

Indiana Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>005034</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C 03/12/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>INDIANA UNIVERSITY HEALTH WHITE MEMORIAL HC</b>		STREET ADDRESS, CITY, STATE, ZIP CODE  <b>720 SOUTH SIXTH ST MONTICELLO, IN 47960</b>		
(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	<p>INITIAL COMMENTS</p> <p>This visit was for investigation of a State Licensure hospital complaint.</p> <p>Complaint Number: IN00404262</p> <p>Date of Survey: 3/12/2025</p> <p>Facility Number: 005034</p> <p>Upon investigation, it was found that the patient referenced in the complaint was not a patient at the facility or offsite under the facility license.</p> <p>QA: 3/13/2025</p>	S 000		

Indiana Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE