STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005075	A. BUILDING: _____ B. WING _____	11/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASCENSION ST VINCENT HOSPITAL	2001 W 86TH ST INDIANAPOLIS, IN 46260

(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: 005075 Survey Date: 11/19/2020 The following patient rooms were converted and met the requirements listed in ISDH CSHCR: Program Advisory Letter Number: AC-2020-02-HOSP. Rooms: CVOR 201, CVOR 202. This request is the conversion/addition of two (2) cardiovascular operating rooms as required by the facility for use during the Covid-19 period. Each room will hold four (4) beds. All rooms were checked to ensure 3 foot clearance, portable oxygen and vacuum, call light, hand washing station/alternative cleaning supplies, and duplex electrical outlet per patient bed, and are in compliance with ISDH CSHCR: Program Advisory Letter Number: AC-2020-02-HOSP. No rooms are indicated for negative pressure usage. QA: 12/4/20	S 000		