

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 003932	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/10/2021
NAME OF PROVIDER OR SUPPLIER ASCENSION ST VINCENT CARMEL		STREET ADDRESS, CITY, STATE, ZIP CODE 13500 N MERIDIAN ST CARMEL, IN 46032		
(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 investigation of a state hospital licensure complaint.</p> <p>Complaint Number: IN00319241.</p> <p>Unsubstantiated: No deficiency related to the allegation is cited.</p> <p>Survey Date: 03/10/2021</p> <p>Facility Number: 003932</p> <p>Ascension St. Vincent Carmel is in compliance with 410 IAC 15-1.5-5, Medical Staff, and 410 IAC 15-1.5-6, Nursing Service, Hospital Licensure Rules.</p> <p>QA: 3/15/2021</p>	S 000		

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

TITLE

(X6) DATE