

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 005022	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/20/2014
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NAME OF PROVIDER OR SUPPLIER UNION HOSPITAL INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1606 N SEVENTH ST TERRE HAUTE, IN 47804
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(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	<p>INITIAL COMMENTS</p> <p>This visit was for the investigation of one (1) licensure complaint.</p> <p>Date of survey: 02-20-14</p> <p>Facility number: 005022</p> <p>Complaint number: IN00136977</p> <p>Unsubstantiated: Lack of sufficient evidence.</p> <p>Union Hospital is in compliance with 410 IAC 15-1.5-6, Nursing services, 410 IAC 15-1.5-5, Medical staff and 410 IAC 15-1.6-2, Emergency services, Hospital Licensure Rules.</p> <p>QA: claughlin 02/25/14</p>	S 000		

Indiana State Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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