

Indiana Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>005109</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/29/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>COMMUNITY HOSPITAL SOUTH</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1402 E COUNTY LINE RD S</b> <b>INDIANAPOLIS, IN 46227</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: IN00427125 - No deficiencies related to the allegations are cited.</p> <p>Survey Date: 01/29/2025</p> <p>Facility Number: 005109</p> <p>Community Hospital South, is in compliance with 410 IAC 15-1.5-1, Dietetic Services, Hospital Licensure Rules, in regard to the investigation of complaint IN00427125.</p> <p>QA: 2/6/2025</p>	S 000		

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

TITLE

(X6) DATE