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

PRINTED: 03/21/2022 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		155222	B. WING			R-C		
NAME OF PROVIDER OR SUPPLIER			B. WING_	STREET ADDRESS, CITY, STATE, Z	IP CODE	03/	14/2022	
TVAME OF T	TOVIDEIT OIT OOI I EIEIT			429 W LINCOLN RD	II OODL			
KOKOMO HEALTHCARE CENTER				KOKOMO, IN 46902				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI) TAG	(EACH CORRECTIVE A CROSS-REFERENCED 1	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
{F 000}	0) INITIAL COMMENTS		{F 0	00}				
		ost Survey Revisit (PSR) to omplaint IN00369184 ber 29, 2021.						
	This visit was in conjunction with the PSR to the COVID-19 Focused Infection Control Survey and unrelated deficiency completed on November 22, 2021.							
	This visit was in conju Investigation of Comp completed on Decem							
		unction with the PSR to the nfection Control Survey 95, 2022.						
	Investigation of Comp	unction with the PSR to the blaint IN00370894 and the infection Control survey y 31, 2022.						
	Complaint IN0036871	12 - Corrected.						
	Complaint IN0036918	34 - Corrected.						
	Complaint IN0037089	94 - Corrected.						
	Survey dates: March	11 and 14, 2022						
	Facility number: 0001 Provider number: 155 AIM number: 100291	5222						
	Census Bed Type: SNF/NF: 63 Total: 63							
_ABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATUF	 RE	TITLE			(X6) DATE	

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

(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.

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NAME OF PROVIDER OR SUPPLIER KOKOMO HEALTHCARE CENTER (X4) ID PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) R-C 03/14/2022 STREET ADDRESS, CITY, STATE, ZIP CODE 429 W LINCOLN RD KOKOMO, IN 46902 ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE COMPLETED TO THE APPROPRIATE DEFICIENCY) COMPLETED TO THE APPROPRIATE DEFICIENCY)	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION NG	(X3) DA	(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER KOKOMO HEALTHCARE CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 429 W LINCOLN RD KOKOMO, IN 46902 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) STREET ADDRESS, CITY, STATE, ZIP CODE 429 W LINCOLN RD KOKOMO, IN 46902 (EACH CORRECTIVE ACTION SHOULD BE COMPLETED TO THE APPROPRIATE DATE DATE OSTREET ADDRESS, CITY, STATE, ZIP CODE 429 W LINCOLN RD KOKOMO, IN 46902							R-C	
KOKOMO HEALTHCARE CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (X5) PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			155222	B. WING _			03/14/2022	
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLETED TO THE APPROPRIATE DEFICIENCY					429 W LINCOLN RD	į		
(F 000) Continued From page 4	PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFI)	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		
Census Payor Type: Medicare: 1 Medicaid: 52 Other: 10 Total: 63 Kokomo Healthcare Center was found to be in compliance with 42 CFR Part 483 Subpart B and 410 IAC 16.2-3.1 in regard to the PSR to the Investigation of Complaint IN00369184. Quality review was completed on March 18, 2022.	Ce Me Me Oth Tot Kol cor 410 Inv	edicare: 1 edicaid: 52 her: 10 tal: 63 ekomo Healthcare 0 mpliance with 42 C 0 IAC 16.2-3.1 in revestigation of Comp	Center was found to be in FR Part 483 Subpart B and egard to the PSR to the plaint IN00369184.	{F 0	00}			