STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	004718	A. BUILDING: _____ B. WING _____	10/17/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARGARET MARY HEALTH	321 MITCHELL AVE BATESVILLE, IN 47006

(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 one state hospital complaint. Complaint number: IN00199702 Unsubstantiated; Lack of sufficient evidence. Facility number: 004718 Survey date: October 17, 2017 Margaret Mary Health is in compliance with 410 IAC 15-1.5-5 Medical Staff and 410 IAC 15-1.6.2 Emergency services, Hospital Licensure Rules. QA: 12/14/17	S 000		