

## Indiana State Department of Health

<b>STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS</b>		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: <b>240121491</b>		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED <b>06/25/2024</b>	
NAME OF PROVIDER OR SUPPLIER <b>ST FRANCIS MOORESVILLE SURGERY CENTER LLC</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1215 HADLEY RD STE 100, MOORESVILLE, Indiana, 46158</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	INITIAL COMMENTS  This visit was for a State Licensure Survey of an Ambulatory Surgery Center.  Facility Number: 012149  Survey Dates: 06/24/2024 & 06/25/2024  St. Francis Mooresville Surgery Center, LLC is in compliance with 410 IAC 15-2, Ambulatory Surgery Center Licensure Rules.  QA: 7/10/2024		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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