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 01/21/2020

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 the investigation of a state hospital complaint. Complaint Number: IN00317056 Substantiated: No deficiencies related to allegations are cited. Dates: 1/21/2020 to 1/22/2020 Facility Number: 004683 IU Health Bedford is in compliance with 410 IAC 15-1.6-2 Emergency services, Hospital Licensure Rules. QA: 1/29/2020	S 000		