STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	1214AS	A. BUILDING: _____ B. WING _____	05/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAPITAL CARE NETWORK OF TOLEDO	1160 WEST SYLVANIA AVENUE TOLEDO, OH 43612

(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
C 000	Initial Comments Initial Licensure Compliance Inspection Administrator: Schuyler Beckwith County: Lucas Number of Procedure Rooms: Two Capital Care Network of Toledo is in compliance with the rules for ambulatory surgical facilities at O.A.C. 3701-83 at the time of the Initial Licensure Compliance Inspection completed on 05/08/18.	C 000		