

Indiana Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 005109	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 02/02/2024
NAME OF PROVIDER OR SUPPLIER COMMUNITY HOSPITAL SOUTH		STREET ADDRESS, CITY, STATE, ZIP CODE 1402 E COUNTY LINE RD S INDIANAPOLIS, IN 46227		
(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: IN00422461</p> <p>Date of Survey: 2/2/24 & 2/7/24</p> <p>Facility Number: 005109</p> <p>Community Hospital South is in compliance with 410 IAC 15-1.6-2, Emergency Services, Hospital Licensure Rules in regard to investigation of complaint IN00422461.</p> <p>QA: 2/15/24</p>	S 000		

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

TITLE

(X6) DATE