STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	154064	A. BUILDING _____ B. WING _____	C 09/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASSURANCE HEALTH PSYCHIATRIC HOSPITAL	**900 NORTH HIGH SCHOOL ROAD INDIANAPOLIS, IN 46214**

(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) COMPLETION DATE
A 000	INITIAL COMMENTS This visit was for the investigation of a Federal hospital complaint. Complaint Number: IN00414954 - No deficiencies related to the allegations are cited. Date: 09/12/2023 Facility Number: 013889 Assurance Health Psychiatric Hospital, is in compliance with 42 CFR §482.13 Patient Rights, and 42 CFR §482.23 Nursing Services, Medicare Conditions of Participation, in regard to the investigation of complaint IN00414954. QA: 9/14/23	A 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE