AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLET C 155064 B. WING COMPLET C B. WING BUILDING COMPLET C B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 3518 S LAFOUNTAIN ST KOKOMO, IN 46902 COMPLET C (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION CO	CENTER	S FOR MEDICARE &	MEDICAID SERVICES				FORM APPROVE OMB NO. 0938-039	
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BORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6)							(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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DEDADTMENT OF HEALTH AND HUMAN SEDVICES