STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	011506	A. BUILDING: _____ B. WING _____	10/29/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INDIANA UNIVERSITY HEALTH ARNETT HOSPITAL	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	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: 011506 Survey Date: 10/29/2020 The following patient rooms were converted and met the requirements listed in ISDH CSHCR: Program Advisory Letter: Rooms: CA-150-1, CA-150-2, CA-150-3, CA-150-4, CA-150-5, CA-150-6, CA-150-7, CA-150-8, CA-150-9. This request is the conversion/addition of nine (9) emergency department holding rooms as required by the facility for use during the Covid-19 period. All rooms were checked to ensure 3 foot clearance, portable oxygen and vacuum, alternative call light method (bell), hand washing station/alternative cleaning supplies, and duplex electrical outlet per patient bed. The following patient rooms failed to be successfully verified as negative pressure: None. QA: 11/4/20	S 000		