STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005009	A. BUILDING: _____ B. WING _____	C 03/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARK MEMORIAL HEALTH	1220 MISSOURI AVE JEFFERSONVILLE, IN 47130

(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 survey was for a State Licensure hospital complaint survey. Complaint Number: IN00333937 Substantiated: No deficiency related to the allegations is cited. Date of survey: 3/02/21 Facility Number: 005009 Clark Memorial Health is in compliance with 410 IAC 15-1.5-2, Infection Control, Hospital Licensure Rules. QA: 3/9/21	S 000		