Indiana Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005075	A. BUILDING: ______ B. WING ______	C 09/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASCENSION ST VINCENT HOSPITAL	**2001 W 86TH ST INDIANAPOLIS, IN 46260**

(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 an investigation of two State Licensure Hospital Complaints. Complaint Number: IN00376323 - No deficiencies related to the allegations are cited. Complaint Number: IN00417772 - No deficiencies related to the allegations are cited. Survey Date: 9/25/2023 Facility Number: 005075 Ascension St. Vincent Hospital is in compliance with 410 IAC 15-1.5-2, Infection Control, Hospital Licensure Rules, in regard to the investigation of Complaint IN00376323 and 410 IAC 15-1.5-8, Physical Environment, Hospital Licensure Rules, in regard to the investigation of Complaint IN00417772. QA: 10/6/2023 & 10/11/2023	S 000		

Indiana Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE