| 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 03/20/2024 |

| 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<br><br>This visit was for the investigation of a state licensure hospital complaint.<br><br>Complaint Number: IN00392909<br><br>Survey Date: 03/20/2024<br><br>Facility Number: 005051<br><br>Indiana University Health, is in compliance with 410 IAC 15-1.5-6, Nursing Service, and 410 IAC 15-1.5-8, Physical Plant, Hospital Licensure Rules, in regard to the investigation of complaint IN00392909.<br><br>QA: 4/3/2024 | S 000 | | |