

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 011788	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/18/2017
NAME OF PROVIDER OR SUPPLIER KENTUCKIANA MEDICAL CENTER LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 4601 MEDICAL PLAZA WAY CLARKSVILLE, IN 47129		
(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 Licensure hospital complaint.</p> <p>Complaint Number: IN00209663 Unsubstantiated; Lack of Sufficient Evidence.</p> <p>Survey Date: 8/18/17</p> <p>Facility number: 011788</p> <p>Kentuckiana Medical Center is in compliance with 410 IAC 15-1.5-5, Medical Staff, Hospital Licensure Rules.</p> <p>QA: 5/29/18</p>	S 000		

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

TITLE

(X6) DATE