

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>005075</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C 08/20/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>ASCENSION ST VINCENT HOSPITAL</b>		STREET ADDRESS, CITY, STATE, ZIP CODE  <b>2001 W 86TH ST INDIANAPOLIS, IN 46260</b>		
(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	<p>INITIAL COMMENTS</p> <p>This visit was for the investigation of two state licensure hospital complaints.</p> <p>Complaint Number: IN00258772 Unsubstantiated: Lack of sufficient evidence.</p> <p>Complaint Number: IN00274754 Substantiated: No deficiency related to the allegation is cited.</p> <p>Dates of Survey: 08/19/21 and 08/20/21</p> <p>Facility Number: 005075</p> <p>QA: 8/24/2021</p>	S 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE