STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155852	A. BUILDING _____ B. WING _____	C 09/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARRISON SPRINGS HEALTH CAMPUS	**871 PACER DRIVE NW CORYDON, IN 47112**

(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 IN00416557. Complaint IN00416557 - No deficiencies related to the allegation is cited. Survey date: September 19, 2023 Facility number: 013702 Provider number: 155852 AIM number: 300018569 Census Bed Type: SNF: 29 SNF/NF: 23 Residential: 25 Total: 77 Census Payor Type: Medicare: 22 Medicaid: 19 Other: 11 Total: 52 Harrison Springs Health Campus was found to be in compliance with 42 CFR Part 483, Subpart B and 420 IAC 16.2-3.1 in regard to the Investigation of Complaint IN00416557. Quality review completed on September 21, 2023.	F 000		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.