Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	012741		07/28/2016

NAME OF PROVIDER OR SUPPLIER

RETINA INSTITUTE OF INDIANA SURGERY CENTER,

STREET ADDRESS, CITY, STATE, ZIP CODE

11192 DIEBOLD ROAD
FORT WAYNE, IN 46845

(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) COMPLETE DATE
S 000	INITIAL COMMENTS AAAHC Facility Number: 012741 Type of Survey: State Licensure Off Site AAAHC Accreditation Survey Date of AAAHC On Site Survey - ASC full survey July 27-28/2016 Date of ISDH off site review - 4/11/2017 Based on review of the 7/28/2016 AAAHC Accreditation Survey Report, it has been determined that Retina Institute of Indiana meets the requirements for ASC Licensure in Indiana for 2016.	S 000		

Indiana State Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE