STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005062	A. BUILDING: _____ B. WING _____	C 11/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DUKES MEMORIAL HOSPITAL	275 W 12TH ST PERU, IN 46970

(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: IN00265189 Unsubstantiated: Lack of sufficient evidence. Dates of survey: 11/9/21 and 11/10/21 Facility number: 005062 Dukes Memorial Hospital is in compliance with 410 IAC 15-1.5-5, Medical Staff and 410 IAC 15-1.5-6, Nursing Service, Hospital Licensure Rules. QA: 11/23/2021	S 000		