STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	004747	A. BUILDING: _____ B. WING _____	C 04/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADAMS MEMORIAL HOSPITAL	1100 MERCER AVE DECATUR, IN 46733

(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 investigation of a state licensure hospital complaint. Complaint Number: IN0346367 Unsubstantiated: Lack of sufficient evidence. Date of survey: 4/5/21 Facility number: 004747 Adams Memorial Hospital is in compliance with 410 IAC 15-1.5-2, Infection Control, 410 IAC 15-1.5-4, Medical Record Services and 410 IAC 15-1.5-8, Physical Plant, Hospital Licensure Rules. QA: 4/15/21	S 000		