PRINTED: 09/21/2020 FORM APPROVED

Indiana State Department of Health

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1316 E SEVENTH ST AUBURN, IN 46708 (CA4) ID PREPIX TAG SUMMARY STATEMENT OF DEFICIENCY MUST BE PRECEDED BY FULL TAG SOUD 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: 005041 Survey Date: 9/17/20 The following patient rooms were successfully verified as negative pressure: 3 and 5. The following patient rooms failed to be successfully verified as negative pressure: None. QA: 9/18/20	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
PARKVIEW DEKALB HOSPITAL (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG			005041	B. WING		09/17/2020		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE