STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005093	A. BUILDING: _____ B. WING _____	12/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WITHAM HEALTH SERVICES	2605 N LEBANON ST LEBANON, IN 46052

(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
S 000	INITIAL COMMENTS This visit was for a licensure review for conversion of hospital space to patient rooms per ISDH CSHCR: Program Advisory Letter Number: AC-2020-02-HOSP. Facility Number: 005093 Survey Date: 12/09/2020 The facility requested hospital space be converted to patient care rooms, and would meet the requirements listed in ISDH CSHCR: Program Advisory Letter Number: AC-2020-02-HOSP. This request is the conversion was unable to be verified as the space has not yet been converted, and lacks required clinical equipment. No estimated date of completion was available at this time. The State will be notified when ready for inspection. No rooms will be indicated for negative pressure usage. QA: 12/11/20	S 000		