STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005051	A. BUILDING: _____ B. WING _____	10/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INDIANA UNIVERSITY HEALTH	1701 N SENATE BLVD 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: IN00268412 Unsubstantiated: Lack of sufficient evidence. Complaint Number: IN00268652 Substantiated: No deficiencies related to the allegations are cited. Date of Survey: 10/07/19 Facility Number: 005051 Indiana University Health is in compliance with 410 IAC 15-1.5-6, Nursing Service, and 410 IAC 15-1.5-8, Physical Plant, Maintenance and Environmental Services, Hospital Licensure Rules. QA: 10/10/19	S 000		