

Indiana State Department of Health

| <b>STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS</b>                 |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><b>2400257801</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING<br>B. WING  | (X3) DATE SURVEY COMPLETED<br><b>02/13/2025</b> |
|--|--|---|---|---|
| NAME OF PROVIDER OR SUPPLIER<br><b>COMMUNITY SURGERY CENTER HAMILTON</b> |  |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>9700 E 146TH ST , NOBLESVILLE, Indiana, 46060</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 complaint investigation of an Ambulatory Surgery Center.</p> <p>Complaint Number: 112728 - No deficiencies related to the allegation are cited.</p> <p>Facility Number: 002578</p> <p>Date of Survey: 02/13/2025</p> <p>Community Surgery Center Hamilton is in compliance with 410 IAC 15-2.5-7 Physical Plant, Equipment Maintenance, and Environmental Services, Ambulatory Surgery Centers Licensure Rules, in regard to the investigation of complaint 112728.</p> <p>QA: 2/26/2025</p> | S0000   |   |   |

Office of Primary Care and Health Systems Management

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