

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 03/25/2025</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: IN00435456 - No deficiencies related to the allegations are cited.</p> <p>Date of Survey: 3/25/2025</p> <p>Facility Number: 005034</p> <p>Indiana University Health White Memorial Hospital is in compliance with 410 IAC 15-1.5-4, Medical Record Services, and 410 IAC 15-1.6-2, Emergency Services, Hospital Licensure Rules, in regard to the investigation of complaint IN00435456.</p> <p>QA: 4/17/2025</p>	S 000		

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

TITLE

(X6) DATE