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 10/12/2021

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	F 000		

This visit was for Investigation of Complaint IN00364339. This visit included a COVID-19 Focused Infection Control Survey.

Complaint IN00364339 - Unsubstantiated due to lack of evidence.

Survey date: October 12, 2021

Facility number: 013126
Provider number: 155823
AIM number: 300029591

Census Bed Type:
SNF/NF: 81
Total: 81

Census Payor Type:
Medicare: 16
Medicaid: 46
Other: 19
Total: 81

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 Complaint IN00364339 and the COVID-19 Focused Infection Control Survey.

Quality Review completed on October 13, 2021.

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