

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 005012	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/18/2014
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NAME OF PROVIDER OR SUPPLIER SAINT JOSEPH REGIONAL MEDICAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5215 HOLY CROSS PKWY MISHAWAKA, IN 46545
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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>JCAHO Surveyor: 34586 Facility Number: 005012</p> <p>Type of Survey: State Licensure Off Site JCAHO Accreditation Survey</p> <p>Date of JCAHO On Site Survey - Hospital full survey July 15-18/2014</p> <p>Date of ISDH off site review -Dec. 17/2014</p> <p>Reviewer/Surveyor -Kerry Sawin, RN, PHNS</p> <p>Based on review of the July/ 2014 JCAHO Accreditation Survey Report, it has been determined that St. Joseph Regional Medical Center meets the requirements for Hospital Licensure in Indiana for 2014.</p>	S 000		

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