

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 011437	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/25/2013
--	---	---	---

NAME OF PROVIDER OR SUPPLIER COMMUNITY HOSPITAL NORTH	STREET ADDRESS, CITY, STATE, ZIP CODE 7150 CLEARVISTA DR INDIANAPOLIS, IN 46256
---	---

(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 the investigation of a State complaint.</p> <p>Complaint: IN00136894 Substantiated, no deficiencies related to allegations cited.</p> <p>Date of Survey: 10-25-13</p> <p>Facility number: 011437</p> <p>Surveyor: John Lee, R.N. Public Health Nurse Surveyor</p> <p>Community Hospital North is in compliance with 410 IAC 15-1.5-2, Infection control, and 410 IAC 15-1.5-8, Physical plant, maintenance, and environmental services, Hospital Licensure Rules.</p> <p>QA: cloughlin 11/01/13</p>	S 000		

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