

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>C 08/15/2022</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 the Investigation of Complaints IN00386707 and IN00387409.</p> <p>Complaint IN00387409 - Unsubstantiated due to lack of evidence.</p> <p>Complaint IN00386707 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>Survey date: August 15, 2022</p> <p>Facility number: 003984</p> <p>Residential Census: 25</p> <p>Worthington Place was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaints IN00386707 and IN00387409.</p> <p>Quality review completed August 19, 2022.</p>	R 000		

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

TITLE

(X6) DATE