

Indiana Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 005015	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 08/10/2023
NAME OF PROVIDER OR SUPPLIER FRANCISCAN HEALTH MICHIGAN CITY		STREET ADDRESS, CITY, STATE, ZIP CODE 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	<p>INITIAL COMMENTS</p> <p>This visit was for a State licensure hospital complaint investigation.</p> <p>Complaint Number: IN00361149 - No deficiencies related to allegations are cited.</p> <p>Date of Survey: 8/10/2023</p> <p>Facility Number: 005015</p> <p>Franciscan Health - Michigan City is in compliance with 410 IAC 15-1.5-2, Infection Control, Hospital licensure rules, in regard to the investigation of complaint IN00361149.</p> <p>QA: 8/22/23</p>	S 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE