STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	014264	A. BUILDING: _____ B. WING _____	C 11/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHOLE WOMAN'S HEALTH ALLIANCE, INC	**3511 LINCOLNWAY WEST SOUTH BEND, IN 46628**

(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
T 000	INITIAL COMMENTS This was an off site State complaint investigation. Complaint Number: IN00273591 Unsubstantiated, lack of sufficient evidence. Date of Survey: 11/12/19 Facility Number: 014264 Whole Woman's Health Alliance is in compliance with the applicable sections of 410 IAC 26.5-3 pursuant to U.S. Court of Appeals for the Seventh Circuit Order No 19-2051. QA: 11/13/2019	T 000		