

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  150044	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/29/2014
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NAME OF PROVIDER OR SUPPLIER  FLOYD MEMORIAL HOSPITAL AND HEALTH SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 1850 STATE ST NEW ALBANY, IN 47150
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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) COMPLETION DATE
S000000	<p>This visit was for the investigation of one (1) State complaint.</p> <p>Date of survey: 01-29-14</p> <p>Facility number: 005040</p> <p>Complaint number: IN00134748 Substantiated: No deficiencies cited.</p> <p>Surveyor: Jennifer Hembree, RN Public Health Nurse Surveyor</p> <p>Floyd Memorial Hospital is in compliance with 410 IAC 15-1.6-2, Emergency services and 410 IAC 15-1.5.5, Medical staff, Hospital Licensure Rules.</p> <p>QA: claughlin 02/10/14</p>	S000000		

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

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.