STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005099	A. BUILDING: _____ B. WING _____	C 08/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLUMBUS REGIONAL HOSPITAL	2400 E 17TH ST COLUMBUS, IN 47201

(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 investigation of two (2) state licensure hospital complaints. Complaint Number: IN00323483- No deficiencies related to allegations are cited. Complaint Number: IN00325632- No deficiencies related to allegations are cited. Facility Number: 005099 Survey Date: 08/02/2023 Columbus Regional Hospital is in compliance with 410 IAC 15-1.5-2 Infection Control, 410 IAC 15-1.5-8 Physical Plant, 410 IAC 15-1.5-10 Utilization REview and Discharge Planning, Hospital Licensure Rules in regard to the investigation of complaint IN00323483 and IN00325632. QA: 8/8/23	S 000		