

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 005007	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/19/2021
--	---	---	---

NAME OF PROVIDER OR SUPPLIER COMMUNITY HOWARD REGIONAL HEALTH INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3500 S LAFOUNTAIN ST KOKOMO, IN 46902
---	---

(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 a licensure review of negative pressure patient rooms per ISDH CSHCR: Program Advisory Letter Number: AC-2020-01-HOSP.</p> <p>Facility Number: 005007</p> <p>Survey Date: 7/19/2021</p> <p>The following patient rooms were successfully verified as negative pressure: Rooms: ICU 1, ICU 2, ICU 3, ICU 4, ICU 5, ICU 6 and ICU 7.</p> <p>This request is the conversion/addition of seven (7) emergency department rooms to negative pressure use as required by the facility for Covid-19 use. All rooms were tested for negative air pressure, venting, and having a functioning visual monitoring device, as well as central monitoring. The facility engineering staff checks and records monitor recordings daily on a electronic log. Staff log and daily staff checks on respective units.</p> <p>The following patient rooms failed to be successfully verified as negative pressure: None</p> <p>QA: 7/21/2021</p>	S 000		

Indiana State Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____