

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>005044</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>11/24/2020</b>
NAME OF PROVIDER OR SUPPLIER  <b>REID HEALTH</b>		STREET ADDRESS, CITY, STATE, ZIP CODE  <b>1100 REID PKWY RICHMOND, IN 47374</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>INITIAL COMMENTS</p> <p>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.</p> <p>Facility Number: 005044</p> <p>Survey Date: 11/24/2020</p> <p>The following patient rooms were converted and met the requirements listed in ISDH CSHCR: Program Advisory Letter Number: AC-2020-02-HOSP. Rooms: Lingle Hall.</p> <p>This request is the conversion/addition of one (1) common meeting area, as required by the facility for use during the Covid-19 period. The room will hold twenty-one (21) 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.</p> <p>No rooms are indicated for negative pressure usage.</p> <p>QA: 12/4/20</p>	S 000		

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

**TITLE**

(X6) DATE