

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 011506	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/14/2020
NAME OF PROVIDER OR SUPPLIER INDIANA UNIVERSITY HEALTH ARNETT HOSPITAL		STREET ADDRESS, CITY, STATE, ZIP CODE 5165 MCCARTY LN LAFAYETTE, IN 47905		
(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 for conversion of hospital space to patient rooms per ISDH CSHCR: Program Advisory Letter Number: AC-2020-02-HOSP.</p> <p>Facility Number: 011506</p> <p>Survey Date: 12/14/2020</p> <p>The following patient rooms were converted and met the requirements listed in ISDH CSHCR: Program Advisory Letter: Rooms: AG410, AG411.</p> <p>QA: 12/15/20</p>	S 000		

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

TITLE

(X6) DATE