

Indiana Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>005017</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/01/2024</b>
NAME OF PROVIDER OR SUPPLIER  <b>ELKHART GENERAL HOSPITAL</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>600 E BLVD</b> <b>ELKHART, IN 46514</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 investigation of a state licensure hospital complaint.</p> <p>Complaint Number: IN00416492 - No deficiencies related to the allegations are cited.</p> <p>Date of Survey: 7/1/24</p> <p>Facility Number: 005017</p> <p>Elkhart General Hospital is in compliance with 410 IAC 15-1.5-4, Medical Record Services, and 410 IAC 15-1.5-6, Nursing Service, Hospital Licensure Rules in regard to the investigation of complaint IN00416492.</p> <p>QA: 7/15/2024</p>	S 000		

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

TITLE

(X6) DATE