STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005109	A. BUILDING: _____ B. WING _____	03/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY HOSPITAL SOUTH	1402 E COUNTY LINE RD S INDIANAPOLIS, IN 46227

(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 rooms per ISDH CSHCR: Program Advisory Letter Number: AC-2020-01-HOSP. Facility Number: 005109 Survey Date: 3/3/2021 The following patient rooms were sucessfully verified as negative pressure: 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 3104, 3105, 3106, 3108, 3109, 3110, 3111, 3112, 3113, 3114, 3115, 3116, 3117, 3118, 5101, 5102, 5103, 5104, 5105, 5106, 5108, 5110, 5111, 5112, 5113, 5114, 5115, 5116, 5117, 5118. The following patient rooms failed to be sucessfully verified as negative pressure: None QA: 03/15/2021	S 000		