STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	154064	A. BUILDING _____ B. WING _____	C 06/10/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASSURANCE HEALTH PSYCHIATRIC HOSPITAL	**900 NORTH HIGH SCHOOL ROAD INDIANAPOLIS, IN 46214**

(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) COMPLETION DATE
A 000	INITIAL COMMENTS This visit was for the investigation of two federal hospital complaints and a focused Infection Control Survey. Complaint Numbers: IN00329806 and IN00329848 Unsubstantiated: Lack of sufficient evidence. Date of Survey: 06/10/20 Facility Number: 013899 Assurance Health Psychiatric Hospital is in compliance with 42 CFR 482.23, Nursing Service and 42 CFR 482.42, Infection Control, Medicare Conditions of Participation. QA: 6/15/20	A 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.