

Indiana State Department of Health

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>005020</b>                          | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><b>09/22/2021</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>PARKVIEW REGIONAL MEDICAL CENTER</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>11109 PARKVIEW PLAZA DRIVE<br/>FORT WAYNE, IN 46845</b> |                                                                                                                          |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                                    | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                         | ID<br>PREFIX<br>TAG                                                                                 | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                                           |
| S 000                                                                       | <p><b>INITIAL COMMENTS</b></p> <p>This visit was for investigation of a state licensure hospital complaint.</p> <p>Complaint Number: IN00253257</p> <p>Unsubstantiated: Lack of sufficient evidence.</p> <p>Date of survey: 9/21/21 and 9/22/21</p> <p>Facility number: 005020</p> <p>Parkview Regional Medical Center is in compliance with 410 IAC 15-1.5-5, Medical Staff and 410 IAC 15-1.5-6, Nursing Service, Hospital Licensure Rules.</p> <p>QA: 9/30/21</p> | S 000                                                                                               |                                                                                                                          |                                                                    |

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

TITLE

(X6) DATE