Indiana State Department of Health

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 ______	04/21/2020

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 This visit was for a licensure review of patient rooms per ISDH CSHCR: Program Advisory Letter Number: AC-2020-02-HOSP. Facility Number: 004683 Survey Date: 4/21/2020 The following Medical/surgical patient rooms were converted to Observation, Med/Surg, PCU or ICU rooms: #403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 416, 417, 418, 419, 421, 423, 424, and 425. A classroom on the first floor was converted to an extension of the Emergency Department as reception and treatment area. The following converted rooms failed to be successfully verified as meeting criteria: None. QA: 4/27/2020	S 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE　　TITLE　　(X6) DATE