

Indiana Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 011187	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 07/29/2024
NAME OF PROVIDER OR SUPPLIER GLEN OAKS HEALTH CAMPUS		STREET ADDRESS, CITY, STATE, ZIP CODE 601 W CR 200 S NEW CASTLE, IN 47362		
(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	<p>INITIAL COMMENTS</p> <p>This visit was for the Investigation of Complaint IN00439519.</p> <p>Complaint IN00439519 -- No deficiencies related to the allegations are cited.</p> <p>Survey date: July 29, 2024</p> <p>Facility number: 011187</p> <p>Residential Census: 22</p> <p>Glen Oaks Health Campus was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaint IN00439519.</p> <p>Quality review completed on July 30, 2024.</p>	R 000		

Indiana Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE