 15-1.5-6, Nursing Service, Hospital Licensure Rules. QA: 4/4/2023	S 000		

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

TITLE

(X6) DATE