

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>R-C 10/05/2022</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 Post Survey Revisit (PSR) to the Investigation of Complaint IN00386391 completed on August 12, 2022.</p> <p>This visit was in conjunction with the PSR to the Investigation of Complaint IN00381855 completed on July 27, 2022.</p> <p>Complaint IN00386391-Corrected.</p> <p>Complaint IN00381855-Corrected.</p> <p>Survey date: October 5, 2022</p> <p>Facility number: 011555</p> <p>Residential Census: 65</p> <p>Primrose Retirement Community of Kokomo was found to be in compliance with 410 IAC 16.2-5 in regard to the PSR to the Investigation of Complaint IN00386391.</p> <p>Quality review was completed on October 11, 2022.</p>	{R 000}		

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

TITLE

(X6) DATE