STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005099	A. BUILDING: _____ B. WING _____	08/18/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLUMBUS REGIONAL HOSPITAL	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	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: 005099 Survey Date: 8/18/2021 The following patient rooms were successfully verified as negative pressure with proper venting, external monitoring and facility record keeping: ICU (Intensive Care Unit) 2T: 201, 202, 203, 204, 205, 206, 207, 209, 210, 211, 212, 214, 215, 216 and 252; 4T: 401, 402, 403, 404, 405, 406, 407, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423 and 424; 6T: 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624 and 625. The following patient rooms failed to be successfully verified as negative pressure: None. QA: 8/19/2021	S 000		