

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>005081</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>12/07/2011</b>
NAME OF PROVIDER OR SUPPLIER  <b>PARKVIEW HUNTINGTON HOSPITAL</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>2001 STULTS RD HUNTINGTON, IN 46750</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><b>INITIAL COMMENTS</b></p> <p>This visit was for investigation of one State hospital complaint.</p> <p>Complaint Number: IN00096610 Unsubstantiated: Lack of Sufficient Evidence</p> <p>Date: 12/7/11</p> <p>Facility: 005081</p> <p>Surveyor: Linda Plummer, R.N. Public Health Nurse Surveyor</p> <p>Parkview Huntington Hospital is in compliance with 410 IAC 15-1.5-2, Infection Control; 410 IAC 15-1.5-3, Laboratory Services; and 410 IAC 15-1.5-6, Nursing Services, Hospital Licensure Rules.</p> <p>QA: claughlin 12/20/11</p>	S 000		

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TITLE

(X6) DATE

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