

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 005099	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/04/2021
NAME OF PROVIDER OR SUPPLIER COLUMBUS REGIONAL HOSPITAL		STREET ADDRESS, CITY, STATE, ZIP CODE 2400 E 17TH ST COLUMBUS, IN 47201		
(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 of patient care rooms per ISDH CSHCR: Program Advisory Letter Number: AC-2020-02-HOSP.</p> <p>Facility Number: 005099</p> <p>Survey Date: 03/04/2021</p> <p>Columbus Regional Hospital rooms Catheterization Lab Intensive Care Unit (ICU) surge rooms were decommissioned, and converted back to standard usage.</p> <p>QA: 03/11/21</p>	S 000		

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

TITLE

(X6) DATE