

Indiana Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 011596	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 09/30/2024
NAME OF PROVIDER OR SUPPLIER MORRISON WOODS HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 4100 N MORRISON RD MUNCIE, IN 47304		
(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	
{R 000}	<p>INITIAL COMMENTS</p> <p>Paper compliance to the State Residential Licensure Survey completed on August 23, 2024.</p> <p>Review Date: September 30, 2024</p> <p>Facility number: 011596</p> <p>Morrison Woods Health Campus was found to be in compliance with 410 IAC 16.2-5 in regard to the paper review to the State Residential Licensure Survey.</p>	{R 000}			

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

TITLE

(X6) DATE