

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>01/07/2021</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 Residential COVID-19 Quality Assurance Walk Through.</p> <p>Survey date: January 7, 2021</p> <p>Facility number: 003984</p> <p>Residential census: 28</p> <p>Worthington Place was found to be in compliance with 410 IAC 16.2-5 in regard to the Residential COVID-19 Quality Assurance Walk Through.</p> <p>Quality Review completed on January 08, 2021.</p>	R 000		

Indiana State Department of Health

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

## TITLE

(X6) DATE