STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	003776	A. BUILDING: _____ B. WING _____	C 11/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IU HEALTH WEST HOSPITAL	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	INITIAL COMMENTS This visit was for the investigation of a state licensure hospital complaint. Complaint Number: IN00400627 - No deficiencies related to the allegations are cited. Survey Date: 11/15/2023 Facility Number: 003776 IU Health West Hospital, is in compliance with 410 IAC 15-1.5-6, Nursing Service, Hospital Licensure Rules, in regard to the investigation of complaint IN00400627. QA: 11/26/2023	S 000		