

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>005106</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/07/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>COMMUNITY HOSPITAL</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>901 MACARTHUR BLVD</b> <b>MUNSTER, IN 46321</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: IN00238162</p> <p>Unsubstantiated: Lack of sufficient evidence.</p> <p>Date of Survey: 7/7/2021</p> <p>Facility Number: 005106</p> <p>Community Hospital is in compliance with 410 IAC 15-1.5-6, Nursing Service, Hospital Licensure Rules.</p> <p>QA: 7/12/2021</p>	S 000			

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

TITLE

(X6) DATE