

Indiana Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>015081</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>03/13/2025</b>
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NAME OF PROVIDER OR SUPPLIER  <b>VITA OF MARION</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>4211 S ADAMS STREET MARION, IN 46953</b>
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(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><b>INITIAL COMMENTS</b></p> <p>This visit was for the Investigation of Complaint IN00452726.</p> <p>Complaint IN00452726- No deficiencies related to the allegations are cited.</p> <p>Survey date: March 13, 2025</p> <p>Facility number: 015081</p> <p>Residential Census: 91</p> <p>Vita of Marion was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaint IN00452726.</p> <p>Quality review completed March 19, 2025.</p>	R 000		

Indiana Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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