STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005010	A. BUILDING: _____ B. WING _____	C 06/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASCENSION ST VINCENT KOKOMO	1907 W SYCAMORE ST KOKOMO, IN 46904

(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: IN00320859 - No deficiencies related to the allegations are cited. Date of Survey: 06/20/2023 Facility Number: 005010 Ascension St. Vincent Kokomo is in compliance with 410 IAC 15-1.5-6, Nursing Service, and 410 IAC 15-1.5-10, Utilization Review and Discharge Planning Services, Hospital Licensure Rules in regard to the investigation of complaint IN00320859. QA: 7/7/2023 & 7/12/2023	S 000		