

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/22/2024	
NAME OF PROVIDER OR SUPPLIER VITA OF NEW WHITELAND		STREET ADDRESS, CITY, STATE, ZIP CODE 532 COUNTRY GATE DRIVE , NEW WHITELAND, , 46184					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...			(X5) COMPLETION DATE	
R 0000	INITIAL COMMENTS This visit was for the Investigation of Complaints IN00440195, IN00441069, IN00441452, and IN00441634. Complaint IN00440195 - No deficiencies related to the allegations are cited. Complaint IN00441069 - No deficiencies related to the allegations are cited. Complaint IN00441452 - No deficiencies related to the allegations are cited. Complaint IN00441634 - No deficiencies related to the allegations are cited. Survey date: August 22, 2024 Facility number: 016046 Residential Census: 46 Vita of New Whiteland was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaint	R 0000					

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FORM APPROVED

OMB NO. 0938-0391

IN00440195, IN00441069, IN00441452, and IN00441634.				
Quality review completed August 26, 2024.				

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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