

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 005109	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/07/2011
NAME OF PROVIDER OR SUPPLIER COMMUNITY HOSPITAL SOUTH		STREET ADDRESS, CITY, STATE, ZIP CODE 1402 E COUNTY LINE RD S INDIANAPOLIS, IN 46227		
(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 1 (one) State hospital complaint investigation.</p> <p>Complaint: #IN00090563 Unsubstantiated; lack of sufficient evidence.</p> <p>Facility: #005109</p> <p>Date: 7/7/2011</p> <p>Surveyor: Karilyn M. Tretter, RN Public Health Nurse Surveyor</p> <p>Community Hospital South is in compliance with 410 IAC 15-1.6.2, Emergency services, Indiana State Hospital Licensure Rules.</p> <p>QA: cloughlin 07/12/11</p>	S 000		

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TITLE

(X6) DATE

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