

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 005101	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/06/2020
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NAME OF PROVIDER OR SUPPLIER INDIANA UNIVERSITY HEALTH BLACKFORD HOSPIT	STREET ADDRESS, CITY, STATE, ZIP CODE 410 PILGRIM BLVD HARTFORD CITY, IN 47348
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(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 patient rooms per ISDH CSHCR: Program Advisory Letter Number: AC-2020-01-HOSP.</p> <p>Facility Number: 005101</p> <p>Survey Date: 4/6/20</p> <p>The following patient rooms were successfully verified as negative pressure: None</p> <p>The following patient rooms failed to be successfully verified as negative pressure: 3</p> <p>QA: 4/8/20</p>	S 000		

Indiana State Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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