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

PRINTED: 01/10/2025 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED R 01/09/2025	
		155486	155486 B. WING				
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP CODE	,	00.2020
MIDDLETOWN NURSING AND REHABILITATION CENTER				131 S 10TH ST MIDDLETOWN, IN 47356			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI 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			
	Paper compliance to and State Licensure s November 26, 2024.	the Annual Recertification survey completed on					
	Review Date: January 9, 2025						
	Facility Number: 000343 Provider Number: 155486 AIM Number: 100289600						
	was found to be in co 483, Subpart B and 4	and Rehabilitation Center impliance with 42 CFR Part 10 IAC 16.2-3.1, in regard to ne Recertification and State					
	Quality review comple	eted on January 9, 2025.					
LAROPATOPY	DIRECTOR'S OR PROVINCED	SUPPLIER REPRESENTATIVE'S SIGNATUI	DE DE		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.