

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>005845</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/09/2011</b>
NAME OF PROVIDER OR SUPPLIER  <b>ORTHOPAEDIC HOSPITAL AT PARKVIEW NORTH LLC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>11130 PARKVIEW CIRCLE DR FORT WAYNE, IN 46845</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>INITIAL COMMENTS</p> <p>Surveyor: 30405 Facility Number: 005845</p> <p>Type of Survey: State Licensure Off Site JCAHO Accreditation Survey</p> <p>Date of JCAHO On Site Survey - Hospital full survey August 8-9, 2011</p> <p>Date of ISDH off site review - April 24, 2013</p> <p>Reviewer/Surveyor - Deborah Franco RN, PHNS</p> <p>Based on review of the August 8-9, 2011 JCAHO Accreditation Survey Report, it has been determined that Orthopedic Hospital at Parkview North meets the requirements for Hospital Licensure in Indiana.</p>	S 000			

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TITLE

(X6) DATE

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