STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005074	A. BUILDING: _____ B. WING _____	C 05/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEACONESS HOSPITAL INC	600 MARY ST EVANSVILLE, IN 47747

(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: IN00314734 Unsubstantiated: Lack of sufficient evidence Survey Date: 5/14/21 & 5/21/21 Facility Number: 005074 Deaconess Hospital Inc. is in compliance with 410 IAC 15-1.5-4, Medical Record Services and 410 IAC 15-1.5-6, Nursing Service, Hospital Licensure Rules. QA: 5/25/21	S 000		