

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 005069	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 11/05/2021
NAME OF PROVIDER OR SUPPLIER BLUFFTON REGIONAL MEDICAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 303 S MAIN ST BLUFFTON, IN 46714		
(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>The visit was for investigation of a State licensure hospital complaint.</p> <p>Complaint Number: IN00292245</p> <p>Unsubstantiated: Lack of sufficient evidence.</p> <p>Survey Date: 11/5/2021</p> <p>Facility Number: 005069</p> <p>Bluffton Regional Medical Center is in compliance with 410 IAC 15-1.5-3, Laboratory Services, and 410 IAC 15-1.5-6, Nursing Service, Hospital Licensure Rules.</p> <p>QA: 11/19/2021</p>	S 000			

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

TITLE

(X6) DATE