

Indiana Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>005011</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C 01/31/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>MARION GENERAL HOSPITAL</b>		STREET ADDRESS, CITY, STATE, ZIP CODE  <b>441 N WABASH AVE MARION, IN 46952</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: IN00448673- No deficiencies related to the allegations are cited.</p> <p>Date of survey: 1/31/25</p> <p>Facility number: 005011</p> <p>Marion General Hospital is in compliance with 410 IAC 15-1.5-2, Infection Control, Hospital Licensure Rules in regard to the investigation of complaint IN00448673.</p> <p>QA: 2/19/2025</p>	S 000		

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

**TITLE**

(X6) DATE