

Indiana Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>005054</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C 02/26/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>RIVERVIEW HEALTH</b>		STREET ADDRESS, CITY, STATE, ZIP CODE  <b>395 WESTFIELD RD NOBLESVILLE, IN 46060</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 the investigation of a State Licensure hospital complaint.</p> <p>Complaint Number: IN00452794 - No deficiencies related to the allegations are cited.</p> <p>Survey Date: 02/26/2025</p> <p>Facility Number: 005054</p> <p>Riverview Health is in compliance with 410 IAC 15-1.6-2, Emergency Services, Hospital Licensure Rules, in regard to the investigation of complaint IN00452794.</p> <p>QA: 3/11/2025</p>	S 000		

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

TITLE

(X6) DATE