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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155819	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 05/01/2023

NAME OF PROVIDER OR SUPPLIER **WELLBROOKE OF KOKOMO**	STREET ADDRESS, CITY, STATE, ZIP CODE **2200 SOUTH DIXON ROAD** **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** This visit was for a Post Survey Revisit (PSR) to the Investigation of Complaint IN00402582 completed on March 8, 2023. Complaint IN00402582 - Corrected. Survey dates: May 1, 2023 Facility number: 013153 Provider number: 155819 AIM number: 201254360 Census Bed Type: SNF/NF: 11 SNF: 36 Total: 47 Census Payor Type: Medicare: 26 Medicaid: 11 Other: 10 Total: 47 Wellbrooke of Kokomo 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 IN00402582. Quality review was completed on May 5, 2023.	{F 000}		

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