STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005051	A. BUILDING: _____ B. WING _____	C 06/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INDIANA UNIVERSITY HEALTH	1701 N SENATE BLVD INDIANAPOLIS, IN 46202

(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 (2) State licensure hospital complaints. Complaint Number: IN00242692 Unsubstantiated: Lack of sufficient evidence Complaint Number: IN00233381 Unsubstantiated: Lack of sufficient evidence Survey Date: 06/28/2021 and 06/30/2021 Facility Number: 005051 Indiana University Health is in compliance with 401 IAC 15-1.5-6 Nursing Service and 401 IAC 15-1.5-8 Physical Plant, Hospital Licensure Rules. QA: 7/8/21	S 000		