

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>005106</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>08/17/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>COMMUNITY HOSPITAL</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>901 MACARTHUR BLVD MUNSTER, IN 46321</b>		
(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><b>INITIAL COMMENTS</b></p> <p>This visit was for a licensure review of negative pressure patient rooms per ISDH CSHCR: Program Advisory Letter Number: AC-2020-01-HOSP.</p> <p>Facility Number: 005106</p> <p>Date Of Survey: 8/17/2021</p> <p>The following patient rooms at Community Hospital were successfully verified as negative pressure: 3rd floor - Parkview Tower - Rooms: 3020 and 3021. 6th floor - West Building - Room: 674.</p> <p>The following patient rooms failed to be successfully verified as negative pressure: None.</p> <p>The facility lacked visual pressure monitoring mechanism indicating the air pressure status of the rooms at all times, however facility checks the rooms daily using a Wand Velocity Meter (Vaneometer) and maintains a log for same.</p> <p>QA: 8/18/2021</p>	S 000		

Indiana State Department of Health

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

TITLE

(X6) DATE