

Indiana State Department of Health

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                  |  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>005001</b>                       | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><b>03/18/2021</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>JOHNSON MEMORIAL HOSPITAL</b> |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1125 W JEFFERSON ST</b><br><b>FRANKLIN, IN 46131</b> |  |  |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE   |
| S 000  | <p>INITIAL COMMENTS</p> <p>This visit was for investigation of a state licensure hospital complaint.</p> <p>Complaint Number: IN00324274.</p> <p>Unsubstantiated: Lack of sufficient evidence.</p> <p>Survey Date: 03/18/2021</p> <p>Facility Number: 005001</p> <p>Johnson Memorial Hospital is in compliance with 410 IAC 15-1.5-2, Infection Control, Hospital Licensure Rules.</p> <p>QA: 03/23/2021</p> | S 000  |  |  |

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

TITLE

(X6) DATE