

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 005080	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/19/2020
NAME OF PROVIDER OR SUPPLIER FRANCISCAN HEALTH DYER		STREET ADDRESS, CITY, STATE, ZIP CODE 24 JOLIET ST DYER, IN 46311		
(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: 005080</p> <p>Date Of Survey: 10/19/2020</p> <p>The following patient rooms at Franciscan Health Dyer were successfully verified as negative pressure: 6th floor - IMCU (Intermediate Care Unit) - Rooms: 6506, 6507, 6508 and 6509.</p> <p>The following patient rooms failed to be successfully verified as negative pressure: None.</p> <p>QA: 10/21/20</p>	S 000		

Indiana State Department of Health

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

TITLE

(X6) DATE