

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 012355	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 02/27/2023
NAME OF PROVIDER OR SUPPLIER WHITE OAK HEALTH CAMPUS		STREET ADDRESS, CITY, STATE, ZIP CODE 814 S 6TH ST MONTICELLO, IN 47960		
(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>Paper compliance to the State Residential Licensure Survey completed on January 30, 2023. This visit included paper compliance to the Recertification and State Licensure Survey.</p> <p>Survey dates: February 27, 2023.</p> <p>Facility number: 012355</p> <p>White Oak Health Campus was found to be in compliance with 410 IAC 16.2-5 in regard to the paper compliance review to the State Residential Licensure Survey.</p>	{R 000}		

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

TITLE

(X6) DATE