

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 005017	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/11/2012
NAME OF PROVIDER OR SUPPLIER ELKHART GENERAL HOSPITAL		STREET ADDRESS, CITY, STATE, ZIP CODE 600 E BLVD ELKHART, IN 46514		
(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 one hospital licensure complaint.</p> <p>Complaint Number: IN00103427: Unsubstantiated: Lack of Sufficient Evidence</p> <p>Date: 4/11/12</p> <p>Facility Number: 005017</p> <p>Surveyor: Linda Plummer, R.N., Public Health Nurse Surveyor</p> <p>Elkhart General Hospital is in compliance with 410 IAC 15-1.6.2, Emergency Services, Indiana Hospital Licensure Rules.</p> <p>QA: cloughlin 04/26/12</p>	S 000		

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TITLE

(X6) DATE

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