

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 005087	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 04/14/2023
NAME OF PROVIDER OR SUPPLIER ASCENSION ST VINCENT SALEM		STREET ADDRESS, CITY, STATE, ZIP CODE 911 N SHELBY ST SALEM, IN 47167		
(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 the investigation of a state licensure hospital complaint.</p> <p>Complaint Number: IN00378301- No deficiencies related to the allegations are cited.</p> <p>Survey Date: 04/14/2023</p> <p>Facility Number: 005087</p> <p>Ascension St. Vincent Salem is in compliance with 410 IAC 15-1.6-2, Emergency Services, Hospital Licensure Rules in regard to the investigation of complaint IN00378301.</p> <p>QA: 4/21/2023 & 6/2/2023</p>	S 000		

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

TITLE

(X6) DATE