

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 005013	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/29/2012
NAME OF PROVIDER OR SUPPLIER SULLIVAN COUNTY COMMUNITY HOSPITAL		STREET ADDRESS, CITY, STATE, ZIP CODE 2200 N SECTION ST SULLIVAN, IN 47882		
(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 State complaint.</p> <p>Complaint Number: IN00102263 Substantiated: No deficiencies related to the allegations are cited.</p> <p>Facility #: 005013</p> <p>Survey Dates: 02-29-12</p> <p>Surveyor: Billie Jo Fritch RN, BSN, MBA Public Health Nurse Surveyor</p> <p>Sullivan County Community Hospital was found in compliance with 410 IAC 15-1.5-6, Nursing service, Hospital Licensure Rules.</p> <p>QA: cloughlin 03/14/12</p>	S 000		

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TITLE

(X6) DATE

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