

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 004171	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 03/29/2021
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NAME OF PROVIDER OR SUPPLIER INDIANA UNIVERSITY HEALTH NORTH HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 11700 N MERIDIAN ST CARMEL, IN 46032
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(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 for a State licensure hospital complaint. Complaint Number: IN00322595 Unsubstantiated: Lack of sufficient evidence. Survey Date: 3/29/2021 Facility Number: 004171 Indiana University Health North Hospital is in compliance with 410 IAC 15-1.5-6, Nursing Service, Hospital Licensure Rules. QA: 04/06/2021	S 000		

Indiana State Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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