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	10/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
KOKOMO HEALTHCARE CENTER	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 10/28/24 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 63 at the time of this survey. Quality Review completed on 10/30/24	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: 10/28/24 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	11/14/2024

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 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			
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Based on observation and interview, the facility failed to ensure 1 of over 9 hazardous areas such as trash collection rooms (exceeding 64 gallons) were separated from other spaces by smoke resistant partitions and doors. Doors shall be self closing or automatic closing in accordance with 7.2.1.8. This deficient practice could affect over 20 residents, staff and visitors in the main dining room. Findings include: Based on observations with the Maintenance Director and Executive Director during a tour of the facility from 1:45 p.m. to 3:15 p.m. on 10/28/24, over two 32 gallon capacity portable trash	K 0321	**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	11/20/2024

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	155222	A. BUILDING 01 B. WING	10/28/2024

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	containers were stored in the kitchen. The two side by side entry doors to the kitchen from the main dining room were equipped with a self closing device and latching hardware but the doors failed to fully self close and latch into the door frames when tested to close multiple times. Both doors were rubbing on the floor, which prevented them from closing fully and latching into the frame. Based on interview at the time of the observations, the Executive Director agreed the aforementioned hazardous area was not separated from other spaces by smoke resistant partitions and doors due to the kitchen doors not self closing and latching into the door frame. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference. 3.1-19(b)		residents, staff, and visitors. A whole house audit of all hazardous area doors was completed during the survey with no other discrepancies noted in the 2567. **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 K321 Life Safety Code with an emphasis on 7.2.1.8. **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 to ensure all hazardous areas are separated from other spaces by smoke resistant doors that self-close upon release. Any discrepancies found will be immediately corrected. 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.	

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K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Based on observation and interview, the facility failed to ensure in 1 of 1 Wound Care room that flexible cords were not used as a substitute for fixed wiring. LSC 9.1.2 requires electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code. NFPA 70, 2011 Edition, Article 400.8 requires that, unless specifically permitted, flexible cords and cables 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. Findings include: Based on observation with the Executive Director and Maintenance Director on 10/28/24 during a tour of the facility from 1:45 p.m. to 3:15 p.m., a power strip plugged into the wall had another power strip plugged into it powering computer 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 and plugged it directly into the wall upon observation. This finding was reviewed with the Executive Director and Maintenance Director at 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 facility immediately corrected the alleged deficiency during the survey, as stated on page 5 of the 2567. **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 18 residents. A whole house audit of employee offices was completed during the survey with no other discrepancies noted in the 2567. **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 the management team on NFPA 70, National Electrical Code. NFPA 70, 2011 Edition, Article 400.8 with an emphasis on ensuring flexible cords are not used as a substitute for fixed wiring. **How the corrective action will be monitored to ensure the deficient practice will not**	11/20/2024

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			recur: The Maintenance Director/Designee will conduct weekly rounds of 5 offices for 12 weeks, then monthly rounds of 4 offices for 12 weeks to ensure flexible cords are not used as a substitute for fixed wiring. Any discrepancies found will be immediately corrected. 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.	