

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 005008	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 01/14/2021
NAME OF PROVIDER OR SUPPLIER ST CATHERINE HOSPITAL INC		STREET ADDRESS, CITY, STATE, ZIP CODE 4321 FIR STREET EAST CHICAGO, IN 46312		
(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: IN00344674</p> <p>Unsubstantiated: Lack of sufficient evidence.</p> <p>Dates of Survey: 1/13/2021 to 1/14/2021</p> <p>Facility Number: 005008</p> <p>St. Catherine Hospital, Inc is in compliance with 410 IAC 15-1.5-2, Infection Control, Hospital Licensure Rules.</p> <p>QA: 1/21/21</p>	S 000		

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

TITLE

(X6) DATE