

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 005068	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/18/2021
NAME OF PROVIDER OR SUPPLIER COMMUNITY HOSPITAL EAST		STREET ADDRESS, CITY, STATE, ZIP CODE 1500 N RITTER AVE INDIANAPOLIS, IN 46219		
(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 of negative pressure rooms per ISDH CSHCR: Program Advisory Letter Number: AC-2020-01-HOSP.</p> <p>Facility Number: 005068</p> <p>Survey Date: 8/18/2021</p> <p>The following patient rooms were verified as decommissioned for use as negative air pressure rooms: PCU (Progressive Care Unit) 330, PCU 331, PCU 332, Neuro 502 and Renal 436.</p> <p>QA: 8/19/2021</p>	S 000		

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

TITLE

(X6) DATE