

Indiana Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>005090</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>01/03/2024</b>
NAME OF PROVIDER OR SUPPLIER  <b>PARKVIEW WHITLEY HOSPITAL</b>		STREET ADDRESS, CITY, STATE, ZIP CODE  <b>1260 E SR 205 COLUMBIA CITY, IN 46725</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>This visit was for a Pre-occupancy survey of an inpatient remote offsite location.</p> <p>Facility Number: 005090</p> <p>Date of Survey: 1/3/2024</p> <p>As of 1/10/2024, Parkview Whitley inpatient remote location at 1355 Mariners Drive, Warsaw, Indiana is in compliance with 410 IAC 15-1.5-8 Physical Plant and 410 IAC 15-1.6-8 Surgical Services, Hospital Licensure Rules.</p> <p>QA: 1/11/24</p>	S 000		

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

TITLE

(X6) DATE