

Indiana State Department of Health

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| 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