

Indiana State Department of Health

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                       |   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>005059</b>                       | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>04/26/2016</b> |
|---|---|--|--|--|
| NAME OF PROVIDER OR SUPPLIER<br><br><b>FAYETTE REGIONAL HEALTH SYSTEM</b> |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br><b>1941 VIRGINIA AVE<br/>CONNERSVILLE, IN 47331</b> |  |  |
| (X4) ID<br>PREFIX<br>TAG  | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| S 000   | <p>HFAP<br/>Surveyor: 33212<br/>Facility Number: 005059</p> <p>Type of Survey: State Licensure Off Site HFAP<br/>Accreditation Survey</p> <p>Date of HFAP On Site Survey - Hospital full<br/>survey 4/25-26/2016</p> <p>Date of ISDH off site review- 10/25-26/2016</p> <p>Based on review of the April 26, 2016 HFAP<br/>Accreditation Survey Report, it has been<br/>determined that Fayette Memorial Hospital meets<br/>the requirements for Hospital Licensure in Indiana<br/>for 2016.</p> | S 000  |  |  |

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE