STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	003776	A. BUILDING: _____ B. WING _____	C 06/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IU HEALTH WEST HOSPITAL	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	INITIAL COMMENTS INITIAL COMMENTS: This visit was for the investigation of a State licensure hospital complaint. Complaint Number: IN00319935 Unsubstantiated: Lack of sufficient evidence. Survey Date: 06/22/2021 Facility Number: 003776 IU Health West Hospital is in compliance with 401 IAC 15-1.5.5 Medical Staff and 410 IAC 15-1.5-6, Nursing Service, and 401 IAC 15-1.5-8 Physical Plant, Hospital Licensure Rules. QA: 6/29/21	S 000		