STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005068	A. BUILDING: _____ B. WING _____	12/18/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY HOSPITAL EAST	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	INITIAL COMMENTS This visit was for a licensure review of negative pressure patient rooms per ISDH CSHCR: Program Letter Number: AC-2020-01-HOSP. Facility Number: 005068 Survey Date: 12/18/20 The following patient rooms were successfully verified at the 1500 N Ritter Avenue, Indianapolis facility: Emergency Department 5, 6 and 7, 301, 314, 337, 330, 502, 436, 437, 503 and 504. The following patient rooms were successfully verified at the 8075 N Shadeland Avenue, Indianapolis facility: 176, 173 and 174. The following patient rooms failed to be successfully verified as negative pressure: None. QA: 12/22/2020	S 000		