STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005044	A. BUILDING: _____ B. WING _____	C 10/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REID HEALTH	1100 REID PKWY RICHMOND, IN 47374

(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 the investigation of two state licensure hospital complaints. Complaint Number: IN00346379 - No deficiencies related to the allegations are cited. Complaint Number: IN00347757 - No deficiencies related to the allegation are cited. Date of Survey: 10/10/23 Facility Number: 005044 Reid Health is in compliance with Hospital Licensure Rules 410 IAC 15-1.5-2, Infection Control, and 410 IAC 15-1.5-6, Nursing Service, in regard to the investigation of complaints IN00346379 and IN00347757. QA: 10/30/2023	S 000		