

<b>STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS</b>		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: <b>15C0001185</b>		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED <b>02/11/2025</b>	
NAME OF PROVIDER OR SUPPLIER <b>SOUTH BEND SPECIALTY SURGERY CENTER, LLC</b>				STREET ADDRESS, CITY, STATE, ZIP CODE <b>335 FLORENCE AVENUE, STE 1B , GRANGER, Indiana, 46530</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
E0000	<p>Initial Comments</p> <p>Paper Compliance to the Emergency Preparedness Survey that exited on 01/30/25 was completed on 02/11/25.</p> <p>Review Date: 02/11/25</p> <p>Facility Number: 012996</p> <p>Provider Number: 15C0001185</p> <p>Aim Number: 160129961</p> <p>South Bend Specialty Surgery Center, LLC was found in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.73, Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers.</p> <p>Quality Review completed on 02/11/25</p>			E0000			

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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