

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>009776</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>10/02/2012</b>
NAME OF PROVIDER OR SUPPLIER  <b>ADVANCED SURGERY CENTER LLC</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1400 TEAL RD STE 7 LAFAYETTE, IN 47905</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>This visit was for a standard licensure survey.</p> <p>Facility Number: 009776</p> <p>Survey Date: 10/1/2012 &amp; 10/2/2012</p> <p>Surveyors: ReBecca Lair, LCSW Medical Surveyor</p> <p>Jacqueline Brown, RN Public Health Nurse Surveyor</p> <p>Advanced Surgery Center is in compliance with 410 IAC 15.2, Ambulatory Surgery Center Licensure Rules.</p> <p>QA: claughlin 11/01/12</p>	S 000		

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TITLE

(X6) DATE

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