STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155823	A. BUILDING _____ B. WING _____	C 04/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHPOINTE HEALTHCARE CENTER	**4904 WAR ADMIRAL DRIVE INDIANAPOLIS, IN 46237**

(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 Complaints IN00400622, IN00403039, IN00404793, IN00405952, IN00406409, IN00406550, and IN00406780. Complaint IN00400622 - No deficiencies related to the allegations are cited. Complaint IN00403039 - No deficiencies related to the allegations are cited. Complaint IN00404793 - No deficiencies related to the allegations are cited. Complaint IN00405952 - No deficiencies related to the allegations are cited. Complaint IN00406409 - No deficiencies related to the allegations are cited. Complaint IN00406550 - No deficiencies related to the allegations are cited. Complaint IN00406780 - No deficiencies related to the allegations are cited. Survey dates: April 20 and 24, 2023 Facility number: 013126 Provider number: 155823 AIM number: 300029591 Census Bed Type: SNF/NF: 99 Total: 99 Census Payor Type:	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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155823	A. BUILDING _____ B. WING _____	C 04/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHPOINTE HEALTHCARE CENTER	**4904 WAR ADMIRAL DRIVE INDIANAPOLIS, IN 46237**

(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	Continued From page 1 Medicare: 14 Medicaid: 66 Other: 19 Total: 99 Southpointe Healthcare Center 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 Complaints IN00400622, IN00403039, IN00404793, IN00405952, IN00406409, IN00406550, and IN00406780. Quality review completed April 25, 2023.	F 000		