

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>005012</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>08/04/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>SAINT JOSEPH REGIONAL MEDICAL CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>5215 HOLY CROSS PKWY</b> <b>MISHAWAKA, IN 46545</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>INITIAL COMMENTS</p> <p>This visit was for a State licensure hospital complaint investigation.</p> <p>Complaint Number: IN00242934</p> <p>Unsubstantiated: Lack of sufficient evidence.</p> <p>Date of Survey: 8/4/2021</p> <p>Facility Number: 005012</p> <p>Saint Joseph Regional Medical Center is in compliance with 410 IAC 15-1.5-5, Medical Staff, and 410 IAC 15-1.5-6, Nursing Service, Hospital Licensure Rules.</p> <p>QA: 8/11/2021</p>	S 000		

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

TITLE

(X6) DATE