

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 005043	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/28/2021
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NAME OF PROVIDER OR SUPPLIER ST JOSEPH HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 700 BROADWAY FORT WAYNE, IN 46802
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(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: IN00294524</p> <p>Unsubstantiated: Lack of sufficient evidence.</p> <p>Date of survey: 6/28/21</p> <p>Facility number: 005043</p> <p>St. Joseph Hospital is in compliance with 410 IAC 15-1.6-5, Psychiatric Services, Hospital Licensure Rules.</p> <p>QA: 7/15/2021</p>	S 000		

Indiana State Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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