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 11/02/2022

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	F 000		

This visit was for the Investigation of Complaint IN00393347.

Complaint IN00393347 -- Substantiated. No deficiencies related to the allegations are cited.

Survey dates: November 1 and 2, 2022

Facility number: 005954
Provider number: 155767
AIM number: 201068810

Census Bed Type:
SNF: 19
SNF-NF: 32
Residential: 45
Total: 96

Census Payor Type:
Medicare: 15
Medicaid: 17
Other: 19
Total: 51

Springhurst Health Campus was found to be in substantial compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2-3.1 in regards to the Investigation of Complaint IN00393347.

Quality review completed on November 4, 2022

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