

Indiana State Department of Health

<b>STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS</b>		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: <b>230041741</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED <b>08/02/2023</b>
NAME OF PROVIDER OR SUPPLIER <b>COMMUNITY DIGESTIVE CENTER ANDERSON</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1601 MEDICAL ARTS BLVD STE 300 , ANDERSON, Indiana, 46011</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) COMPLETION DATE
S0000	<p>INITIAL COMMENTS</p> <p>This visit was for a State Licensure Survey of an Ambulatory Surgery Center.</p> <p>Facility Number: 004174</p> <p>Survey Dates: 08/01/2023 &amp; 08/02/2023</p> <p>Community Digestive Center Anderson, is in compliance with 410 IAC 15-2, Ambulatory Surgery Center Licensure Rules.</p> <p>QA: 8/7/2023</p>	S0000		

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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