Indiana State Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 005077 | A. BUILDING: ______<br>B. WING ______ | 11/09/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **DEARBORN COUNTY HOSPITAL** | **600 WILSON CREEK RD<br>LAWRENCEBURG, IN 47025** |

| (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 | INITIAL COMMENTS<br><br>This visit was for one State hospital complaint investigation.<br><br>Complaint number: IN00207216<br>Unsubstantiated: lack of sufficient evidence.<br><br>Survey date: 11/9/2016<br><br>Facility Number: 005077<br><br>QA: 01/25/2017 LH<br><br>Dearborn County Hospital is in compliance with 410 IAC 15-1.5-6, Nursing Services, Indiana Hospital Licensure Rules. | S 000 | | |

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE