STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005075	A. BUILDING: _____ B. WING _____	06/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST VINCENT HOSPITAL & HEALTH SERVICES	2001 W 86TH ST INDIANAPOLIS, IN 46260

(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 investigation of a state licensure hospital complaint. Complaint Number: IN00220558 Unsubstantiated: Lack of sufficient evidence. Date: 6/19/2019 Facility Number: 005075 St Vincent Hospital and Health Services is in compliance with 410 IAC 15-1.5-6, Nursing Services, and 410 IAC 15-1.6-7, Respiratory Care Services, Hospital Licensure Rules. QA: 7/1/2019	S 000		