| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 002434 | A. BUILDING: _____ B. WING _____ | C 02/15/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PARKVIEW NOBLE HOSPITAL | 401 SAWYER RD KENDALLVILLE, IN 46755 |

| (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<br><br>The visit was for investigation of a State licensure hospital complaint.<br><br>Complaint Number: IN00289888<br><br>Unsubstantiated: Lack of sufficient evidence.<br><br>Survey Date: 2/15/2021<br><br>Facility Number: 002434<br><br>Parkview Noble Hospital is in compliance with 410 IAC 15-1.5-10 Utilization Review & Discharge Planning, Hospital Licensure Rules.<br><br>QA: 2/22/21 | S 000 | | |