STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005109	A. BUILDING: _____ B. WING _____	12/29/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY HOSPITAL SOUTH	1402 E COUNTY LINE RD S INDIANAPOLIS, IN 46227

(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, and Negative air pressure room conversion per ISDH CSHCR: Program Advisory Letter Number: AC-2020-01-HOSP. Facility Number: 005109 Survey Date: 12/29/2020 The hospital space in the existing twelve (12) Preoperative rooms was converted into Medical/Surgical rooms. The following patient rooms were successfully verified as negative pressure: Rooms 2116, 2117, and 2118. The following patient rooms failed to be successfully verified as negative pressure: None. QA: 1/4/21	S 000		