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 10/31/2023

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 The visit was for investigation of a State licensure hospital complaint. Complaint Number: IN00396605 - No deficiencies related to allegations are cited. Survey Date: 10/31/2023 Facility Number: 004683 Upon survey investigation, it was discovered that the patient was a patient at a clinic adjacent to the hospital and not the hospital, and the clinic is not under the hospital license. QA: 11/6/23	S 000		