STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	ľ	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER 155222		A. BUILDING B. WING		COMPLETED 10/28/2024		
		100222	В. "			10/20/2		
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP COD LINCOLN RD			
KOKOMO HEALTHCARE CENTER				KOKOMO, IN 46902				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION			ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX				PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION	
TAG E 0000				TAG	DEFICIENC!)		DATE	
_ 0000								
Bldg								
		paredness Survey was	E 0	E 0000	Please accept this plan of			
	_	ndiana Department of Health in			correction as the provider's			
	accordance with 42 CFR 483.73.				credible allegation of complian			
	Survey Date: 10/28	8/24			The provider respectfully requal a desk review with paper			
	Facility Number: 000127 Provider Number: 155222 AIM Number: 100291430				compliance to be considered establishing that the provider			
					substantial compliance.	15 111		
					Substantial compilarioe.			
	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 63 at the time of this survey.							
	or tins survey.							
	Quality Review con	mpleted on 10/30/24						
K 0000								
Bldg. 01								
Diag. 01	A Life Safety Code	Recertification and State	K 0	000	Please accept this plan of			
	1	vas conducted by the Indiana	IX 0	000	correction as the provider's			
	1	lth in accordance with 42 CFR			credible allegation of complian	nce.		
	483.90(a).				The provider respectfully requ	ıests		
					a desk review with paper			
	Survey Date: 10/28	8/24			compliance to be considered			
	Facility Nameba	000127			establishing that the provider	is in		
	Facility Number: (Provider Number:				substantial compliance.			
	AIM Number: 100291430							
	1002							
	At this Life Safety	Code survey, Kokomo						
	Healthcare Center was found not in compliance							
	with Requirements	for Participation in						
l .	I		1		į.			

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

(X6) DATE

TITLE

Sydnie Reed Executive Director 11/14/2024

Any defiency statement 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 disclodays 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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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN OF CORRECTION IDENTIFICATION		IDENTIFICATION NUMBER	A. BUILDING <u>01</u>			COMPLETED		
155222		B. W	B. WING			10/28/2024		
NAME OF PROVIDER OR SUPPLIER KOKOMO HEALTHCARE CENTER				STREET ADDRESS, CITY, STATE, ZIP COD 429 W LINCOLN RD KOKOMO, IN 46902				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID PROVIDER'S PLAN OF CORRECTION			(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		TE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
K 0321 SS=E Bldg. 01	REGULATORY OR LSC IDENTIFYING INFORMATION 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 II (000) 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 powered smoke detectors in the resident sleeping rooms. The facility has a capacity of 80 and had a census of 63 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 10/30/24 NFPA 101 Hazardous Areas - Enclosure			TAG DEFICIENCY)				
	failed to ensure 1 of as trash collection rewere separated from resistant partitions a closing or automatic 7.2.1.8. This deficit residents, staff and room. Findings include: Based on observation Director and Executive facility from 1:4	on and interview, the facility f over 9 hazardous areas such cooms (exceeding 64 gallons) in other spaces by smoke and doors. Doors shall be self to closing in accordance with ent practice could affect over 20 visitors in the main dining ons with the Maintenance tive Director during a tour of 15 p.m. to 3:15 p.m. on 10/28/24, capacity portable trash	K 0	321	What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice: The facility adjusted the kitchen doors to ensure they were able to self-close upon release. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: The alleged deficient practice has the potential to affect up to 20	the e e e	11/20/2024	

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Event ID:

GEGS21 Facility ID: 000127

If continuation sheet Page 2 of 5

STATEMENT OF DEFICIENCIES X1) PROV		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDE		IDENTIFICATION NUMBER	a. building <u>01</u>		COMPLETED		
155222		B. WING			10/28/	10/28/2024	
				CTREET	ADDRESS CITY STATE ZIR COD	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIEI	R			ADDRESS, CITY, STATE, ZIP COD		
WOWOMO LIENTING A DE CENTED					LINCOLN RD		
KUKUM	O HEALTHCARE C	ENTER		KUKUN	MO, IN 46902		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TF.	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	containers were sto	red in the kitchen. The two			residents, staff, and visitors. A	\	
	side by side entry d	loors to the kitchen from the			whole house audit of all hazar	dous	
	main dining room	were equipped with a self			area doors was completed du	ring	
	closing device and	latching hardware but the			the survey with no other		
	doors failed to fully	y self close and latch into the			discrepancies noted in the 2567.		
	door frames when tested to close multiple times.				·		
	Both doors were ru	bbing on the floor, which			What measures will be put in	nto	
	prevented them fro	m closing fully and latching			place or what systemic		
	into the frame. Bas	ed on interview at the time of		changes will be made to			
	the observations, th	ne Executive Director agreed			ensure that the deficient		
	the aforementioned	hazardous area was not			practice does not recur:		
	separated from other	er spaces by smoke resistant			Education was completed with	1	
	partitions and doors due to the kitchen doors not				maintenance staff with an		
	self closing and latching into the door frame.			emphasis on K321 Life Safety		<i>'</i>	
					Code with an emphasis on		
	This finding was re	eviewed with the Executive			7.2.1.8.		
	Director and Maint	enance Director during the exit					
	conference.				How the corrective action wi	II	
					be monitored to ensure the		
	3.1-19(b)				deficient practice will not		
					recur: The Maintenance		
					Director/Designee will conduc	t	
					weekly rounds for 12 weeks, t	hen	
					monthly rounds for 12 weeks	to	
					ensure all hazardous areas ar	e	
					separated from other spaces I	by	
					smoke resistant doors that		
					self-close upon release. Any		
					discrepancies found will be		
					immediately corrected. The re	sults	
					of these reviews will be discus	sed	
					at the monthly facility Quality		
					Assurance Committee meetin	•	
					monthly for three months and	then	
					quarterly thereafter once full		
					compliance has been achieve		
					a total of 6 months of monitori	-	
					Frequency and duration of rev		
					will be increased as needed, i		
					areas of noncompliance exist.		

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	a. building <u>01</u>		COMPLETED		
155222		B. W	B. WING 10			10/28/2024	
NA 55 05 5	DOLUMBER OF STARY			STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF PROVIDER OR SUPPLIER				429 W	LINCOLN RD		
KOKOMO HEALTHCARE CENTER				KOKON	MO, IN 46902		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL DEFINITION OF THE PROPERTY OF T			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX				PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY		DATE
K 0920	NFPA 101						
SS=E	Electrical Equipment - Power Cords and						
Bldg. 01	Extens						
	Based on observation and interview, the facility		K 0	920	What corrective action will be accomplished for those		11/20/2024
		iled to ensure in 1 of 1 Wound Care room that					
		not used as a substitute for			residents found to have been		
	_	1.2 requires electrical wiring			affected by the alleged		
		be in accordance with NFPA			deficient practice: The facility		
	· ·	cal Code. NFPA 70, 2011			immediately corrected the alleged		
	· ·	.8 requires that, unless			deficiency during the survey, a	as	
	specifically permitted, flexible cords and cables				stated on page 5 of the 2567.		
	shall not be used as a substitute for fixed wiring of					_	
	a structure. This deficient practice affects staff and up to 18 residents in one smoke compartment.			How other residents			
					potential to be affected by th		
					same deficient practice will b		
	Findings include:				identified and what correctiv	е	
	.	14 4 F 2 5 F			action will be taken: The		
		on with the Executive Director			alleged deficient practice has	the	
		irector on 10/28/24 during a			potential to affect up to 18		
	tour of the facility from 1:45 p.m. to 3:15 p.m., a				residents. A whole house audit of		
	power strip plugged into the wall had another power strip plugged into it powering computer				employee offices was complete		
					during the survey with no other		
	equipment in the Wound Care room. This room is located across the corridor from the nurse station in the 400 wing on the south side of the facility. Based on interview at the time of observation, the Maintenance Director confirmed a power strip had another power strip plugged into it and was powering computer equipment. The Maintenance Director unplugged the daisy chained power strip				discrepancies noted in the 256	JI.	
					What measures will be put in	nto.	
					place or what systemic		
					changes will be made to		
					ensure that the deficient		
					practice does not recur:		
					Education was completed with	the	
and plugged it directly into the wa					management team on NFPA		
	observation.	1			National Electrical Code. NFP	-	
	This finding was reviewed with the Executive				70, 2011 Edition, Article 400.8		
					with an emphasis on ensuring		
		enance Director at the exit			flexible cords are not used as		
	conference.				substitute for fixed wiring.		
	3.1-19(b)				How the corrective setion		
	J.1-19(U)				How the corrective action wi	"	
					deficient practice will not		

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155222	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 10/28/2024			
NAME OF PROVIDER OR SUPPLIER KOKOMO HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP COD 429 W LINCOLN RD KOKOMO, IN 46902					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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 APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE			
	REGULATORY OR ESC IDENTIFYING INFORMATION			recur: The Maintenance Director/Designee will conduct weekly rounds of 5 offices for weeks, then monthly rounds o offices for 12 weeks to ensure flexible cords are not used as substitute for fixed wiring. Any discrepancies found will be immediately corrected. The re- of these reviews will be discus at the monthly facility Quality Assurance Committee meeting monthly for three months and quarterly thereafter once full compliance has been achieved a total of 6 months of monitori Frequency and duration of rev will be increased as needed, if areas of noncompliance exist.	12 f 4 a / sults ssed then d for ng. iews			

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