STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	013907	A. BUILDING: _____ B. WING _____	C 09/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONROE HOSPITAL	**4011 S MONROE MEDICAL PARK BLVD BLOOMINGTON, IN 47403**

(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 Licensure Hospital complaint. Complaint Number: IN00410599 - No deficiencies related to the allegation are cited. Survey Dates: 09/13/24 and 9/16/24 Facility Number: 013907 Monroe Hospital is in compliance with 410 IAC 15-1.4-2 Quality Assessment and Improvement, Hospital Licensure Rules, in regard to the investigation of complaint IN00410599. QA: 10/1/24	S 000		