STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005009	A. BUILDING: _____ B. WING _____	C 03/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARK MEMORIAL HEALTH	1220 MISSOURI AVE JEFFERSONVILLE, IN 47130

(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 two (2) state licensure hospital complaints. Complaint Number: IN00400984 No deficiencies related to the allegation are cited. Complaint Number: IN00401981 Lack of sufficient evidence. Facility Number: 005009 Date: 03/15/2023 Clark Memorial Health is in compliance with 410 IAC 15-1.5-5 Medical Staff, and 410 IAC 15-1.6-8 Surgical Services, Hospital Licensure Rules, in regard to the investigation of complaints IN00400984 and IN00401981. QA: 4/20/2023	S 000		