

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>011555</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>05/30/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>PRIMROSE RETIREMENT COMMUNITY OF KOKOMO</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>329 W RAINBOW DR KOKOMO, IN 46901</b>		
(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) COMPLETE DATE	
R 000	<p><b>INITIAL COMMENTS</b></p> <p>This visit was for a State Residential Licensure Survey.</p> <p>Survey dates: May 29 &amp; 30, 2013</p> <p>Facility number: 011555</p> <p>Survey team: Michelle Carter, RN-TC Bobbette Messman, RN Sandra Nolder, RN</p> <p>Census bed type: Residential- 44 Total= 44</p> <p>Census payor type: Other- 44 Total= 44</p> <p>Sample: 8</p> <p>Primrose Retirement Community of Kokomo was found to be in compliance with 410 IAC 16.2 in regard to the State Residential Licensure Survey.</p> <p>Quality Review 05/30/13 by Lisa McColly</p>	R 000			

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TITLE

(X6) DATE

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