STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	011437	A. BUILDING: _____ B. WING _____	12/18/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY HOSPITAL NORTH	7150 CLEARVISTA DR INDIANAPOLIS, IN 46256

(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 a licensure review of negative pressure patient rooms per ISDH CSHCR: Program Letter Number: AC-2020-01-HOSP. Facility Number: 011437 Survey Date: 12/18/20 The following patient rooms were successfully verified as negative pressure: 3306, 3307, 3308, 3309, 3310, 2301, 2302, 2318, 3301, 3305, 3317, 3318, 2317, 2322, 2325, 2328, 2329, 3302, 3303, 3304, 3319, 2326 and 2327. The following patient rooms failed to be successfully verified as negative pressure: None. QA: 12/22/20	S 000		