

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>012104</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/21/2014</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>LAGRANGE SURGERY CENTER LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2500 VENTURA WAY LAGRANGE, IN 46761</b>
--	---

(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>AAAHC</p> <p>Surveyor: 34586</p> <p>Facility Number: 012104</p> <p>Type of Survey: State Licensure Off Site AAAHC Accreditation Survey</p> <p>Date of AAAHC On Site Survey-ASC full survey 2/20-21/14</p> <p>Date of ISDH off site review-8/19/14</p> <p>Reviewer/Surveyor--Kerry Sawin, RN, MBA, NE-BC, Public Health Nurse Surveyor</p> <p>Based on review of the 2/20-21/14 AAAHC Accreditation Survey Report, it has been determined that Lagrange Surgery Center meets the requirements for ASC Licensure in Indiana for 2014</p>	S 000		

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