STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005020	A. BUILDING _____ B. WING _____	03/28/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKVIEW REGIONAL MEDICAL CENTER	11109 PARKVIEW PLAZA DRIVE FORT WAYNE, IN 46805

(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 investigation of three hospital licensure complaints. Complaint Numbers: IN00097853: Unsubstantiated for Lack of Sufficient Evidence IN00097855: Unsubstantiated for Lack of Sufficient Evidence IN00100982: Unsubstantiated for Lack of Sufficient Evidence Date: 3/26/12 and 3/27/12 Facility Number: 005020 Surveyor: Linda Plummer, R.N., Public Health Nurse Surveyor Parkview Hospital is in compliance with 410 IAC 15-1.5-5, Medical Staff; 410 IAC 15-1.5-10, Utilization Review and Discharge Planning Services, 410 IAC 15-1.6.2, Emergency Services; and 410 IAC 15-1.6.5, Psychiatric Services, Indiana Hospital Licensure Rules. QA: claughlin 05/01/12	S 000		