

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>003984</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R-C 08/26/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>WORTHINGTON PLACE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE  <b>10799 ALLIANCE DR CAMBY, IN 46113</b>		
(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 a Post Survey Revisit (PSR) to Investigation of Complaint IN00357494 completed on July 21, 2021.</p> <p>Complaint IN00357494 - Corrected.</p> <p>Survey date: August 26, 2021</p> <p>Facility number: 003984</p> <p>Residential Census: 31</p> <p>Worthington Place was found to be in compliance with 410 IAC 16.2-5 in regard to the PSR to Investigation of Complaint IN00357494.</p> <p>Quality Review completed on August 27, 2021.</p>	{R 000}		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

**TITLE**

(X6) DATE