

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 005070	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/22/2021
NAME OF PROVIDER OR SUPPLIER SAINT JOSEPH REGIONAL MEDICAL CENTER - PLYN		STREET ADDRESS, CITY, STATE, ZIP CODE 1915 LAKE AVE PLYMOUTH, IN 46563		
(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 investigation of a state licensure hospital complaint.</p> <p>Complaint Number: IN00298814</p> <p>Unsubstantiated: Lack of sufficient evidence.</p> <p>Date of Survey: 3/22/2021</p> <p>Facility Number: 005070</p> <p>Saint Joseph Regional Medical Center - Plymouth is in compliance with 410 IAC 15-1.5-2, Infection Control, and 410 IAC 15-1.5-8, Physical Plant, Hospital Licensure Rules.</p> <p>QA: 3/26/21</p>	S 000		

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

TITLE

(X6) DATE