

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

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| STATEMENT OF DEFICIENCIES AND<br>PLAN OF CORRECTIONS                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:                                  |                                  | (X2) MULTIPLE<br>CONSTRUCTION<br><br>A. BUILDING<br><br>B. WING |  | (X3) DATE SURVEY<br>COMPLETED<br><br>09/05/2024 |  |
| NAME OF PROVIDER OR SUPPLIER<br><br>KOKOMO PLACE ASSISTED LIVING                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | STREET ADDRESS, CITY, STATE, ZIP<br>CODE<br><br>3025 W SYCAMORE ST, KOKOMO, ,<br>46901 |                                  |                                                                 |  |                                                 |  |
| (X4) ID<br>PREFIX TAG                                                                                                                                                                                                                             | SUMMARY STATEMENT OF<br>DEFICIENCIES...                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | ID PREFIX<br>TAG                                                                       | PROVIDER'S PLAN OF CORRECTION... |                                                                 |  | (X5)<br>COMPLETION<br>DATE                      |  |
| R 0000                                                                                                                                                                                                                                            | <p>INITIAL COMMENTS</p> <p>This survey was for a State Residential Licensure Survey. This visit included the Investigation of Complaint IN00440657.</p> <p>Complaint IN00440657-No deficiencies related to the allegations are cited.</p> <p>Survey dates: September 4 and 5, 2024</p> <p>Facility number: 011075</p> <p>Residential: 35</p> <p>Kokomo Place Assisted Living was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey and the Investigation of Complaint IN00440657.</p> <p>Quality review was completed on September 11, 2024.</p> | R 0000                                                                                 |                                  |                                                                 |  |                                                 |  |
| Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                        |                                  |                                                                 |  |                                                 |  |

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| LABORATORY DIRECTOR'S OR<br>PROVIDER/SUPPLIER REPRESENTATIVE'S<br>SIGNATURE | TITLE | (X6) DATE |
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