STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005044	A. BUILDING: _____ B. WING _____	01/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REID HEALTH	1100 REID PKWY RICHMOND, IN 47374

(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 for conversion of hospital space to patient rooms per ISDH CSHCR: Program Advisory Letter Number: AC-2020-02-HOSP. Facility Number: 005044 Survey Date: 1/18/2022 The ten (10) inpatient and outpatient surgery rooms were already reconverted by the facility before an initial inspection could be completed to determine if the rooms met the requirements listed in ISDH CSHCR: Program Advisory Letter Number: AC-2020-02-HOSP. This request was for the conversion/addition of five (5) outpatient surgery rooms, and five (5) inpatient surgery rooms as was required by the facility for use during the Covid-19 period. No rooms were inspected as all had been reconverted by 12/15/2021. Unable to determine compliance with ISDH CSHCR: Program Advisory Letter Number: AC-2020-02-HOSP. QA: 1/21/2022	S 000		