

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 011366	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 02/14/2013
NAME OF PROVIDER OR SUPPLIER WELLINGTON AT KOKOMO THE		STREET ADDRESS, CITY, STATE, ZIP CODE 2800 S DIXON RD KOKOMO, IN 46902		
(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>This visit was for a Post Survey Revisit (PSR) for the State Residential Licensure Survey completed on November 27, 2012.</p> <p>This visit was in conjunction with the Investigation of Complaint IN00124224.</p> <p>Survey date: February 14, 2013</p> <p>Facility Number: 011366 Provider Number: 011366 AIM Number: N/A</p> <p>Survey Team: Tammy Alley, RN</p> <p>Census Bed Type: Residential: 35 Total: 35</p> <p>Census Payor Type: Other: 35 Total: 35</p> <p>Sample: 4</p> <p>Wellington of Kokomo was found to be in compliance with 410 IAC 16.2 in regard to the PSR to the State Residential Licensure survey.</p> <p>Quality Review completed on February 20, 2013, by Brenda Meredith, R.N.</p>	{R 000}		

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TITLE

(X6) DATE

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