STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	004683	A. BUILDING: _____ B. WING _____	C 10/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INDIANA UNIVERSITY HEALTH BEDFORD HOSPITAL	2900 W 16TH ST BEDFORD, IN 47421

(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 INITIAL COMMENTS This visit was for investigation of a State licensure hospital complaint. Complaint Number: IN00318006 Unsubstantiated: Lack of sufficient evidence. Survey Date: 10/05/21 Facility Number: 004683 Indiana University Health Bedford Hospital is in compliance with 410 IAC 15-1.5-5, Medical Staff, and 410 IAC 15-1.5-10, Utilization Review & Discharge Planning, Hospital Licensure Rules. QA: 10/7/2021	S 000		