

Indiana Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 005097	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/05/2023
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NAME OF PROVIDER OR SUPPLIER COMMUNITY HOSPITAL OF BREMEN INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1020 HIGH RD BREMEN, IN 46506
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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) COMPLETE DATE
S 000	<p>INITIAL COMMENTS</p> <p>This visit was for a State Licensure Survey.</p> <p>Facility Number: 005097</p> <p>Dates of Survey: 12/4/2023 to 12/5/2023</p> <p>Community Hospital Of Bremen, Inc. is in compliance with 410 IAC 15.1, Hospital Licensure Rules.</p> <p>QA: 12/13/23</p>	S 000		

Indiana Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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