STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005023	A. BUILDING: _____ B. WING _____	05/20/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESKENAZI HEALTH	720 ESKENAZI AVENUE INDIANAPOLIS, IN 46202

(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 Advisory Letter Number: AC-2020-01-HOSP. Facility Number: 005023 Survey Date: 5/20/2020 Burn Unit room H4-601 was prepared for negative air usage if required, but was never used in a negative air capacity. At this time the facility has demobilized this room from the facility "Negative Air Activation Plan." This request to convert one (1) burn unit room to negative pressure use as required by the facility for Covid-19 use. Room H4-601 was never used in a negative pressure configuration. No logs or data sheets were completed by staff per conversation with the Facilities Manager (S1), as the room was never "on-line." The facility has since demobilized this room from the "Negative Air Activation Plan." The following patient rooms failed to be successfully verified as negative pressure: None QA: 6/3/20	S 000		