STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005005	A. BUILDING: _____ B. WING _____	C 02/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HENDRICKS REGIONAL HEALTH	1000 E MAIN ST DANVILLE, IN 46122

(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 a State licensure hospital complaint. Complaint Number: IN00401341 Unsubstantiated: Lack of sufficient evidence. Survey Date: 02/22/2023 Facility Number: 005005 Hendricks Regional Health is in compliance with 410 IAC 15-1.6-2 Emergency Services, Hospital Licensure Rules. QA: 2/28/2023	S 000		