STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005015	A. BUILDING: _____ B. WING _____	C 01/27/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANCISCAN HEALTH MICHIGAN CITY	3500 FRANCISCAN WAY MICHIGAN CITY, IN 46360

(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: IN00262367 Unsubstantiated: Lack of sufficient evidence. Date of Survey: 1/27/2021 Facility Number: 005015 Franciscan Health Michigan City is in compliance with 410 IAC 15-1.5-10, Utilization Review & Discharge Planning, Hospital Licensure Rules. QA: 2/4/21	S 000		