

Indiana Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>004171</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/15/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>INDIANA UNIVERSITY HEALTH NORTH HOSPITAL</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>11700 N MERIDIAN ST</b> <b>CARMEL, IN 46032</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><b>INITIAL COMMENTS</b></p> <p>This visit was for the investigation of a State Licensure hospital complaint.</p> <p>Complaint Number: IN00436029- No deficiencies related to the allegations are cited.</p> <p>Date: 01/15/2025</p> <p>Facility Number: 004171</p> <p>Indiana University Health North Hospital is in compliance with 410 IAC 15-1.5-6, Nursing Service, Hospital Licensure Rules in regard to the investigation of complaint IN00436029.</p> <p>QA:1/23/2025</p>	S 000		

Indiana Department of Health  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE