STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005051	A. BUILDING: _____ B. WING _____	12/08/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INDIANA UNIVERSITY HEALTH	1701 N SENATE BLVD INDIANAPOLIS, IN 46202

(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 for conversion of hospital space to patient rooms per ISDH CSHCR: Program Advisory Letter Number: AC-2020-02-HOSP. Facility Number: 005051 Survey Date: 12/08/2020 The following patient rooms were converted and met the requirements listed in ISDH CSHCR: Program Advisory Letter: Rooms: MG110, MG111, MG112, MG113, MG114, MG115, MG116, MG117, MG118, MG119, MG120, MG121, MG122, MG123, MG124, MG125, MG126, MG127, and MG128. This request is the conversion/addition of nineteen (19) holding rooms as required by the facility for use during the Covid-19 period. All rooms were checked to ensure 3 foot clearance, portable oxygen and vacuum, alternative call light, hand washing station/alternative cleaning supplies, and duplex electrical outlet per patient bed. No rooms are indicated for negative pressure usage. QA: 12/11/20	S 000		