

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 013846	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/30/2023
NAME OF PROVIDER OR SUPPLIER PRIMROSE OF NEWBURGH		STREET ADDRESS, CITY, STATE, ZIP CODE 9800 LINCOLN AVE NEWBURGH, IN 47630		
(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 IN00399634.</p> <p>Complaint IN00399634 - No deficiencies related to the allegations are cited.</p> <p>Survey date: March 29, 30, 2023</p> <p>Facility number: 013846</p> <p>Residential Census: 63</p> <p>Primrose of Newburgh was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaint IN00399634.</p> <p>Quality review completed on March 30, 2023.</p>	R 000		

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

TITLE

(X6) DATE