STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155767	A. BUILDING _____ B. WING _____	C 07/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGHURST HEALTH CAMPUS	**628 N MERIDIAN RD GREENFIELD, IN 46140**

(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
F 000	INITIAL COMMENTS This visit was for the Investigation of Complaint IN00358509. Complaint IN00358509 - Substantiated. No deficiencies related to the allegations were cited. Survey date: July 28, 2021 Facility number: 005954 Provider number: 155767 AIM number: 201068810 Census Bed Type: SNF/NF: 33 SNF: 22 Residential: 45 Total: 100 Census Payor Type: Medicare: 17 Medicaid: 14 Other: 24 Total: 55 Springhurst Health Campus was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2-3.1 in regard to the Investigation of Complaint IN00358509. Quality review completed on August 4, 2021	F 000		

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