STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	004972	A. BUILDING: _____ B. WING _____	C 10/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANCISCAN HEALTH INDIANAPOLIS	8111 S EMERSON AVE INDIANAPOLIS, IN 46237

(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 the investigation of two state licensure hospital complaints. Complaint Number: IN00259157 Unsubstantiated: Lack of sufficient evidence. Complaint Number: IN00291129 Unsubstantiated: Lack of sufficient evidence. Date of Survey: 10/05/21 Facility Number: 004972 Franciscan Health Indianapolis is in compliance with 410 IAC 15-1.5-5, Medical Staff, 410 IAC 15-1.5-6, Nursing Service, and 410 IAC 15-1.6-2, Emergency Service, Hospital Licensure Rules. QA: 10/7/2021	S 000		