

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 003776	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 10/13/2021
NAME OF PROVIDER OR SUPPLIER IU HEALTH WEST HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 1111 N RONALD REAGAN PKWY AVON, IN 46123		
(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 a State licensure hospital complaint.</p> <p>Complaint Number: IN00334815</p> <p>Unsubstantiated: Lack of sufficient evidence.</p> <p>Survey Date: 10/13/2021</p> <p>Facility Number: 003776</p> <p>IU Health West Hospital is in compliance with 410 IAC 15-1.5-6, Nursing Service, and 410 IAC 15-1.6-2, Emergency Services, Hospital Licensure Rules.</p> <p>QA: 10/19/2021</p>	S 000			

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

TITLE

(X6) DATE