STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005023	A. BUILDING: _____ B. WING _____	C 06/25/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESKENAZI HEALTH	720 ESKENAZI AVENUE INDIANAPOLIS, IN 46202

(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: IN00330207 Unsubstantiated: Lack of sufficient evidence. Date: 06/25/20 Facility Number: 005023 Eskenazi Health is in compliance with 410 IAC 15-1.5-6 Nursing and 410 IAC 15-1.6-2 Emergency Service Hospital Licensure Rules. QA: 7/2/20	S 000		