STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155222	A. BUILDING _____ B. WING _____	C 08/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KOKOMO HEALTHCARE CENTER	**429 W LINCOLN 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) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		

This visit was for Investigation of Complaint IN00358690.

Complaint IN00358690-Substantiated. No deficiencies related to the allegations were cited.

Survey dates: August 2 and 3, 2021

Facility number: 000127
Provider number: 155222
AIM number: 100291430

Census bed type:
SNF/NF: 72
Total: 72

Census payor type:
Medicare: 6
Medicaid: 52
Other: 12
Total: 72

Kokomo Healthcare was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2-3.1 in regards to the Investigation of Complaint IN00358690.

Quality review completed August 5, 2021.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE