STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	004972	A. BUILDING: _____ B. WING _____	07/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANCISCAN HEALTH INDIANAPOLIS	8111 S EMERSON AVE INDIANAPOLIS, IN 46237

(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 investigation of a State licensure hospital complaint. Complaint Number: IN00226327 Unsubstantiated: Lack of sufficient evidence. Survey Date: 7/31/19 Facility Number: 004972 Franciscan Health Indianapolis is in compliance with 410 IAC 15-1.5-10, Utilization Review and Discharge Planning, Hospital Licensure Rules. QA: 8/7/19	S 000		