STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	07/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KOKOMO PLACE ASSISTED LIVING	3025 W SYCAMORE ST, KOKOMO, , 46901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...	(X5) COMPLETION DATE
R 0000	INITIAL COMMENTS This visit was for a State Residential Licensure Survey. Survey dates: July 14 and 15, 2025 Facility number: 011075 Residential Census: 43 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review was completed on July 22, 2025.	R 0000		
R 0296	Pharmaceutical Services - Noncompliance 410 IAC 16.2-5-6(b) (b) The facility shall maintain clear written policies and procedures on medication assistance. The facility shall provide for ongoing training to ensure competence of medication staff. Based on observation, interview	R 0296	There were not any residents found to be affected by the deficiency.We determined no one was affected as all compromised/blister packs still contained the medication tablet. DON trained QMA and LPNs on 7/15/25 that any compromised narcotic blister packs, ie; cut or slit in foil must be	08/08/2025

	and record review, the facility failed to ensure controlled substance medications were stored in a tamper free container for 1 of 2 medication carts observed for medication storage. (Cart 2) Findings include: During a medication storage observation, on 7/14/25 at 1:25 p.m., the following were observed in the medication cart 2: 1. One (1) card of Ativan (for anxiety) 0.5 milligram (mg) for Resident 23. The foil was torn on the back of the card over the number 27 slot. 2. One (1) card of hydrocodone/acetaminophen (for pain) 7.5-325 mg for Resident 24. The foil was torn on the back of the narcotic card over the number 6 slot. The slot had a piece of clear tape covering the back to hold the pill in the card 3. One (1) card of Pregabalin (used for pain or seizures) 25 mg for Resident 32. The foil was torn on the back of the card over the number 14, 16 and 24 slots. During an interview, on 7/14/25 at 1:26 p.m., Qualified Medical Assistant (QMA) 3 indicated pain pills should not be taped on the back of the medication cards		destroyed and initials and date must be written on pack next to the number that was destroyed. They will follow facility destruction policy by placing unused medication into a drug buster container, and documentation of disposal must be kept per state regulation.No blister pack should have tape over the medication. Narcotic punch cards will be monitored at each shift change during narcotic count starting 7/28/25. Compliance Date: 7/28/25	

and the pills should have been destroyed.

During an interview, on 7/14/25 at 1:39 p.m., the Executive Director (ED) indicated the pills locked in the narcotic box should not be taped or left in the cart with cuts on the back of the cards. The medication cards needed to be taken out of the cart.

During an interview, on 7/14/25 at 1:59 p.m., the Director of Nursing (DON) indicated she did not find a problem with the narcotics having tape or cuts on the back of the cards. If the medication was in the card, then it did not matter if the back was cut open or taped over the open pill slot.

During an interview, on 7/15/25 at 10:32 a.m., the ED indicated the facility did not have any other policies for medication storage.

A current facility policy, titled "Disposal of Unused Medication," dated as reviewed 1/10/24 and received from the ED on 7/14/25 at 3:10 p.m., indicated "...Medication disposal should follow federal and state laws for all unused controlled and non-controlled medications...The dispensing pharmacy should be notified, and medication destroyed per individual Board of Pharmacy or

state licensing agency regulation...Controlled medication disposal documentation must be kept per pharmacy provider and state regulations...."

A current facility policy, titled "Controlled Medication Count," dated as reviewed 1/10/24 and received from the DON on 7/15/25 at 10:03 a.m., indicated "...Controlled substances should be counted at the end of each shift or when control of the medication keys is passed to another associate...An on-coming associate and an out-going associate should count each controlled substance and verify the amount of controlled substances remaining against the amount listed on the Controlled Substance Count Sheet...If there is a discrepancy, associates should immediately notify the nurse, DHW or Executive Director, or designee...."

A current facility policy, titled "Common Medication Storage Guidance and Terminology," dated 2025 and received from the DON on 7/15/25 at 10:05 a.m., indicated "...Controlled substances may have additional storage, security and disposal requirements not addressed in this document...."

Based on observation, interview and record review, the facility

failed to ensure controlled substance medications were stored in a tamper free container for 1 of 2 medication carts observed for medication storage. (Cart 2)

Findings include:

During a medication storage observation, on 7/14/25 at 1:25 p.m., the following were observed in the medication cart 2:

1. One (1) card of Ativan (for anxiety) 0.5 milligram (mg) for Resident 23. The foil was torn on the back of the card over the number 27 slot.

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3. One (1) card of Pregabalin (used for pain or seizures) 25 mg for Resident 32. The foil was torn on the back of the card over the number 14, 16 and 24 slots.

During an interview, on 7/14/25 at 1:26 p.m., Qualified Medical Assistant (QMA) 3 indicated pain pills should not be taped on the back of the medication cards and the pills should have been

destroyed.

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