STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	003930	A. BUILDING: _____ B. WING _____	C 08/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ORTHOINDY HOSPITAL	8400 NORTHWEST BLVD INDIANAPOLIS, IN 46278

(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: IN00223632 Unsubstantiated: Lack of sufficient evidence. Survey Date: 8/4/2021 Facility Number: 003930 Orthoindy Hospital is in compliance with 410 IAC 15-1.5-2, Infection Control, and 410 IAC 15-1.5-6, Nursing Services, Hospital Licensure Rules. QA: 8/10/2021	S 000		