STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005015	A. BUILDING: _____ B. WING _____	02/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANCISCAN HEALTH MICHIGAN CITY	3500 FRANCISCAN WAY MICHIGAN CITY, IN 46360

(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 room conversion per ISDH CSHCR: Program Advisory Letter Number: AC-2020-02-HOSP. Facility Number: 005015 Date of Survey: 2/3/2021 The following rooms in Ambulatory Surgery (Outpatient) unit, were converted to Medical/Surgical room(s): OPS 5, OPS 6, OPS 7, OPS 8, OPS 9 and OPS 10. QA: 2/8/21	S 000		