

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>011437</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>09/22/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>COMMUNITY HOSPITAL NORTH</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>7150 CLEARVISTA DR INDIANAPOLIS, IN 46256</b>		
(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><b>INITIAL COMMENTS</b></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: 011437</p> <p>Survey Date: 9/22/2021</p> <p>The following patient rooms were successfully verified as negative pressure: 2327 and 2332.</p> <p>The following patient rooms failed to be successfully verified as negative pressure: None</p> <p>QA: 11/9/21</p>	S 000		

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

TITLE

(X6) DATE