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

FORM APPROVED
OMB NO. 0938-039

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	11/13/2023

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: 11/13/23 Facility Number: 000127 Provider Number: 155222 AIM Number: 100291430 At this Emergency Preparedness survey, Kokomo Healthcare Center was found not 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 70 at the time of this survey. Quality Review completed on 11/20/23 The requirements of 42 CFR, Subpart 483.73 are Not Met as evidenced by:	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.	
E 0039 SS=F Bldg. --	403.748(d)(2), 416.54(d)(2), 418.113(d)(2), 441.184(d)(2), 482.15(d)(2), 483.475(d)(2), 483.73(d)(2), 484.102(d)(2), 485.625(d)(2), 485.68(d)(2), 485.727(d)(2), 485.920(d)(2), 486.360(d)(2), 491.12(d)(2), 494.62(d)(2) EP Testing Requirements §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, OPO, "Organizations" under §485.727,			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Sydnie Reed	Executive Director	12/08/2023

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.

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	11/13/2023

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
	CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2) (i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed.			

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	11/13/2023

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
	*[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following:			

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	11/13/2023

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
	(i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or			

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	11/13/2023

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
	(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or			

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	11/13/2023

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
	(B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an			

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	11/13/2023

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

actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event.
(ii) Conduct an additional annual exercise that may include, but is not limited to the following:
(A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or
(B) A mock disaster drill; or
(C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.
(iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed.

*[For ICF/IIDs at §483.475(d)]:
(2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following:
(i) Participate in an annual full-scale exercise that is community-based; or
(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or.
(B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required

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	11/13/2023

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

full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event.
(ii) Conduct an additional annual exercise that may include, but is not limited to the following:
(A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or
(B) A mock disaster drill; or
(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.
(iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed.

*[For HHAs at §484.102]
(d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following:
(i) Participate in a full-scale exercise that is community-based; or
(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or.
(B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event.

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	11/13/2023

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
	(ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop			

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	11/13/2023

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
	exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed.			
	Based on record review and interview, the facility failed to conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The LTC facility must do the following: (i) Participate in an annual full-scale exercise that is community-based; or a. When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. b. If the LTC facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required full-scale in a community-based or individual, facility-based full-scale functional exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following: a. A second full-scale exercise that is	E 0039	**What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice:** No resident was harmed by the facilities alleged deficient practice. Facility completed an ad hoc exercise on 11/29/23 to review EPP policies were followed and outcomes reviewed were documented on the exercise. **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. Facility completed an ad hoc exercise on 11/29/23 to	12/15/2023

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	11/13/2023

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
	community-based or an individual, facility-based functional exercise. b. A mock disaster drill; or c. A tabletop exercise or workshop that is led by a facilitator that includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the LTC facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the LTC facility's emergency plan, as needed in accordance with 42 CFR 483.73(d)(2). This deficient practice could affect all occupants. Findings include: Based on records review with the Administrator and the Maintenance Supervisor on 11/13/23 at 01:00 p.m., documentation for the community-based exercise conducted on 04/04/23 and the facility-based exercise conducted on 09/28/23 were incomplete. Both exercises did not show if the facility's response was analyzed to ensure the EPP policies were effective. Based on interview at the time of records review, the Maintenance Supervisor stated no documentation for analyzing the LTC facility's response was completed. These findings were reviewed with the Administrator and Maintenance Supervisor at the exit conference.		review EPP policies were followed and outcomes reviewed were documented on the exercise. **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 on CFR 483.73 with an emphasis on documenting the analysis of the exercise to ensure the EPP policies were followed. **How the corrective action will be monitored to ensure the deficient practice will not recur:** The Executive Director/Designee will audit all exercises completed in regards to testing the emergency plan for 6 months. 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 0000 Bldg. 01	A Life Safety Code Recertification and State	K 0000	Please accept this plan of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155222	A. BUILDING 01 B. WING	11/13/2023

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
	Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 11/13/2023 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 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 70 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 11/20/23		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 0211 SS=E Bldg. 01	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155222	A. BUILDING 01 B. WING	11/13/2023

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
	of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 Based on observation and interview, the facility failed to ensure 1 of 6 means of egress were continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. This deficient practice could affect 10 residents in the 400 hall. Findings include: Based on an observation during a tour of the facility with the Maintenance Supervisor (MS) on 11/13/23 at 2:40 p.m., the corridor by resident room 415 contained a wood framed chair with padded seat that was not attached to the floor or wall. Based on an interview at the time of observations, the MS agreed there was a chair stored in the corridor that was not attached to the floor or wall. This finding was reviewed with the Administrator and MS during the exit conference. 3.1-19(b)	K 0211	**What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice:** No resident was harmed by the facilities alleged deficient practice. Facility immediately removed the chair in the corridor 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:** This alleged deficient practice has the potential to affect 10 residents in the facility. Facility completed a whole house audit on 11/7/23 to ensure all 6 means of egress were free of all obstructions. **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 direct care staff on ensuring all 6 means of egress remain free of all obstructions. **How the corrective action will be monitored to ensure the deficient practice will not recur:** The Maintenance Director/Designee will audit all 6 means of egress 3 times per week	12/15/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155222	A. BUILDING 01 B. WING	11/13/2023

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
			for 4 weeks, 1 time per week for 8 weeks, then 1 time per month for 3 months to ensure all are free of obstructions. 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 0300 SS=E Bldg. 01	NFPA 101 Protection - Other Protection - Other List in the REMARKS section any LSC Section 18.3 and 19.3 Protection requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Based on observation and interview; the facility failed to ensure 60 of 80 battery operated smoke alarms in resident rooms were maintained. NFPA 101 in 4.6.12.3 states existing life safety features obvious to the public, if not required by the Code, shall be maintained. NFPA 72, National Fire Alarm and Signaling Code, 2010 Edition, Section 29.10 states fire-warning equipment shall be maintained and tested in accordance with the manufacturer's published instructions and per the requirements of Chapter 14. Section 14.2.1.1.1 Inspection, testing, and maintenance programs shall satisfy	K 0300	**What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice:** No resident was harmed by the facilities alleged deficient practice. Facility replaced all 60 smoke detectors on 11/14/23. **How other residents having the potential to be affected by the same deficient practice will be**	12/15/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155222	A. BUILDING 01 B. WING	11/13/2023

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
	the requirements of this Code and conform to the equipment manufacturer's published instructions. Section 14.4.8.1 states unless otherwise recommended by the manufacturer's published instructions, single- and multiple-station smoke alarms shall be replaced when they fail to respond to operability tests but shall not remain in service longer than 10 years from the date of manufacture. This deficient practice could affect 60 residents. Findings include: Based on observation and interview; the facility failed to ensure all battery operated smoke alarms in resident rooms were manufactured within the past 10 years. Based on observation at 02:20 p.m. on 11/13/23, two battery operated smoke alarms pressented by the Maintenance Supervisor from resident rooms for inspection, had a manufacture date of 01/25/2012 which is more than 10 years old . Based on interview with the Maintenance Supervisor, he stated that he was working to replace all of the smoke alarms in the resident sleeping rooms. The Maintenance Supervisor indicated he had replaced about 20 battery operated smoke alarms in the residents' rooms with about 60 more to replace at the time of this survey. This deficiency was discussed with Maintenance Supervisor and Administrator at the exit conference. 3.1-19(c)		**identified and what corrective action will be taken:** This alleged deficient practice has the potential to affect 60 residents in the facility. Facility replaced all 60 smoke detectors on 11/14/23. **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 on NFPA 72 section 14.4.8.1. with an emphasis on replacing battery operated smoke detectors every 10 years. **How the corrective action will be monitored to ensure the deficient practice will not recur:** The Maintenance Director/Designee will audit battery operated smoke detectors 3 times per week for 4 weeks, 1 time per week for 8 weeks, then 1 time per month for 3 months to ensure all have been manufactured within the last 10 years. 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	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155222	A. BUILDING 01 B. WING	11/13/2023

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
			increased as needed, if areas of noncompliance exist.	
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322)			
	Based on observation and interview, the facility failed to ensure the corridor doors to 2 of 2	K 0321	**What corrective action will be accomplished for those**	12/15/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155222	A. BUILDING 01 B. WING	11/13/2023

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
	hazardous rooms were provided with a self-closing device which would cause the door to automatically close and latch into the door frame. This deficient practice could affect 15 residents in two smoke compartments. Findings include: Based on observations during a tour of the facility with the Maintenance Supervisor (MS) on 11/13/23 between 02:25 p.m. and 02:55 p.m., the corridor doors to the following hazardous areas did not meet the requirements for protection of a hazardous area: a) Both doors to the Activity room which was larger than 50 square feet and contained over 20 boxes of supplies had self-closing devices but the doors did not close and latch when tested. b) The Laundry room larger than 100 square feet, which contained trash and dirty linen did not latch into the frame because the closer arm was disconnected. Based on interview at the time of observation, the MS agreed both rooms were hazardous storage areas and the doors to the rooms were self-closing but did not latch into the frame. This finding was reviewed with the Administrator and MS during the exit conference. 3.1-19(b)		**residents found to have been affected by the alleged deficient practice:** No resident was harmed by the facilities alleged deficient practice. Facility immediately repaired the laundry door during the survey and Activities door was completed 12/7/23. **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 15 residents in the facility. Facility completed an audit of all hazardous area doors to ensure all latched properly. **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 activities and housekeeping staff on TELS system to ensure they know how to report if the doors do not latch. **How the corrective action will be monitored to ensure the deficient practice will not recur:** The Maintenance Director/Designee will audit all hazardous area doors 3 times per week for 4 weeks, 1 time per week for 8 weeks, then 1 time per month for 3 months to ensure latch properly. Any discrepancies found will be immediately	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155222	A. BUILDING 01 B. WING	11/13/2023

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
			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 0324 SS=E Bldg. 01	NFPA 101 Cooking Facilities Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 Based on observation and interview, the facility failed to ensure staff were instructed in the use of	K 0324	**What corrective action will be accomplished for those**	12/15/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155222	A. BUILDING 01 B. WING	11/13/2023

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
	the UL 300 hood system in 1 of 1 Kitchen. NFPA 96, 11.1.4 states instructions for manually operating the fire extinguishing system shall be posted conspicuously in the kitchen and shall be reviewed with employees by management. This deficient practice could affect staff in the kitchen and 25 residents in the dining room. Findings include: Based on observation with the Maintenance Supervisor (MS) on 11/13/23 at 03:05 p.m., the kitchen was provided with a UL 300 hood system and a K-class fire extinguisher with posted instructions. Based on interview, the Cook was asked; what is the correct response if there was a grease fire underneath the hood. The employee replied; I would use the fire extinguisher. The employee failed to indicate activating the UL 300 hood extinguishing system first and then using the K class fire extinguisher for a hood grease fire. The MS acknowledged the Cooks response and educated the cook on the proper procedure. This finding was reviewed with the Administrator and MS at the exit conference. 3.1-19(b)		**residents found to have been affected by the alleged deficient practice:** No resident was harmed by the facilities alleged deficient practice. Facility immediately educated dietary staff during survey to ensure they were instructed in the use of UL 300 hood system. **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 25 residents in the dining room and staff in the kitchen. Facility completed education with all dietary staff to ensure they were instructed in the use of UL 300 hood system. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** Facility completed education with all dietary staff to ensure they were instructed in the use of UL 300 hood system. **How the corrective action will be monitored to ensure the deficient practice will not recur:** The Maintenance Director/Designee will survey dietary staff 3 times per week for 4 weeks, 1 time per week for 8 weeks, then 1 time per month for 3 months to ensure they have been instructed in the use of UL	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155222	A. BUILDING 01 B. WING	11/13/2023

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
			300 hood system. 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 0345 SS=F Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72			
	Based on observation and interview, the facility failed to ensure 1 of 1 fire alarm systems was continuously in proper operating condition. NFPA 72, National Fire Alarm and Signaling Code, 2010 Edition, Section 14.2.1.2.2 states system defects and malfunctions shall be corrected. This deficient practice could affect all residents, staff and visitors. Findings include:	K 0345	**What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice:** No resident was harmed by the facilities alleged deficient practice. Facility already had Koorsen scheduled to repair panel the next day, as stated in the 2567. Koorsen completed the repair as	12/15/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155222	A. BUILDING 01 B. WING	11/13/2023

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
	Based on observation of the fire alarm control panel on 11/13/23 at 03:00 p.m. during a tour of the facility with the Maintenance Supervisor (MS), there was a yellow trouble light illuminated on the fire alarm control panel. At the time of observation, the fire alarm system panel display showed that the trouble light was due to the North room smoke monitor. During an interview at the time of observation, the Maintenance Supervisor (MS) stated that the Fire Alarm Panel was scheduled to be repaired tomorrow. This finding was reviewed with the Administrator and MS at the exit conference. 3.1-19(b)		scheduled. **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, staff, and visitors. Facility had panel repaired the next day, as scheduled. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** Facility completed education with maintenance staff on ensuring the fire alarm system is continuously in proper operating condition. **How the corrective action will be monitored to ensure the deficient practice will not recur:** The Maintenance Director/Designee will audit the fire panel 3 times per week for 4 weeks, 1 time per week for 8 weeks, then 1 time per month for 3 months to the fire alarm system is continuously in proper operating condition. 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	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155222	A. BUILDING 01 B. WING	11/13/2023

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
			months of monitoring. Frequency and duration of reviews will be increased as needed, if areas of noncompliance exist.	
K 0355 SS=E Bldg. 01	NFPA 101 Portable Fire Extinguishers Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 Based on observation and interview, the facility failed to ensure 1 of 20 Portable Fire Extinguishers pressure gauge reading was in the acceptable range. LSC section 4.5.8 requires whenever or wherever any device, equipment, system, condition, arrangement, level of protection, or any other feature shall thereafter be maintained, unless the Code exempts such maintenance. NFPA 10, the Standard for Portable Fire Extinguishers, Chapter 7.2.2(3) requires the periodic monthly check shall ensure the pressure gauge reading is in the operable range. Chapter 7.2.3 requires when an inspection of any fire extinguisher reveals a deficiency in any of the conditions listed in 7.2.2, immediate corrective action shall be taken. This deficient practice could affect 5 residents. Findings include: Based on observation during a tour of the facility with the Maintenance Supervisor (MS) on 11/13/23 at 02:15 p.m., the pressure gauge reading was below the operable range for the fire extinguisher located in the boiler room. Based on interview at the time of observation, the MS confirmed the pressure gauge reading was below	K 0355	**What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice:** No resident was harmed by the facilities alleged deficient practice. Facility immediately replace fire extinguisher with low pressure 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:** This alleged deficient practice has the potential to affect 5 residents. Facility completed whole house audit on fire extinguishers to ensure all 20 were within acceptable pressure ranges. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** Facility completed education with	12/15/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155222	A. BUILDING 01 B. WING	11/13/2023

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
	the operable range for the fire extinguisher located in the boiler room. This finding was reviewed with the Administrator and MS at the exit conference. 3.1-19(b)		maintenance staff on ensuring replacing fire extinguishers immediately if they are not within acceptable ranges. **How the corrective action will be monitored to ensure the deficient practice will not recur:** The Maintenance Director/Designee will audit the fire extinguishers 3 times per week for 4 weeks, 1 time per week for 8 weeks, then 1 time per month for 3 months to ensure the pressure gauges are within acceptable ranges. 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=D 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			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155222	A. BUILDING 01 B. WING	11/13/2023

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
	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 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 corridor 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 the vicinity of resident room 425.	K 0363	**What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice:** No resident was harmed by the facilities alleged deficient practice. Facility repaired room 425 and the Beauty	12/15/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155222	A. BUILDING 01 B. WING	11/13/2023

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
	Findings include: 1. Based on observation with the Maintenance Supervisor (MS) on 11/13/23 at 02:35 p.m., the corridor door to resident sleeping room 425 would not close and latch into the frame when tested. Based on interview at the time of observation, the MS agreed the corridor door to room 425 would not close and latch into the door frame. The finding was reviewed with the Administrator and MS during the exit conference. 3.1-19(b) Findings include: 2. Based on observation with the Maintenance Supervisor (MS) on 11/13/23 at 02:35 p.m., the door to the Beauty Shop was equipped with a self-closing device, but the self-closing device would not fully close and latch to keep the door in the closed position. Based on interview at the time of observation, the MS agreed the self-closing device on the door to the Beauty Shop was not functioning properly as it did not allow the door to self latch when tested. The finding was reviewed with the Administrator and MS during the exit conference. 3.1-19(b)		Shop doors on 11/15/23. **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 2 residents. Facility completed whole house audit on all corridor doors to ensure all latch properly. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** Facility completed education with maintenance staff on ensuring all corridor doors are provided with the means suitable for keeping the door closed, has no impediment to closing, latching, and would resist the passage of smoke. **How the corrective action will be monitored to ensure the deficient practice will not recur:** The Maintenance Director/Designee will audit 5 doors per week for 4 weeks, 3 doors per week for 8 weeks, then 3 doors per month for 3 months to ensure the pressure gauges are within acceptable ranges. 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	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155222	A. BUILDING 01 B. WING	11/13/2023

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
			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 0511 SS=E Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 Based on observation and interview, the facility failed to ensure 2 of over 20 ground fault circuit interrupter (GFCI) was properly maintained for protection against electric shock. NFPA 70, NEC 2011 Edition at 210.8 Ground-Fault Circuit-Interrupter Protection for Personnel, states, ground-fault circuit-interruption for personnel shall be provided as required in 210.8. This deficient practice could affect 4 residents. Findings include: 1. Based on observation with the Maintenance Supervisor (MS) on 11/13/23 between 01:55 and 02:05 p.m. when the electric receptacle located 3 feet from the sink in the room 303 at Nurses station West was tested with a GFCI tester the electric receptacle failed to trip and did not break the electrical circuit. Based on interview at the time of observation, the MS agreed the electric receptacle 3 feet from the sink was not GFCI protected..	K 0511	**What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice:** No resident was harmed by the facilities alleged deficient practice. Facility bypassed both circuits in room 303 and at West's nurse's station to outlets that are more than 3 feet away from the sink on 12/8. The West nurse's station electric panel was immediately corrected 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:** This alleged deficient practice has the potential to affect 4 residents in the facility. Facility completed an	12/15/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155222	A. BUILDING 01 B. WING	11/13/2023

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
	This finding was reviewed with the Administrator and the MS during the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 5 electrical panels in the West nurses station was secured from non-authorized personnel. NFPA 70, 2011 edition states 230.62 Energized parts of service equipment shall be enclosed as specified in 230.62(A) or guarded as specified in 230.62(B). (A) Enclosed. Energized parts shall be enclosed so that they will not be exposed to accidental contact or shall be guarded as in 230.62(B). (B) Guarded. Energized parts that are not enclosed shall be installed on a switchboard, panelboard, or control board and guarded in accordance with 110.18 and 110.27. Where energized parts are guarded as provided in 110.27(A)(1) and (A)(2), a means for locking or sealing doors providing access to energized parts shall be provided. This deficient practice could affect 10 residents in the vicinity of the West Nurses station. Findings include: Based on observation with Administrator and MS on 11/13/23 at 02:05 p.m., the electrical panel in the West nurses station was unlocked when tested. The panel included breakers to the lights, emergency lighting, and outlets in the West Hall. Based on interview at the time of observation, the MS stated the electrical panel will need to be locked. This finding was reviewed with the Administrator and MS at the exit conference.		audit of outlets on West unit to ensure there are no others that are within 3 feet of a sink. Facility also completed an audit of all electric panels to ensure all are properly secured with no concerns noted on 11/14. **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 to ensure all GFCI are properly maintained for protection against electric shock and that electrical panels are secured from non-authorized personnel. **How the corrective action will be monitored to ensure the deficient practice will not recur:** The Maintenance Director/Designee will audit 3 GFCI outlets per week for 4 weeks, 2 GFCI outlet per week for 8 weeks, then 1 GFCI outlet per month for 3 months to ensure they are properly maintained. The Maintenance Director/Designee will audit 3 electric panels per week for 4 weeks, 2 electric panels per week for 8 weeks, then 1 electric panel per month for 3 months 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	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155222	A. BUILDING 01 B. WING	11/13/2023

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
	3.1-19(b)		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 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 conduct fire drills on each shift for 1 of 2 quarters. LSC 19.7.1.6 states drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions. This deficient practice affects all staff and residents. Findings include: Based on records review with the Maintenance Supervisor (MS) on 11/13/23 at 10:00 a.m., no documentation was available to show a third shift fire drill for the second quarter of 2023 was	K 0712	**What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice:** No resident was harmed by the facilities alleged deficient practice. Education was completed with maintenance staff with an emphasis on LSC 19.7.1.6 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**	12/15/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155222	A. BUILDING 01 B. WING	11/13/2023

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
	conducted. Based on interview at the time of record review, the MS stated the aforementioned drill was not conducted. This finding was reviewed with the Administrator and MS during the exit conference. 3.1-19(b) 3.1-51(c)		**identified and what corrective action will be taken:** This alleged deficient practice has the potential to affect all residents in the facility. All other fire drills had appropriate documentation for fire drill completion. **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 LSC 19.7.1.6 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.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155222	A. BUILDING 01 B. WING	11/13/2023

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
K 0754 SS=E Bldg. 01	NFPA 101 Soiled Linen and Trash Containers Soiled Linen and Trash Containers Soiled linen or trash collection receptacles shall not exceed 32 gallons in capacity. The average density of container capacity in a room or space shall not exceed 0.5 gallons/square feet. A total container capacity of 32 gallons shall not be exceeded within any 64 square feet area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gallons shall be located in a room protected as a hazardous area when not attended. Containers used solely for recycling are permitted to be excluded from the above requirements where each container is less than or equal to 96 gallons unless attended, and containers for combustibles are labeled and listed as meeting FM Approval Standard 6921 or equivalent. 18.7.5.7, 19.7.5.7			
	Based on observation and interview, the facility failed to ensure trash receptacles were maintained in accordance with 19.7.5.7. This deficient practice could affect staff and up to 5 residents in the Activity office. Findings include: Based on observations during a tour of the facility with the Maintenance Supervisor (MS) on 11/13/23 at 02:25 p.m., there was a 40-gallon trash collection receptacle in use in the Activity office. In K321 tag of this survey, the Activity office was determined to be a Hazardous storage area but the doors (2) did not self close and latch when tested. Based on interview at the time of observation, the MS agreed there was a 40-gallon trash barrel in use in the Activity office but the doors did not	K 0754	**What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice:** No resident was harmed by the facilities alleged deficient practice. Facility immediately removed the 40 gallon trash container from the activities room on 11/13/23. **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 5 residents. Facility completed whole house	12/15/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155222	A. BUILDING 01 B. WING	11/13/2023

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
	self close and latch when tested. The finding was reviewed with the Administrator and the MS during the exit conference. 3.1-19(b)		audit all hazardous area doors to ensure all latched properly. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** Facility completed education with maintenance staff on ensuring all hazardous area doors latch properly to ensure trash receptacles are maintained. **How the corrective action will be monitored to ensure the deficient practice will not recur:** The Maintenance Director/Designee will audit all hazardous area doors 3 times per week for 4 weeks, 1 time per week for 8 weeks, then 1 time per month for 3 months to ensure latch properly. 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.	