STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005043	A. BUILDING: _____ B. WING _____	C 03/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHERAN DOWNTOWN HOSPITAL	702 VAN BUREN STREET FORT WAYNE, IN 46802

(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: IN00453459 - No deficiencies related to the allegations are cited. Date of Survey: 3/17/2025 Facility Number: 005043 Lutheran Downtown Hospital is in compliance with 410 IAC 15-1.5-6, Nursing Service, and 410 IAC 15-1.6-2, Emergency Services, Hospital Licensure Rules, in regard to the investigation of complaint IN00453459. QA: 4/3/2025	S 000		