Indiana Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005954	A. BUILDING: ______ B. WING ______	C 07/22/2024

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) COMPLETE DATE
R 000	INITIAL COMMENTS This visit was for the Investigation of Residential Complaints IN00438510 and IN00438569. Complaint IN00438510 -- No deficiencies related to the allegations are cited. Complaint IN00438569 -- No deficiencies related to the allegations are cited. Survey date: July 18, 19 and 22, 2024 Facility number: 005954 Residential Census: 52 Springhurst Health Campus was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Residential Complaints IN00438510 and IN00438569. Quality review completed on July 23, 2024.	R 000		

Indiana Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE