STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005053	A. BUILDING: _____ B. WING _____	C 05/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL HOSPITAL OF SOUTH BEND	615 N MICHIGAN ST SOUTH BEND, IN 46601

(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	INITIAL COMMENTS This visit was for a State licensure hospital complaint investigation. Complaint Number: IN00264110 Unsubstantiated: Lack of sufficient evidence. Dates of Survey: 5/19/2021 to 5/20/2021 Facility Number: 005053 Memorial Hospital of South Bend is in compliance with 410 IAC 15-1.5-5, Medical Staff, Hospital Licensure Rules. QA: 6/11/2021	S 000		