

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 012820	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/08/2012
NAME OF PROVIDER OR SUPPLIER COLUMBUS SPECIALTY SURGERY CENTER, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 2425 NORTH PARK DRIVE COLUMBUS, IN 47203		
(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 a pre-occupancy survey.</p> <p>Facility #: 012820</p> <p>Survey Date: 8-8-12</p> <p>Surveyor:</p> <p>Billie Jo Fritch RN, BSN, MBA Public Health Nurse Surveyor</p> <p>Columbus Specialty Surgery Center meets the requirements for 410 IAC 15-2, Ambulatory Surgery Center Licensure Rules to admit and treat patients.</p> <p>QA: claughlin 08/14/12</p>	S 000		

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TITLE

(X6) DATE

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