| 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 06/23/2021 |

| 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<br><br>This visit was for the investigation of two (2) state hospital licensure complaints.<br><br>Complaint Numbers: IN00236292 and IN00236182<br><br>Unsubstantiated: Lack of sufficient evidence.<br><br>Survey Date: 6/23/2021<br><br>Facility Number: 005023<br><br>Eskenazi Health is in compliance with 410 IAC 15-1.4-1 Governing Board, and 410 IAC 15-1.5-10 Utilization Review and Discharge Planning, Hospital Licensure Rules.<br><br>QA: 6/29/21 | S 000 | | |