STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155735	A. BUILDING _____ B. WING _____	R-C 09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHFORD PLACE HEALTH CAMPUS	**2200 N RILEY HWY SHELBYVILLE, IN 46176**

(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 a Post Survey Revisit (PSR) to the Investigation of Complaints IN00440297 and IN00440513 completed on August 14, 2024. Complaint IN00440297 - Corrected. Complaint IN00440513 - Corrected. Survey dates: September 18, 2024 Facility number: 004268 Provider number: 155735 AIM number: 200504460 Census Bed Type: SNF/NF: 36 SNF: 19 Residential: 31 Total: 86 Census Payor Type: Medicare: 13 Medicaid: 31 Other: 11 Total: 55 Ashford Place 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 PSR to the Investigation of Complaints IN00440297 and IN00440513. Quality review completed on September 18, 2024.	{F 000}		

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