| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 005079 | A. BUILDING: _____ B. WING _____ | C 03/09/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| INDIANA UNIVERSITY HEALTH BALL MEMORIAL HOS | 2401 UNIVERSITY AVE MUNCIE, IN 47303 |

| (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<br><br>This visit was for investigation of a state licensure hospital complaint.<br><br>Complaint Number: IN00314899<br><br>Date of survey: 3/9/21<br><br>Facility number: 005079<br><br>Upon arrival at facility, it was found that the patient named in the complaint was not a patient at this facility.<br><br>QA: 3/15/21 | S 000 | | |