

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 005040	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/30/2020
NAME OF PROVIDER OR SUPPLIER BAPTIST HEALTH FLOYD		STREET ADDRESS, CITY, STATE, ZIP CODE 1850 STATE ST NEW ALBANY, IN 47150		
(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 an investigation of a State hospital complaint.</p> <p>Complaint Number: IN00316913</p> <p>Unsubstantiated: Lack of sufficient evidence.</p> <p>Survey Date: 11/30/20</p> <p>Facility Number: 005040</p> <p>Baptist Health Floyd is in compliance with 410 IAC 15-1.5-2, Infection Control, Hospital Licensure Rules.</p> <p>QA: 12/10/20</p>	S 000		

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

TITLE

(X6) DATE