

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 005020	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/20/2021
NAME OF PROVIDER OR SUPPLIER PARKVIEW REGIONAL MEDICAL CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 11109 PARKVIEW PLAZA DRIVE FORT WAYNE, IN 46845		
(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>This visit was for a licensure review of patient rooms per ISDH CSHCR: Program Advisory Letter Number: AC-2020-02-HOSP.</p> <p>Facility Number: 005020</p> <p>Survey Date: 12/20/21</p> <p>The following patient rooms were converted : Prep Recovery Rooms #1, 2, 3, 4, 5, 6, 7, 8, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198 and 2199 were converted to Surge Compacity Rooms. Admission Staging Unit Rooms #1101, 1102, 1103, 1104, 1105, 1106, 1107, 1108, 1121, 1122, 1123, 1124, 1125, 1126, 1127, 1128, 1129, 1130, 1131, 1132, 1133, 1134 and 1135 were converted to Surge Compacity Rooms.</p> <p>QA: 1/03/2022</p>	S 000		

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

TITLE

(X6) DATE