STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005078	A. BUILDING: _____ B. WING _____	C 03/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASCENSION ST VINCENT ANDERSON	2015 JACKSON ST ANDERSON, IN 46016

(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 a State Licensure hospital complaint. Complaint Number: IN00400110 - No deficiencies related to the allegations are cited. Date of Survey: 3/11/25 Facility Number: 005078 Ascension St. Vincent Anderson is in compliance with 410 IAC 15-1.5-6, Nursing Service, Hospital Licensure Rules in regard to the investigation of complaint IN00400110. QA: 3/18/2025	S 000		