

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>011735</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>12/12/2012</b>
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NAME OF PROVIDER OR SUPPLIER  <b>AMBULATORY SURGERY CENTER FOR PAIN RELIEF</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2330 LYNCH RD STE 100 EVANSVILLE, IN 47711</b>
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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
C 000	<p><b>INITIAL COMMENTS</b></p> <p>Surveyor 33212 Facility #: 011735</p> <p>Type of survey: State Licensure Off-Site AAAHC Accreditation Survey Date of AAAHC On-Site survey: 12/11&amp;12/2012. Date of ISDH Off-Site survey 08/30/2013</p> <p>Reviewer/surveyor: Nancy Otten, RN,PHNS</p> <p>Based on review of the 12/12/2012 AAAHC Survey, it has been determined that Ambulatory Surgery Center for Pain Relief meets the requirements for State Licensure in Indiana for 2012.</p>	C 000		

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