STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005038	A. BUILDING: _____ B. WING _____	C 12/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN HOSPITAL	520 S 7TH ST VINCENNES, IN 47591

(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 the investigation of a state licensure hospital complaint. Complaint Number: IN00371787 - No deficiency related to the allegation is cited. Survey Date: 12/18/2023 Facility Number: 005038 Good Samaritan Hospital is in compliance with 410 IAC 15-1.6-2 Emergency Services, Hospital Licensure Rules in regard to the investigation of complaint IN00371787. QA: 1/22/24	S 000		