

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>005008</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>02/03/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>ST CATHERINE HOSPITAL INC</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>4321 FIR STREET EAST CHICAGO, IN 46312</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><b>INITIAL COMMENTS</b></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: 005008</p> <p>Date of Survey: 2/3/2021</p> <p>The following patient rooms at St. Catherine Hospital, Inc were successfully verified as negative pressure: Emergency Department: Ward/area containing rooms: Waiting room and Exam room: # 3.</p> <p>ICU (Intensive Care Unit) - Rooms: 3001, 3002, 3004, 3005, 3006, 3007, 3008, 3010 and 3011.</p> <p>The following patient rooms failed to be successfully verified as negative pressure: None.</p> <p>QA: 2/9/21</p>	S 000		

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

TITLE

(X6) DATE