

Indiana Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>011075</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/23/2023</b>
NAME OF PROVIDER OR SUPPLIER  <b>KOKOMO PLACE ASSISTED LIVING</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>3025 W SYCAMORE ST</b> <b>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 the Investigation of Complaint IN00398539.</p> <p>Complaint IN00398539 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>Survey date: January 23, 2023</p> <p>Facility number: 011075</p> <p>Residential Census: 32</p> <p>Kokomo Place was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaint IN00398539.</p> <p>Quality review was completed on January 26, 2023.</p>	R 000		

Indiana Department of Health  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE