STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005012	A. BUILDING: _____ B. WING _____	C 11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT JOSEPH REGIONAL MEDICAL CENTER	5215 HOLY CROSS PKWY MISHAWAKA, IN 46545

(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	INITIAL COMMENTS This visit was for the investigation of two (2) state licensure hospital complaints. Complaint Number: IN00253678 Unsubstantiated: Lack of sufficient evidence. Complaint Number: IN00257941 Unsubstantiated: Lack of sufficient evidence. Survey Date: 11/21/22 Facility Number: 005012 Saint Joseph Regional Medical Center is in compliance with 410 IAC 15-1.5-3, Laboratory Services, 410 IAC 15-1.5-6, Nursing Service, 410 IAC 15-1.5-8, Physical Plant and 410 IAC 15-1.6-2, Emergency Services, Hospital Licensure Rules. QA: 12/12/2022	S 000		