

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  240092341		(X2) MULTIPLE CONSTRUCTION A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED  06/25/2024	
NAME OF PROVIDER OR SUPPLIER  EVANSVILLE SURGERY CENTER ASSOCIATES LLC				STREET ADDRESS, CITY, STATE, ZIP CODE  520 MARY ST STE 130 PO BOX 2185, EVANSVILLE, Indiana, 47710			
(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	INITIAL COMMENTS  This visit was for a state licensure survey of an Ambulatory Surgery Center.  Facility Number: 009234  Survey Date: 6/25/24  Evansville Surgery Center Associates, LLC, is in compliance with 410 IAC 15-2, Ambulatory Surgery Center Licensure Rules.  QA: 6/26/2024			S0000			

Office of Primary Care and Health Systems Management

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