STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155222	A. BUILDING -- B. WING	04/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
KOKOMO HEALTHCARE CENTER	429 W LINCOLN RD KOKOMO, IN 46902

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E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 04/10/23 Facility Number: 000127 Provider Number: 155222 AIM Number: 100291430 At this Emergency Preparedness survey, Kokomo Healthcare Center was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has a capacity of 80 and had a census of 74 at the time of this survey. Quality Review completed on 04/17/23	E 0000	Please accept this plan of correction as the provider's credible allegation of compliance. The provider respectfully requests a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 04/10/2023 Facility Number: 000127 Provider Number: 155222 AIM Number: 100291430 At this Life Safety Code survey, Kokomo Healthcare Center was found not in compliance with Requirements for Participation in	K 0000	Please accept this plan of correction as the provider's credible allegation of compliance. The provider respectfully requests a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Sydnie Reed	Executive Director	04/28/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, areas open to the corridors and battery operated smoke detectors in the South Hall. The facility has a capacity of 80 and had a census of 74 at the time of this survey. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered. Quality Review completed on 04/17/23			
K 0353 SS=C Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial			

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	automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on observation and interview, the facility failed to ensure 1 of 1 sprinkler systems were provided with spare sprinklers, a spare sprinkler cabinet and a sprinkler wrench on the premises. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.4.1.4 states a supply of spare sprinklers shall be maintained on the premises so that any sprinklers that have been operated or damaged in any way can be promptly replaced. The sprinklers shall correspond to the types and temperature ratings of the sprinklers on the property. The sprinklers shall be kept in a cabinet located where the temperature in which they are subjected will at no time exceed 100 degrees Fahrenheit. A special sprinkler wrench shall be provided and kept in the cabinet to be used in the removal and installation of sprinklers. This deficient practice could affect all residents and staff in the facility. Findings include: Based on observations during a tour of the facility with the Maintenance Director and Executive Director on 04/10/23 at 3:00 p.m., there was a spare sprinkler cabinet in the riser room that included six spare sprinklers; 2 of which were being stored in the sprinkler box but not in their own protective slot. Based on interview at the time of the observation, the Maintenance Director agreed the spare sprinkler cabinet had spare sprinklers not in protected slots. The Maintenance Director corrected the deficiency at the time of observation. This finding was reviewed with the Maintenance Director at the time of discovery and again at the	K 0353	**What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice:** The spare sprinklers that were found in the sprinkler box were moved to a protective slot at the time of observation during the survey. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:** All residents have the potential to be affected. The facility verified there were no other sprinklers out of protective slots during the survey. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** Education was completed with maintenance staff with an emphasis on NFPA 25 Section 5.4.1.4 to ensure facility is in compliance. **How the corrective action will be monitored to ensure the deficient practice will not recur:** The Maintenance Director/Designee will conduct weekly rounds for 12 weeks, then monthly rounds for 12 weeks.	05/03/2023

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	exit conference with the Maintenance Director and Executive Director present. 3.1-19(b)		Any discrepancies found will be immediately corrected and re-education will be provided. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for three months and then quarterly thereafter once full compliance has been achieved for a total of 6 months of monitoring. Frequency and duration of reviews will be increased as needed, if areas of noncompliance exist.	
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that			

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	release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.			
	Based on observation and interview, the facility failed to ensure 1 of 1 resident room corridor door and 1 of 1 North Supply Room door was provided with a means suitable for keeping the door closed, had no impediment to closing, latching and would resist the passage of smoke. This deficient practice could affect 2 residents in resident room 216 and any residents or staff in the area of the North Supply Room. Findings include: Based on observation with the Maintenance Director on 04/10/23 at 2:30 p.m., the corridor door to resident room 216 and the North Supply Room would not close into the frame when tested. Based on interview at the time of observation, the Maintenance Director agreed the corridor door would not close into the door frame. The finding was reviewed with the Executive Director and Maintenance Director during the exit	K 0363	**What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice:** The maintenance director adjusted the door frame for room 214 on 4/10/23 to ensure latching. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:** This alleged deficient practice could affect 2 residents in resident room 216 and any residents or staff in the area of the North Supply Room. The facility completed a house wide sweep with no further concerns noted.	05/03/2023

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	conference. 3.1-19(b)		**What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** Education was completed with maintenance staff with an emphasis on NFPA 101 19.3.6.3 to ensure facility is in compliance. **How the corrective action will be monitored to ensure the deficient practice will not recur:** The Maintenance Director/Designee will conduct weekly rounds of 5 doors for 12 weeks, then monthly rounds of 5 doors for 12 weeks. Any discrepancies found will be immediately corrected and re-education will be provided. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for three months and then quarterly thereafter once full compliance has been achieved for a total of 6 months of monitoring. Frequency and duration of reviews will be increased as needed, if areas of noncompliance exist.	
K 0712 SS=F Bldg. 01	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying			

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	conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 Based on record review and interview, the facility failed to ensure 2 of 12 fire drills included the verification of transmission of the fire alarm signal to the monitoring station in fire drills conducted between 9:00 p.m. and 6:00 a.m. for the last 4 quarters. LSC 19.7.1.4 requires fire drills in health care occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire conditions. This deficient practice affects all residents in the facility as well as staff and visitors. Findings include: Based on records review with the Maintenance Director on 04/10/23 at 11:15 a.m., the fire drill forms for third shift drills indicated transmission of a signal was not tested after the drills completed on 05/02/22 and 06/16/22. Based on interview at the time of record review, the Maintenance Director stated there was no transmission of a signal the next day to test for these two fire drills on third shift. This finding was reviewed with the Executive Director and Maintenance Director at the exit conference. 3.1-19(b) 3.1-51(c)	K 0712	**What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice:** Education was completed with maintenance staff with an emphasis on NFPA 101 19.7.1.4 through 19.7.1.7 to ensure facility is in compliance with documentation required for fire drills. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:** This alleged deficient practice has the potential to affect all residents in the facility as well as staff and visitors. All other fire drills had verification of the transmission of the fire alarm documented. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** Education was completed with maintenance staff with an emphasis on NFPA 101 19.7.1.4	05/03/2023

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			through 19.7.1.7 to ensure facility is in compliance with documentation required for fire drills. **How the corrective action will be monitored to ensure the deficient practice will not recur:** The Executive Director/Designee will audit fire drills monthly for 6 months to ensure follow up documentation is added to conducted fire drills. Any discrepancies found will be immediately corrected and re-education will be provided. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for three months and then quarterly thereafter once full compliance has been achieved for a total of 6 months of monitoring. Frequency and duration of reviews will be increased as needed, if areas of noncompliance exist.	
K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for			

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	non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 Based on observation and interview, the facility failed to ensure 1 of 1 flexible cords power strips in patient care locations met the required UL rating of 1363A or 60601-1. This deficient practice affects two or more residents. Findings include: Based on observations during a tour of the facility with the Maintenance Director on 04/10/23 at 2:50 p.m., in room 422 there was a power strip in use within 6 feet of a resident care area that did not met 1363A or 60601-1. Based on interview at the time of observation, the Maintenance Director agreed a power strip was in use in the resident care area and did not meet 1363A or 60601-1. The Maintenance Director removed the power strip at the time of observation. This finding was reviewed with the Maintenance Director and the Executive Director during the exit conference. 3.1-19(b)	K 0920	**What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice:** The extension cord was immediately unplugged in room 422 and resident was verbally reeducation during survey observation. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:** This alleged deficient practice has the potential to affect two or more residents. Facility completed a whole house audit with no other concerns noted. **What measures will be put into place or what systemic changes will be made to**	05/03/2023

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			ensure that the deficient practice does not recur: Education was completed with maintenance staff with an emphasis on NFPA 101 10.2.4 to ensure facility is in compliance with extension cords within patient care locations. **How the corrective action will be monitored to ensure the deficient practice will not recur:** The Maintenance Director/Designee will conduct rounds of 5 rooms for 12 weeks, then monthly rounds of 5 rooms for 12 weeks. Any discrepancies found will be immediately corrected and re-education will be provided. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for three months and then quarterly thereafter once full compliance has been achieved for a total of 6 months of monitoring. Frequency and duration of reviews will be increased as needed, if areas of noncompliance exist.	