

Indiana Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 003776	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 04/03/2025
NAME OF PROVIDER OR SUPPLIER IU HEALTH WEST HOSPITAL		STREET ADDRESS, CITY, STATE, ZIP CODE 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	<p>INITIAL COMMENTS</p> <p>This visit was for the investigation of a State licensure hospital complaint.</p> <p>Complaint Number: IN00426484- No deficiencies related to the allegations are cited.</p> <p>Survey Date: 04/03/2025</p> <p>Facility Number: 003776</p> <p>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 IN00426484.</p> <p>QA: 5/7/2025</p>	S 000		

Indiana Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE