

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 005633	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/22/2016
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NAME OF PROVIDER OR SUPPLIER MEMORIAL SPINE AND NEUROSCIENCE CENTER LL	STREET ADDRESS, CITY, STATE, ZIP CODE 100 NAVARRE PL STE 4405 SOUTH BEND, IN 46601
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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>Facility Number: 005633</p> <p>Type of Survey: State Licensure Off Site AAAHC Accreditation Survey</p> <p>Date of AAAHC On Site Survey - ASC full survey 4/21-22/2016</p> <p>Date of ISDH off site review - 7/3/2017</p> <p>Based on review of the 4/22/2016 AAAHC Accreditation Survey Report, it has been determined that Memorial Spine and Neuroscience Center meets the requirements for ASC Licensure in Indiana for 2016.</p>	S 000		

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