STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	004811	A. BUILDING: _____ B. WING _____	C 05/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL INDIANA AMG SPECIALTY HOSPITAL LLC	2401 W UNIVERSITY AVE 5TH FLOOR EAST TOWER MUNCIE, IN 47303

(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	INITIAL COMMENTS This visit was for the investigation of a state licensure hospital complaint. Complaint Number: IN00251408 Unsubstantiated: Lack of sufficient evidence. Date of Survey: 05/01/9 and 05/02/19 Facility Number: 004811 Central Indiana AMG Specialty Hospital, LLC is in compliance with 410 IAC 15-1.5-6, Nursing Service, Hospital Licensure Rules. QA: 5/6/19	S 000		