PRINTED: 04/13/2021 FORM APPROVED

Indiana State Department of Health

OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
	005079		B. WING			) 9/2021	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE  2401 LINIVERSITY AVE							
INDIANA UNIVERSITY HEALTH BALL MEMORIAL HOS MUNCIE, IN 47303							
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOU	ACTION SHOULD BE COMPLETE TO THE APPROPRIATE DATE		
S 000 INITIAL COMMENTS			S 000				
This visit was for investigation of a state licensure hospital complaint.							
Complaint Number: IN00314899							
Date of survey: 3/9/21							
Facility number: 005079							
		nt					
QA: 3/15/21							
	ROVIDER OR SUPPLIER SUMMARY STA (EACH DEFICIENCY REGULATORY OR L  INITIAL COMMENTS  This visit was for inve hospital complaint.  Complaint Number: I  Date of survey: 3/9/2  Facility number: 0050  Upon arrival at facility patient named in the of at this facility.	O05079  ROVIDER OR SUPPLIER SIMIVERSITY HEALTH BALL MEMORIAL HOS  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  INITIAL COMMENTS  This visit was for investigation of a state licensul hospital complaint.  Complaint Number: IN00314899  Date of survey: 3/9/21  Facility number: 005079  Upon arrival at facility, it was found that the patient named in the complaint was not a patier at this facility.	O05079  ROVIDER OR SUPPLIER STREET ADDITION NUMBER:  WINVERSITY HEALTH BALL MEMORIAL HOS  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  INITIAL COMMENTS  This visit was for investigation of a state licensure hospital complaint.  Complaint Number: IN00314899  Date of survey: 3/9/21  Facility number: 005079  Upon arrival at facility, it was found that the patient named in the complaint was not a patient at this facility.	ROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STA  2401 UNIVERSITY AVE  MUNCIE, IN 47303  SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)  This visit was for investigation of a state licensure hospital complaint.  Complaint Number: IN00314899  Date of survey: 3/9/21  Facility number: 005079  Upon arrival at facility, it was found that the patient named in the complaint was not a patient at this facility.	TOUR DENTIFICATION NUMBER:    A. BUILDING:	FORRECTION IDENTIFICATION NUMBER:  005079  STREET ADDRESS, CITY, STATE, ZIP CODE  2401 UNIVERSITY AVE MUNCIE, IN 47303  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  INITIAL COMMENTS  S 000  This visit was for investigation of a state licensure hospital complaint.  Complaint Number: IN00314899  Date of survey: 3/9/21  Facility number: 005079  Upon arrival at facility, it was found that the patient named in the complaint was not a patient at this facility.	

Indiana State Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE