

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

PRINTED: 02/27/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 153042		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/07/2023	
NAME OF PROVIDER OR SUPPLIER LAFAYETTE REGIONAL REHABILITATION HOSPITAL				STREET ADDRESS, CITY, STATE, ZIP CODE 950 PARK EAST BLVD LAFAYETTE, IN 47905			
(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
A 000	<p>INITIAL COMMENTS</p> <p>This visit was for a re-certification survey.</p> <p>Facility Number: 012870</p> <p>Survey Date: 02/07/2023</p> <p>Lafayette Regional Rehabilitation Hospital is in compliance with the criteria for Rehabilitation Hospital exclusion from Medicare's Hospital Prospective Payment System 42 CFR 412.25 and 42 CFR 412.29.</p> <p>QA: 2/16/2023</p>			A 000			

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

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.