

Indiana State Department of Health

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

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

TITLE

(X6) DATE