

Indiana Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 003932	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 12/06/2023
NAME OF PROVIDER OR SUPPLIER ASCENSION ST VINCENT CARMEL		STREET ADDRESS, CITY, STATE, ZIP CODE 13500 N MERIDIAN ST CARMEL, IN 46032		
(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: IN00423089 - No deficiencies related to the allegations are cited.</p> <p>Survey Date: 12/06/23</p> <p>Facility Number: 003932</p> <p>Ascension St. Vincent Carmel is in compliance with 410 IAC 15-1.5-6, Nursing Services, Hospital Licensure Rules in regard to the investigation of complaint IN00423089.</p> <p>QA: 12/11/2023</p>	S 000		

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

TITLE

(X6) DATE