PRINTED: 09/30/2022 FORM APPROVED

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		005041	B. WING		09/21/2022	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE						
PARKVIEW DEKALB HOSPITAL 1316 E SEVENTH ST						
AUBURN, IN 46706 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)						
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	CORRECTIVE ACTION SHOULD BE COMPLÉTE REFERENCED TO THE APPROPRIATE DATE	
S 000	00 INITIAL COMMENTS		S 000			
	The visit was for a Stasurvey.	ate Hospital licensure				
	Facility Number: 005041					
	Survey Dates: 09/19-21/2022					
	Parkview Dekalb Hos 410 IAC 15-1, Hospita	pital is in compliance with al Licensure Rules.				
	QA: 9/26/2022					

Indiana State Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE