STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005002	A. BUILDING: _____ B. WING _____	10/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METHODIST HOSPITALS INC	600 GRANT ST GARY, IN 46402

(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 the investigation of a state licensure hospital complaint. Complaint Number: IN00264058 Unsubstantiated: Lack of sufficient evidence. Survey Dates: 10/08/2019 & 10/09/2019 Facility Number: 005002 Methodist Hospital Incorporated is in compliance with 410 IAC 15-1.5-2, Infection Control, 410 IAC 15-1.5-6, Nursing Service, Hospital Licensure Rules. QA: 10/15/2019	S 000		