

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