

Indiana Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>016046</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>04/16/2025</b>
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NAME OF PROVIDER OR SUPPLIER  <b>VITA OF NEW WHITELAND</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>532 COUNTRY GATE DRIVE NEW WHITELAND, IN 46184</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 IN00457574.</p> <p>Complaint IN00457574 - No deficiencies related to the allegations are cited.</p> <p>Survey date: April 16, 2025</p> <p>Facility number: 016046</p> <p>Residential Census: 69</p> <p>Vita of New Whiteland was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaint IN00457574.</p> <p>Quality review completed April 21, 2025.</p>	R 000		

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