

Indiana Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 005096	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/19/2023
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NAME OF PROVIDER OR SUPPLIER FRANCISCAN HEALTH LAFAYETTE	STREET ADDRESS, CITY, STATE, ZIP CODE 1701 S CREASY LN LAFAYETTE, IN 47905
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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>INITIAL COMMENTS</p> <p>This visit is for the investigation of a state licensure hospital complaint.</p> <p>Complaint Number: IN00373305 - No deficiencies related to the allegations are cited.</p> <p>Date of Survey: 09/19/23</p> <p>Facility Number: 005096</p> <p>Franciscan Health Lafayette is in compliance with Hospital Licensure Rules 410 IAC 15-1.5-2, Infection Control, and 410 IAC 15-1.6-2, Emergency Services, in regard to the investigation of complaint IN00373305.</p> <p>QA: 9/25/2023 & 9/26/2023</p>	S 000		

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