PRINTED: 11/01/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	01	COMPLETED
		155222	B. WING		10/03/2013
NAME OF P	PROVIDER OR SUPPLIER	- {		ADDRESS, CITY, STATE, ZIP CODE	-
				LINCOLN RD	
KINDRE	J IRANSIIIONAL (CARE AND REHAB-KOKOMO	KOKO	MO, IN 46902	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG K010000	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCT)	DATE
100000					
	A Life Safety Co	ode Recertification and	K010000	K000 Preparation and executi	on
	1	Survey was conducted by		of this plan does not constitute	
		e Department of Health in		admission or agreement by th	
		42 CFR 483.70(a).		provider of the truth of the fact alleged or conclusions set fou	
		,		on this statement of deficienci	
	Survey Date: 10	0/03/13		This plan of correction is	
	,			prepared and or executed sole	ely
	Facility Number	: 000127		because required.	
	Provider Numbe				
	AIM Number: 1	100291430			
	Surveyor: Philli	p Komsiski, Life Safety			
	Code Specialist				
	•				
	At this Life Safe	ety Code survey, Kindred			
	Transitional Car	e and			
	Rehabilitation-K	Kokomo was found not in			
	compliance with	Requirements for			
	Participation in 1	Medicare/Medicaid, 42			
	CFR Subpart 48	3.70(a), Life Safety from			
	Fire, and the 200	00 edition of the National			
	Fire Protection A	Association (NFPA) 101,			
	Life Safety Code	e (LSC), Chapter 19,			
	Existing Health	Care Occupancies and			
	410 IAC 16.2.				
	This one story fa	acility was determined to			
	be of Type II (00	00) construction and was			
		l. The facility has a fire			
	alarm system wi	th smoke detection in the			
	corridors, in spa	ces open to the corridors,			
	hard wired smok	ke detectors in resident			
			1		

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

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	OF CORRECTION	IDENTIFICATION NUMBER:			NSTRUCTION 01	(X3) DATE COMPL	
I I I I I I I I I I I I I I I I I I I		155222		LDING		10/03/	
			B. WIN		DDRESS, CITY, STATE, ZIP CODE		-
NAME OF P	PROVIDER OR SUPPLIER				INCOLN RD		
	TRANSITIONAL (CARE AND REHAB-KOKOMO			IO, IN 46902		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	*	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
1710		ll and battery powered		1710			DATE
		in all other resident					
		lity has a capacity of 131					
		s of 87 at the time of this					
	survey.	or of we will mind or wind					
	202129						
	All areas where	the residents have					
	customary acces	s were sprinklered and all					
	areas providing t	facility services were					
	sprinklered.						
		by Robert Booher, Life					
	-	cialist-Medical Surveyor					
	on 10/09/13.						
	TTI 6 :1:	0 1 1:					
	_	found not in compliance					
		entioned regulatory					
	requirements as following:	evidenced by the					
	ionowing.						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155222		(X2) MULTIPLE CO	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 10/03/2013	
	PROVIDER OR SUPPLIED	R CARE AND REHAB-KOKOMO	429 W	ADDRESS, CITY, STATE, ZIP CODE LINCOLN RD MO, IN 46902	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
K010018 SS=E	Doors protecting than required end openings, exits, or substantial doors of 1¾ inch solid-l capable of resisting minutes. Doors it only required to resmoke. There is closing of the dowith a means suit closed. Dutch do permitted. 19.3 Roller latches are regulations in all Based on observe facility failed to double leaf corrisindependently in This deficient puresidents on 200 300 west as well. Findings included Based on observe the tour between p.m. with the M the following sed doors required of manually into the second door work.	corridor openings in other closures of vertical or hazardous areas are as, such as those constructed bonded core wood, or ing fire for at least 20 in sprinklered buildings are resist the passage of no impediment to the ors. Doors are provided table for keeping the door pors meeting 19.3.6.3.6 are 3.6.3 The prohibited by CMS health care facilities. Vation and interview, the ensure 2 of 3 sets of idor doors could latch not their door frames. Tractice could affect 22 of hall and 32 residents on a visitors and staff. The prohibited by CMS health care facilities. Vation and interview, the ensure 2 of 3 sets of idor doors could latch not their door frames. Tractice could affect 22 of hall and 32 residents on a visitors and staff. The prohibited by CMS health care facilities. Vation and interview, the ensure 2 of 3 sets of idor doors could latch and 32 residents on a visitors and staff. The prohibited by CMS health care facilities. Vation and interview, the ensure 2 of 3 sets of idor doors could latch and 32 residents on a visitors and staff. The prohibited by CMS health care facilities. Vation and interview, the ensure 2 of 3 sets of idor doors could latch and 32 residents on a visitors and staff. The prohibited by CMS health care facilities. Vation and interview, the ensure 2 of 3 sets of idor doors could latch and interview, the ensure 2 of 3 sets of idor doors could latch and interview, the ensure 2 of 3 sets of idor doors could latch and interview, the ensure 2 of 3 sets of idor doors could latch and interview, the ensure 2 of 3 sets of idor doors could latch and interview, the ensure 2 of 3 sets of idor doors could latch and interview, the ensure 2 of 3 sets of idor doors could latch and interview, the ensure 2 of 3 sets of idor doors could latch and interview, the ensure 2 of 3 sets of idor doors could latch and interview, the ensure 2 of 3 sets of idor doors could latch and interview, the ensure 2 of 3 sets of idor doors could latch and interview.	K010018	K018Two sets of double leaf corridor doors will latch independently. Crash bars to linstalled on pantry doors in 200hall and 300 hall. This will allow doors to self close and la securely and independently in the door frame. All necessary parts ordered and work to be completed by A1 locks. Completion estimated prior to on Nov 2 2013.	atch to

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		IDENTIFICATION NUMBER: 155222	A. BUILDING B. WING	01	COMP	LETED
	PROVIDER OR SUPPLIER D TRANSITIONAL (CARE AND REHAB-KOKOMO	429 \	ET ADDRESS, CITY, STATE, ZIP CO W LINCOLN RD KOMO, IN 46902	DE .	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPENCED TO T	ULD BE	(X5) COMPLETION DATE
	to room # 209. b. The double lenext to room # 3 Based on intervice concurrent with acknowledged by Supervisor, the acknowledged by	the observations, it was y the Maintenance forementioned corridor latch independently into				

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	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	01	COMPL	
		155222	B. WIN	G		10/03/	2013
NAME OF P	ROVIDER OR SUPPLIER		_	STREET A	ADDRESS, CITY, STATE, ZIP CODE	•	
WAINE OF T	KO VIDEK OK SOI I EIEK				LINCOLN RD		
KINDRED	TRANSITIONAL (CARE AND REHAB-KOKOMO		KOKON	MO, IN 46902		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
K010029	NFPA 101						
SS=E	LIFE SAFETY CO	ed construction (with ¾					
		ors) or an approved					
		inguishing system in					
	accordance with 8	8.4.1 and/or 19.3.5.4					
		us areas. When the					
	• •	atic fire extinguishing					
		used, the areas are ther spaces by smoke					
		s and doors. Doors are					
	• .	non-rated or field-applied					
		that do not exceed 48					
	inches from the b	ottom of the door are					
	permitted. 19.3						
		ation and interview, the	K0	10029	K029Door to hazardous areas		11/02/2013
	facility failed to	ensure 1 of 12 doors to			such the identified kitchen doc	r	
	hazardous areas	such as the kitchen would			will self close and latch independently securely into its		
	self close and lat	ch securely into its			frame without assistance. Egre		
	frame. This defi	ciency could affect 8			crash bar will be installed on the		
	residents observe	ed in the dining room			kitchen door. All necessary parts		
	adjacent to the ki	-			ordered and work will be		
					completed by A1 locks.		
	Findings include				Completion estimated prior to on Nov 2, 2013.	Or	
	1 mamgs merade	•			0111107 2, 2013.		
	Based on observa	ation on 10/03/13 at 1:20					
	p.m. with the Ma	aintenance Supervisor,					
	-	n door adjacent to the					
		not latch into its frame					
	_	vided with a closing					
	-	or. Based on interview					
	on 10/03/13 cond						
		the Maintenance					
	-	as acknowledged the					
		kitchen door would not					
		t provided with a self					
	closer to ensure t	the door would close and					
					•		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155222		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 10/03/2013	
	PROVIDER OR SUPPLIER	L R CARE AND REHAB-KOKOMO	STREET A 429 W	ADDRESS, CITY, STATE, ZIP CODE LINCOLN RD MO, IN 46902	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	latch without ass	sistance.			
	3.1-19(b)				

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	OF CORRECTION	IDENTIFICATION NUMBER: 155222	A. BUIL	DING	01	COMPLETED 10/03/2013	
			B. WIN	_	DDDDGG OWN CTATE TIP CODE	. 0, 00,	
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 429 W LINCOLN RD				
KINDRE	TRANSITIONAL C	CARE AND REHAB-KOKOMO			10, IN 46902		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
TAG K010051 SS=F	NFPA 101 LIFE SAFETY CO A fire alarm syste components, devi installed according Fire Alarm Code, warning of fire in a Activation of the cis by manual fire a detection or exting Pull stations in pa be omitted provide stations are within stations. Pull station fegress. Electrotests are available of power is provided are maintained in and records of material available. There is the fire alarm systems in according facility failed to systems in according National Fire Alarm Circuit discountered and the systems in according to the	DDE STANDARD m with approved ces or equipment is g to NFPA 72, National to provide effective any part of the building. complete fire alarm system alarm initiation, automatic guishing system operation. tient sleeping areas may ed that manual pull a 200 feet of nurse's ions are located in the path onic or written records of e. A reliable second source ed. Fire alarm systems accordance with NFPA 72 aintenance are kept readily is remote annunciation of teem to an approved central	K01	TAG 0051	K051Fire alarm circuit breaker system located in the generator transfer switch room on 100 has the required identification. Fire panel in 100 hall adjacent nurse's station has been marked in red and identified as fire alarcircuit control and accessible of to authorized personnel.	or all to ed rm	DATE 10/03/2013
	identified as FIR CONTROL. Thi	d personnel, and shall be E ALARM CIRCUIT s deficient practice could ts as well as visitors and			Completed on Oct 3 2013.		
	Findings include	:					
	Based on observa	ation on 10/03/13 at 2:56					

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	NT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER: 155222	(X2) MULTIPLE CO A. BUILDING B. WING	01	(X3) DATE SURVEY COMPLETED 10/03/2013
KINDRE	PROVIDER OR SUPPLIER D TRANSITIONAL CARE AND REHAB-KOKOMO	429 W I	ADDRESS, CITY, STATE, ZIP CODE LINCOLN RD MO, 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 APPROPR DEFICIENCY)	COMPLETION
	p.m. with the Maintenance Supervisor, the fire alarm system circuit breaker located in the generator transfer switch room on 100 hall lacked identification. Based on interview on 10/03/13 at 2:57 p.m. with the Maintenance Supervisor, it was acknowledged the circuit breaker was not labeled Fire Alarm Circuit Control. 3.1-19(b)			

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	OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	JETIPLE CO	ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	01	COMPL	
		155222	B. WIN	G		10/03/	2013
	ROVIDER OR SUPPLIER			429 W I	ADDRESS, CITY, STATE, ZIP CODE LINCOLN RD		
KINDREI	O TRANSITIONAL C	CARE AND REHAB-KOKOMO		KOKON	/IO, IN 46902		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
K010056 SS=E	installed in accord Standard for the I Systems, to provide all portions of the properly maintain NFPA 25, Standa Testing, and Mair Fire Protection Sysupervised. Ther water supply for the sprinkler systems flow and tamper selectrically connected alarm system. Based on observation facility failed to sprinkler pipes of was installed in a requirements of 1 the Installation on NFPA 13, 1999 of states the cumulation and unsupported a sprinkler drop, of exceed 24 inches inches for copper practices could a west hall as well. Findings include. Based on observation, and 3:22 p.m. and 3:22 p.m. and 3:22 p.m.	matic sprinkler system, it is dance with NFPA 13, nstallation of Sprinkler de complete coverage for building. The system is ed in accordance with ard for the Inspection, ntenance of Water-Based ystems. It is fully the is a reliable, adequate the system. Required are equipped with water switches, which are cted to the building fire 19.3.5 action and interview, the ensure 1 of 4 armover bserved in the facility accordance with the NFPA 13, Standard for if Sprinkler Systems. The edition, Section 6-2.3.4 active horizontal length of armover to a sprinkler, or sprig-up shall not as for steel pipe or 12 artube. This deficient as staff or visitors.	KO	.0056	K056Room 211 has sprinkler pipe arm over within 24 inches Room 211 had sprinkler pipe hanger installed within the 24ir regulation. Completed Oct 4, 2013		10/04/2013

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	DF CORRECTION IDENTIFICATION NUME 155222	ER:	JILDING ING	01	COMPLETED 10/03/2013
	ROVIDER OR SUPPLIER O TRANSITIONAL CARE AND REHAB-	кокомо	429 W L	DDRESS, CITY, STATE, ZIP CODE INCOLN RD O, IN 46902	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIEN (EACH DEFICIENCY MUST BE PRECEDED REGULATORY OR LSC IDENTIFYING INFO	BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
	observed to have a steel sprinkler p armover exposed at the ceiling of th south wall which was measured to be thirty inches in length. Based on interview on 10/03/13 concurrent with the observation with Maintenance Supervisor, it was acknowledged the aforementioned armover steel sprinkler pipe exceed twenty four inches in length and was unsupported. 3.1-19(b)	h the			

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	OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	01		
		155222	B. WIN	G		10/03/	2013
	PROVIDER OR SUPPLIER			429 W	ADDRESS, CITY, STATE, ZIP CODE LINCOLN RD		
KINDKEL	J TRANSITIONAL C	CARE AND REHAB-KOKOMO		KUKU	MO, IN 46902		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
K010147 SS=E	accordance with NElectrical Code. 9 Based on observa	nd equipment is in NFPA 70, National 0.1.2 ation and interview, the	K01	0147	K 147Six prong multi plug ada		10/03/2013
	facility failed to adapters was not fixed wiring. Not requires, unless a multiplug adapte cables shall not be fixed wiring of a practice could aff west hall adjacent room as well as a Findings include. Based on observation, with the Matthere was one, sing adapter connected was used to power monitor, radio ar	ensure 1 of 1 multiplug used as a substitute for FPA 70, Article 400-8 specifically permitted, ers, flexible cords and be used as a substitute for structure. This deficient effect 32 residents on 300 ent to the laundry dryer estaff and visitors. : ation on 10/03/13 at 1:33 eintenance Supervisor, x prong multiplug ed to a wall outlet which er a carbon monoxide			in the laundry room has been removed per regulation. An ocover plate has been placed of the 2 plug electrical outlet. Completed Oct 3, 2013	utlet	10/03/2013
	observation with Supervisor, it wa policy of the faci adapters, however	the Maintenance as acknowledged it is the dility not to use multiplug er, the aforementioned ix prong multiplug as a					

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	OF CORRECTION	IDENTIFICATION NUMBER: 155222	(X2) MULTIPLE CC A. BUILDING B. WING	01		LETED B/2013		
KINDRE		CARE AND REHAB-KOKOMO	STREET ADDRESS, CITY, STATE, ZIP CODE 429 W LINCOLN RD KOKOMO, IN 46902					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		

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