DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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R-C 01/12/2022 NAME OF PROVIDER OR SUPPLIER EAST LAKE NURSING & REHABILITATION CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE R-C 01/12/2022 STREET ADDRESS, CITY, STATE, ZIP CODE 1900 JEANWOOD DR ELKHART, IN 46514 (X5) PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLE	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE									

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards 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.