STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005063	A. BUILDING: _____ B. WING _____	C 02/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KING'S DAUGHTERS' HEALTH	1373 EAST SR 62 MADISON, IN 47250

(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: IN00297832 Unsubstantiated: Lack of sufficient evidence. Date of survey: 2/22/2021 Facility Number: 005063 King's Daughters' Health is in compliance with Infection Control, 410 IAC 15-1.5-2, Hospital Licensure Rules. QA: 2/25/21	S 000		