

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 005053	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 07/12/2021
NAME OF PROVIDER OR SUPPLIER MEMORIAL HOSPITAL OF SOUTH BEND		STREET ADDRESS, CITY, STATE, ZIP CODE 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	<p>INITIAL COMMENTS</p> <p>This visit was for investigation of a state licensure hospital complaint.</p> <p>Complaint Number: IN00233342</p> <p>Unsubstantiated: Lack of sufficient evidence.</p> <p>Date of Survey: 7/12/2021</p> <p>Facility Number: 005053</p> <p>Memorial Hospital of South Bend is in compliance with 410 IAC 15-1.5-6, Nursing Service, Hospital Licensure Rules.</p> <p>QA: 7/15/2021</p>	S 000		

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

TITLE

(X6) DATE