

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 005086	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/09/2011
NAME OF PROVIDER OR SUPPLIER MAJOR HOSPITAL		STREET ADDRESS, CITY, STATE, ZIP CODE 150 W WASHINGTON ST SHELBYVILLE, IN 46176		
(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 a licensure complaint.</p> <p>Survey Type: Licensure complaint IN00083314 Unsubstantiated, lack of sufficient evidence.</p> <p>Date of Survey: 09-09-11</p> <p>Facility number: 005086</p> <p>Surveyors: John Lee, R.N. Public Health Nurse Surveyor</p> <p>Major Hospital was found in compliance with the Indiana Hospital Licensure Rules 410 IAC 15-1.5-5, Medical Staff, and 410 IAC 15-1.5-6, Nursing Services.</p> <p>QA: cloughlin 09/14/11</p>	S 000		

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TITLE

(X6) DATE

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