

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 005068	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/08/2012
NAME OF PROVIDER OR SUPPLIER COMMUNITY HOSPITAL EAST			STREET ADDRESS, CITY, STATE, ZIP CODE 1500 N RITTER AVE INDIANAPOLIS, IN 46219		
(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 investigation of a State complaint.</p> <p>Complaint #: IN00086757 Unsubstantiated; lack od sufficient evidence</p> <p>Date of Survey: 03/08/12</p> <p>Facility #: 005068</p> <p>Surveyor: Carol Laughlin, RN Public Health Nurse Surveyor</p> <p>Community Hospital East is in compliance with 410 IAC 15-1.5-10, Utilization review and discharge planning services, Hospital Licensure Rules.</p> <p>QA: claughlin 06/26/13</p>	S 000			

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TITLE

(X6) DATE

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