STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005098	A. BUILDING: _____ B. WING _____	C 04/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAWN HOSPITAL	1400 E 9TH ST ROCHESTER, IN 46975

(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 a State licensure hospital complaint investigation. Complaint Number: IN00404268 - No deficiencies related to allegations are cited. Dates of Survey: 4/11/2023 to 4/12/2023 Facility Number: 005098 Woodland Hospital is in compliance with 410 IAC 15-1.6-2, Emergency Services, Hospital Licensure Rules, in regard to the investigation of complaint IN00404268. QA: 4/18/2023	S 000		