STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005035	A. BUILDING: _____ B. WING _____	C 06/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HANCOCK REGIONAL HOSPITAL	801 N STATE ST GREENFIELD, IN 46140

(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 This visit was for an investigation of a state licensure hospital complaint. Complaint Number: IN00276824 Unsubstantiated: Lack of sufficient evidence. Date of Survey: 06/07/21 Facility Number: 005035 Hancock regional Hospital is in compliance with 410 IAC 15-1.5-2 Infection Control and 410 IAC 15-1.5-6 Nursing Service, Hospital Licensure Rules. QA: 6/22/21	S 000		