STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	013409	A. BUILDING: _____ B. WING _____	R-C 10/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONECROFT HEALTH CAMPUS	363 SOUTH FIELDSTONE BLVD BLOOMINGTON, IN 47403

(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
{R 000}	INITIAL COMMENTS This visit was for a Post Survey Revisit (PSR) to Investigation of Complaint IN00443577 completed on October 3, 2024. Complaint IN00443577 - Corrected. Survey date: October 29, 2024 Facility number: 013409 Residential Census: 35 Stonecroft Health Campus was found to be in compliance with 410 IAC 16.2-5 in regard to the PSR to Investigation of Complaint IN00443577. Quality review completed October 30, 2024.	{R 000}		