

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>005002</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/28/2015</b>
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NAME OF PROVIDER OR SUPPLIER  <b>METHODIST HOSPITALS INC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>600 GRANT ST GARY, IN 46402</b>
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(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 survey was for the investigation of one State hospital complaint.</p> <p>Complaint Number: IN00160540</p> <p>Unsubstantiated; lack of sufficient evidence.</p> <p>Date: 9/28/2015</p> <p>Facility number: 005002</p> <p>Methodist Hospitals, Inc. is in compliance with 410 IAC 15-1.5-6, Nursing Services, and 410 IAC 15-1.6-2, Emergency Services, Hospital Licensure Rules.</p>	S 000		

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