STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005023	A. BUILDING: _____ B. WING _____	C 06/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESKENAZI HEALTH	720 ESKENAZI AVENUE INDIANAPOLIS, IN 46202

(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 the investigation of two state licensure hospital complaints. Complaint Number: IN00236737 Unsubstantiated: Lack of sufficient evidence. Complaint Number: IN00240168 Unsubstantiated: Lack of sufficient evidence. Date of Survey: 06/23/21 Facility Number: 005023 Eskenazi Health is in compliance with 410 IAC 15-1.5-5 Medical Staff, Hospital Licensure Rules. QA: 6/28/2021	S 000		