

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>15C0001087</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>01/25/2012</b>
NAME OF PROVIDER OR SUPPLIER  <b>INDIANA SURGERY CENTER-EAST</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>5445 E 16TH ST INDIANAPOLIS, IN 46218</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><b>INITIAL COMMENTS</b></p> <p>This visit was for a State complaint survey.</p> <p>Facility Number: 010817</p> <p>Complaint: IN00103227 Unsubstantiated; lack of sufficient evidence</p> <p>Survey Date: 1-25-12</p> <p>Surveyor: Jack I. Cohen, MHA Medical Surveyor</p> <p>Indiana Surgery Center-East is in compliance with Ambulatory Surgery Center Licensure Rules 410 IAC 15-2.5-1, Infection control and 410 IAC 15-2.5-7, Physical plant, equipment maintenance and environmental services.</p> <p>QA: cloughlin 02/13/12</p>	S 000		

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TITLE

(X6) DATE

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