STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005040	A. BUILDING: _____ B. WING _____	C 09/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAPTIST HEALTH FLOYD	1850 STATE ST NEW ALBANY, IN 47150

(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: IN00256239 Unsubstantiated: Lack of sufficient evidence. Survey Date: 9/07/2021 Facility Number: 005040 Baptist Health Floyd is in compliance with 410 IAC 15-1.5-6, Nursing Service and 410 IAC 15-1.6-7, Respiratory Care Services, Hospital Licensure Rules. QA: 9/14/21	S 000		