

Indiana State Department of Health

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>005043</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____ | (X3) DATE SURVEY COMPLETED<br><br><b>10/09/2014</b> |
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| NAME OF PROVIDER OR SUPPLIER<br><br><b>ST JOSEPH HOSPITAL</b> | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>700 BROADWAY<br/>FORT WAYNE, IN 46802</b> |
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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 |
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| S 000 | <p><b>INITIAL COMMENTS</b></p> <p>The visit was for investigation of a State hospital complaint.</p> <p>Complaint Number:<br/>IN 00155937</p> <p>Unsubstantiated: lack of sufficient evidence.</p> <p>Date: 10-8/9-14</p> <p>Facility Number: 005043</p> <p>Surveyor: Brian Montgomery, RN, BSN<br/>Public Health Nurse Surveyor</p> <p>St Joseph Hospital is in compliance with 410 IAC 15-1.5-6. Nursing Service, Indiana Hospital Licensure Rules.</p> <p>QA: claughlin 10/30/14</p> | S 000 |  |  |
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| Indiana State Department of Health<br>LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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