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 07/29/2020

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 investigation of a Federal hospital complaint and a Focused Infection Control Survey. Complaint Number: IN00332649 Unsubstantiated: Lack of sufficient evidence. Survey Date: 7/28/20 through 7/29/20 Facility Number: 013899 Assurance Health Psychiatric Hospital is in compliance 42 CFR 482.13 Patient Rights, 42 CFR 482.23 Nursing Services and 42 CFR 482.42 Infection Prevention Control Abx Stewardship Medicare Conditions of Participation and CMS Focused Infection Control Survey for Acute & Continuing Care. QA: 8/6/20	A 000		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.