

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 005093	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/17/2020
NAME OF PROVIDER OR SUPPLIER WITHAM HEALTH SERVICES		STREET ADDRESS, CITY, STATE, ZIP CODE 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	<p>INITIAL COMMENTS</p> <p>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.</p> <p>Facility Number: 005093</p> <p>Survey Date: 12/17/2020</p> <p>The following room, 2705 North Pavillion "B" was converted to eight (8) patient care beds.</p> <p>QA: 12/18/20</p>	S 000		

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

TITLE

(X6) DATE