

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 005075	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/14/2021
NAME OF PROVIDER OR SUPPLIER ASCENSION ST VINCENT HOSPITAL		STREET ADDRESS, CITY, STATE, ZIP CODE 2001 W 86TH ST INDIANAPOLIS, IN 46260		
(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 two state licensure hospital complaints.</p> <p>Complaint Number: IN00261969</p> <p>Unsubstantiated: Lack of sufficient evidence.</p> <p>Complaint Number: IN00274992</p> <p>Unsubstantiated: Lack of sufficient evidence.</p> <p>Date of Survey: 09/14/21</p> <p>Facility Number: 005075</p> <p>Ascension St. Vincent Hospital is in compliance with 410 IAC 15-1.5-6, Nursing Service and 410 IAC 15-1.5-10, Utilization Review and Discharge Planning, Hospital Licensure Rules.</p> <p>QA: 9/20/21</p>	S 000		

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

TITLE

(X6) DATE