	OF HEALTH AND HU					RM APPROVED
STATEMEN	R MEDICARE & MEDIC IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155222	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE COMPL 11/13/	ETED
NAME OF PROVIDER OR SUPPLIER KOKOMO HEALTHCARE CENTER		429 W I	ADDRESS, CITY, STATE, ZIP COD LINCOLN RD MO, IN 46902			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
E 0000	conducted by the Ir accordance with 42 Survey Date: 11/1: Facility Number: 0 Provider Number: 100 At this Emergency Healthcare Center with Emergency Pr Medicare and Mediand Suppliers, 42 C capacity of 80 and of this survey. Quality Review con	3/23 00127 155222	E 0000	Please accept this plan of correction as the provider's credible allegation of compliar The provider respectfully requa a desk review with paper compliance to be considered i establishing that the provider substantial compliance.	ests n	

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

*[For ASCs at §416.54, CORFs at §485.68, OPO, "Organizations" under §485.727,

Not Met as evidenced by:

EP Testing Requirements

(2), §491.12(d)(2), §494.62(d)(2).

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)

§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)

E 0039

SS=F

Bldg. --

(X6) DATE

TITLE

Sydnie Reed Executive Director 12/08/2023

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 NUMBER	A. BUILDING			COMPLETED		
		155222	B. WIN	B. WING			11/13/2023	
			'	STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF F	PROVIDER OR SUPPLIER	8			INCOLN RD			
KOKOMO	O HEALTHCARE C	ENTER			10, IN 46902			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	CY MUST BE PRECEDED BY FULL	F	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE.	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	_	20, RHCs/FQHCs at						
	§491.12, and ESF 	RD Facilities at §494.62]:						
	(2) Tooting The If	acility) must conduct						
		acility] must conduct he emergency plan						
		ility] must do all of the						
	following:	inty] must do an or the						
	ionowing.							
	(i) Participate in a	full-scale exercise that is						
	community-based							
	(A) When a comn	nunity-based exercise is						
	not accessible, co	nduct a facility-based						
	functional exercise	e every 2 years; or						
	(B) If the [faci	lity] experiences an actual						
		ade emergency that requires						
		mergency plan, the [facility]						
	-	gaging in its next required						
	1	or individual, facility-based						
		e following the onset of the						
	actual event.							
	1 ' '	ditional exercise at least						
		posite the year the full-scale						
		cise under paragraph (d)(2)						
		s conducted, that may						
		limited to the following: scale exercise that is						
	1 ' '	or individual, facility-based						
	functional exercise							
	(B) A mock disast							
	1 ' '	ercise or workshop that is						
	1 ' '	and includes a group						
	discussion using a							
		emergency scenario, and a						
	set of problem sta							
	1	pared questions designed						
	to challenge an er	nergency plan.						
	(iii) Analyze the [fa	acility's] response to and						
	maintain documer	ntation of all drills, tabletop						
		nergency events, and revise						
	the [facility's] eme	rgency plan, as needed.						

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Event ID:

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

PRINTED: 12/12/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING			COMPLETED	
		155222	B. Wl	ING		11/13/2023		
NAME OF T	DDOMINED OD GUDDI IEI		-	STREET A	ADDRESS, CITY, STATE, ZIP COD	-		
NAME OF F	PROVIDER OR SUPPLIEF			429 W I	LINCOLN RD			
KOKOMO	O HEALTHCARE C	ENTER		KOKOMO, IN 46902				
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY		DATE	
	*[For Hospices at	418.113(d):1						
		spices that provide care in						
	. ,	e. The hospice must						
		to test the emergency						
	plan at least annu	ally. The hospice must do						
	the following:							
		a full-scale exercise that is						
	community based							
	' '	nunity based exercise is not						
		ect an individual facility exercise every 2 years; or						
		experiences a natural or						
		ency that requires activation						
	_	plan, the hospital is						
		aging in its next required full						
		based exercise or individual						
	facility-based fund	ctional exercise following the						
	onset of the emer	gency event.						
	' '	dditional exercise every 2						
		e year the full-scale or						
		e under paragraph (d)(2)(i)						
		conducted, that may						
	The second secon	limited to the following:						
	, ,	scale exercise that is or a facility based						
	functional exercise	_						
	(B) A mock disas	•						
	` '	ercise or workshop that is						
		and includes a group						
	discussion using a	- ·						
	clinically-relevant	emergency scenario, and a						
	set of problem sta							
		pared questions designed						
	to challenge an er	mergency plan.						
	(3) Testing for hos	spices that provide inpatient						
	-	hospice must conduct						
		he emergency plan twice						
	per year. The hos	spice must do the following:						

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Facility ID: 000127

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CENTERS FO	R MEDICARE & MEDIC	CAID SERVICES				Ol	MB NO. 0938-039	
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATI	E SURVEY	
AND PLAN	N OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	<u></u>	COMP	PLETED	
		155222	B. W	NG		11/13	3/2023	
				STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF	PROVIDER OR SUPPLIE	R			LINCOLN RD			
KOKOM	IO HEALTHCARE C	ENTER			10, IN 46902			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTION		ION	(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPRO	O BE	COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
		an annual full-scale exercise						
	that is community	/-based; or						
	(A) When a comn	nunity-based exercise is not						
	accessible, condu	uct an annual individual						
	-	ctional exercise; or						
	1 ' '	experiences a natural or						
	_	gency that requires activation						
		plan, the hospice is						
		aging in its next required						
		nity based or facility-based						
		se following the onset of the						
	emergency event							
	` '	dditional annual exercise						
		but is not limited to the						
	following:	and average that is						
	1 ' '	-scale exercise that is						
	functional exercis	d or a facility based						
	(B) A mock disas							
	` '	kercise or workshop led by a						
	1 ' '	ludes a group discussion						
		clinically-relevant						
		ario, and a set of problem						
		ted messages, or prepared						
		ed to challenge an						
	emergency plan.							
		hospice's response to and						
		ntation of all drills, tabletop						
		nergency events and revise						
		ergency plan, as needed.						
	-	441.184(d), Hospitals at						
	- ' '	s at §485.625(d):]						
		PRTF, Hospital, CAH] must	1					
		s to test the emergency						
		ar. The [PRTF, Hospital,						
	CAH] must do the	_						
	(ı) Participate in a	an annual full-scale exercise					1	

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that is community-based; or

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CENTERS FOR MEDICARE & MEDICAID SERVICES						OM	IB NO. 0938-039	
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. Bl	UILDING	<u></u>	COMPLETED		
		155222	B. W	ING		11/13	11/13/2023	
				STREET /	ADDRESS, CITY, STATE, ZIP COD			
NAME OF 1	PROVIDER OR SUPPLIEI	R			LINCOLN RD			
KOKOMO HEALTHCARE CENTER				MO, IN 46902				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTIO	N	(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROF	BE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	(A) When a comm	nunity-based exercise is not						
	accessible, condu	uct an annual individual,						
	facility-based fund	ctional exercise; or						
	(B) If the [PRTF, I	Hospital, CAH] experiences						
	an actual natural	or man-made emergency						
	that requires activ	vation of the emergency						
		is exempt from engaging in						
		ull-scale community based						
		ity-based functional exercise						
	· ·	et of the emergency event.						
	_	an [additional] annual						
	` '	nat may include, but is not						
	limited to the follo							
	(A) A second full-scale exercise that is							
	community-based							
		ctional exercise; or						
		ock disaster drill; or						
	, ,	p exercise or workshop that						
		tor and includes a group						
	discussion, using	~ .						
	_	emergency scenario, and a						
	-	atements, directed						
	1 .	pared questions designed						
	to challenge an e							
	_	he [facility's] response to						
	, ,	umentation of all drills,						
		s, and emergency events						
	•	cility's] emergency plan, as						
	needed.	omity of officeration plant, as						
	*[For PACE at §4	60.84(d):1						
	-	PACE organization must						
	. ,	s to test the emergency						
	plan at least annu							
	organization must	-						
	_	an annual full-scale exercise						
	that is community							
	(A) when a comm	nunity-based exercise is not	1				1	

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accessible, conduct an annual individual, facility-based functional exercise; or

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155222	(X2) MULTIPLE A. BUILDING B. WING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED 11/13/2023	
	PROVIDER OR SUPPLIE		429 \	ET ADDRESS, CITY, STATE, ZIP COD W LINCOLN RD OMO, IN 46902	•	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	OBE COMPLETION	
TAG	•	R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DATE	
	(B) If the PACE e	xperiences an actual natural				
	1 ' '	ergency that requires				
	activation of the e	emergency plan, the PACE				
	is exempt from er	ngaging in its next required				
	full-scale commu	nity based or individual,				
	facility-based fund	ctional exercise following the				
	onset of the emer	~ -				
		an additional exercise every				
		the year the full-scale or				
		e under paragraph (d)(2)(i)				
		conducted that may include,				
	but is not limited t	_				
	(A) A second full-scale exercise that is					
	community-based or individual, a facility based functional exercise; or					
	(B) A mock disas					
		ercise or workshop that is and includes a group				
	discussion, using					
		emergency scenario, and a				
	1	atements, directed				
		pared questions designed				
	to challenge an e	•				
		PACE's response to and				
	1 ' '	ntation of all drills, tabletop				
		nergency events and revise				
		gency plan, as needed.				
	*[For LTC Facilities	es at §483.73(d):]				
	(2) The [LTC facil	ity] must conduct exercises				
	to test the emerge	ency plan at least twice per				
	1 -	announced staff drills using				
		ocedures. The [LTC facility,				
	ICF/IID] must do	<u> </u>				
		an annual full-scale exercise				
	that is community					
		nunity-based exercise is not				
		uct an annual individual,				
	facility-based fund					
	(B) If the [LTC fac	cility] facility experiences an				

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Event ID:

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

PRINTED: 12/12/2023 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155222		A. BUILDING B. WING			PLETED	
	PROVIDER OR SUPPLIER O HEALTHCARE CI		429 W	ADDRESS, CITY, STATE, ZIP C LINCOLN RD MO, IN 46902	OD	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION
TAG	actual natural or manage actual natural or manage activation LTC facility is exert required a full-sca individual, facility-following the onse (ii) Conduct an actual may include, I following: (A) A second full-community-based based functional et (B) A mock disast (C) A tabletop exeled by a facilitator discussion, using a clinically-relevant aset of problem star messages, or prepto challenge an en (iii) Analyze the [Linesponse to and mall drills, tabletop events, and revise emergency plan, at (2) Testing. The IC exercises to test the twice per year. The following: (i) Participate in an that is community-(A) When a commaccessible, condufacility-based function (B) If the ICF/IID en atural or man-maccessivation of the elicity-based function of the	ter drill; or ercise or workshop that is includes a group a narrated, emergency scenario, and a tements, directed pared questions designed ergency plan. TC facility] facility's enaintain documentation of exercises, and emergency ethe [LTC facility] facility's as needed. 483.475(d)]: CF/IID must conduct the emergency plan at least the ICF/IID must do the enanual full-scale exercise and exercise exercise exercise is not ct an annual individual,	TAG	DEFICIENCY		DATE

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Event ID:

H14621

Facility ID: 000127

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

PRINTED: 12/12/2023 FORM APPROVED OMB NO. 0938-039

	of correction identification number 155222	A. BUILDING B. WING	nstruction 	COMPLETED 11/13/2023
	PROVIDER OR SUPPLIER O HEALTHCARE CENTER	429 W I	ADDRESS, CITY, STATE, ZIP COD LINCOLN RD MO, 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 APPROPRI 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 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.			

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Event ID:

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Facility ID: 000127

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 155222		ľ í	ILDING	NSTRUCTION	(X3) DATE COMPL 11/13/	ETED	
	PROVIDER OR SUPPLIEI O HEALTHCARE C			429 W L	DDRESS, CITY, STATE, ZIP COD INCOLN RD IO, IN 46902		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ATE	(X5) COMPLETION
TAG	(ii) Conduct an adyears, opposite the functional exercise of this section is continued, but is not (A) A second community-based facility-based function (B) A mock of (C) A tabletor is led by a facilitar discussion, using clinically-relevant set of problem state messages, or preto challenge an error (iii) Analyze the H maintain documer exercises, and enthe HHA's emergent the HHA's emergent (i) Conduct a papor workshop at lease exercise is led by group discussion, relevant emergent problem statemer prepared question emergency planactual natural or requires activation OPO is exempt for required testing enthe of the emergency (ii) Analyze the O	ditional exercise every 2 e year the full-scale or e under paragraph (d)(2)(i) conducted, that may limited to the following: full-scale exercise that is or an individual, ctional exercise; or isaster drill; or o exercise or workshop that for and includes a group a narrated, emergency scenario, and a attements, directed pared questions designed mergency plan. HA's response to and attation of all drills, tabletop mergency events, and revise ency plan, as needed. 86.360] e OPO must conduct he emergency plan. The following: er-based, tabletop exercise ast annually. A tabletop a facilitator and includes a using a narrated, clinically cy scenario, and a set of ats, directed messages, or as designed to challenge an annumade emergency plan, the om engaging in its next exercise following the onset		TAG			DATE

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Event ID:

H14621

Facility ID: 000127

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED	COMPLETED	
155222 B. WING 11/13/2023	11/13/2023	
STREET ADDRESS, CITY, STATE, ZIP COD		
NAME OF PROVIDER OR SUPPLIER 429 W LINCOLN RD		
KOKOMO HEALTHCARE CENTER 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	N	
TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE		
exercises, and emergency events, and revise		
the [RNHCI's and OPO's] emergency plan, as		
needed.		
*[DNCLUe at \$402,740].		
*[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 $E 0039$ What corrective action will be $12/15/202$	23	
failed to conduct exercises to test the emergency accomplished for those		
plan at least twice per year, including residents found to have been		
unannounced staff drills using the emergency affected by the alleged		
procedures. The LTC facility must do the deficient practice: No resident		
following: was harmed by the facilities		
(i) Participate in an annual full-scale exercise that alleged deficient practice. Facility		
is community-based; or completed an ad hoc exercise on		
a. When a community-based exercise is not		
accessible, conduct an annual individual, were followed and outcomes		
facility-based functional exercise. reviewed were documented on the		
b. If the LTC facility experiences an actual natural exercise. or man-made emergency that requires activation How other residents having the		
of the emergency plan, the LTC facility is exempt from engaging its next required full-scale in a potential to be affected by the same deficient practice will be		
community-based or individual, facility-based identified and what corrective		
full-scale functional exercise for 1 year following action will be taken: This		
the onset of the actual event. the onset of the actual event. alleged deficient practice has the		
(ii) Conduct an additional exercise that may potential to affect all residents in		
include, but is not limited to the following: the facility. Facility completed an		
a. A second full-scale exercise that is ad hoc exercise on 11/29/23 to		

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Event ID:

H14621

Facility ID: 000127

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUIL	LDING		COMPLETED	
		155222	B. WING	G		11/13/	2023
		<u> </u>	' T	STREET A	DDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	8			INCOLN RD		
кокомо	HEALTHCARE C	ENTER	KOKOMO, IN 46902				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PI	REFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG DEFICIENCY)			DATE
		r an individual, facility-based			review EPP policies were follo	wed	
	functional exercise.				and outcomes reviewed were		
	b. A mock disaster	drill; or			documented on the exercise.		
	_	se or workshop that is led by a			What measures will be put in	to	
		des a group discussion, using			place or what systemic		
		y-relevant emergency scenario,			changes will be made to		
	_	n statements, directed			ensure that the deficient		
		red questions designed to			practice does not recur:		
	challenge an emerg				Education was completed with		
		CC facility's response to and			maintenance staff on CFR 483		
		ation of all drills, tabletop			with an emphasis on documer	nting	
	·	gency events, and revise the	the analysis of the exercise to				
	LTC facility's emergency plan, as needed in				ensure the EPP policies were		
	accordance with 42 CFR 483.73(d)(2). This				followed.		
	deficient practice co	ould affect all occupants.	ccupants. How the corre		How the corrective action will	ll	
					be monitored to ensure the		
	Findings include:				deficient practice will not		
					recur: The Executive		
		eview with the Administrator			Director/Designee will audit all		
		e Supervisor on 11/13/23 at			exercises completed in regard		
	01:00 p.m., docume				testing the emergency plan for		
	-	exercise conducted on 04/04/23			months. Any discrepancies for		
	•	ed exercise conducted on			will be immediately corrected a		
		mplete. Both exercises did not			re-education will be provided.		
		s response was analyzed to			results of these reviews will be		
		cies were effective. Based on			discussed at the monthly facili	•	
		e of records review, the			Quality Assurance Committee		
	•	visor stated no documentation			meeting monthly for three mor		
		ΓC facility's response was			and then quarterly thereafter of		
	completed.				full compliance has been achie	eved	
	Th £ 1'				for a total of 6 months of		
	These findings were				monitoring. Frequency and		
	exit conference.	Maintenance Supervisor at the			duration of reviews will be	of	
	exil conference.				increased as needed, if areas	OI	
					noncompliance exist.		
K 0000							
Bldg. 01							
	A Life Safety Code	Recertification and State	K 000	00	Please accept this plan of		

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Event ID:

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155222		A. BUILDING <u>01</u> COMPLETI		(X3) DATE SURVEY COMPLETED 11/13/2023			
	PROVIDER OR SUPPLIER D HEALTHCARE C		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 DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	COMPLETION		
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE		
	•	as conducted by the Indiana		correction as the provider's			
	Department of Health in accordance with 42 CFR			credible allegation of complia			
	483.90(a).			The provider respectfully requ	uests		
	Survey Date: 11/13	3/2023		a desk review with paper compliance to be considered establishing that the provider			
	Facility Number: 0	00127		substantial compliance.			
	Provider Number: 1	55222					
	AIM Number: 1002	291430					
	At this Life Safety	Code survey, Kokomo					
	-	vas found not in compliance					
with Requirements for Participation in							
	Medicare/Medicaid	, 42 CFR Subpart 483.90(a),					
		re and the 2012 edition of the					
	National Fire Protect	ction Association (NFPA) 101,					
	Life Safety Code (I	LSC), Chapter 19, Existing					
	Health Care Occupa	ancies and 410 IAC 16.2.					
	-	ity was determined to be of ruction and was fully					
		cility has a fire alarm system					
	-	on in the corridors, areas open					
		battery powered smoke					
		dent sleeping rooms. The					
		ity of 80 and had a census of					
	70 at the time of thi						
	All areas where the	residents have customary					
		ered. All areas providing					
	facility services we						
		npleted on 11/20/23					
	(
K 0211	NFPA 101						
SS=E	Means of Egress	- General					
Bldg. 01	Means of Egress						
		ays, corridors, exit					
	_	cations, and accesses are					
	in accordance witl	n Chapter 7, and the means					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	JILDING	01	COMPL	ETED
		155222	B. W	ING		11/13/	2023
	PROVIDER OR SUPPLIER		•	429 W L	ADDRESS, CITY, STATE, ZIP COD LINCOLN RD MO, IN 46902		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID PROVIDER'S PLAN OF CORREC		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	all obstructions to emergency, unless through 18/19.2.1 18.2.1, 19.2.1, 7.1 Based on observation failed to ensure 1 of continuously maintage or impediments to fiftee or other emerge could affect 10 resides. Findings include: Based on an observation facility with the Ma 11/13/23 at 2:40 p.r. 415 contained a work seat that was not att Based on an interviet the MS agreed there corridor that was not search as a contract of the maintain the maintenance of the maintain the	s modified by 18/19.2.2 110.1 on and interview, the facility f 6 means of egress were ained free of all obstructions full instant use in the case of ency. This deficient practice dents in the 400 hall. ation during a tour of the intenance Supervisor (MS) on m., the corridor by resident room od framed chair with padded ached to the floor or wall. ew at the time of observations, e was a chair stored in the of attached to the floor or wall.	K 0	211	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. Factimmediately removed the chair 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 potential to affect 10 residents the facility. Facility completed whole house audit on 11/7/23 ensure all 6 means of egress of free of all obstructions. What measures will be put in 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 a means of egress remain free obstructions. How the corrective action with the deficient practice will not recur: The Maintenance Director/Designee will audit all means of egress 3 times per vision affects.	n t illity ir in the ee the sin a to were nto	12/15/2023

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

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155222	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 11/13/2023
	PROVIDER OR SUPPLIER		429 W	ADDRESS, CITY, STATE, ZIP COD LINCOLN RD MO, IN 46902	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL 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
K 0300	NFPA 101			for 4 weeks, 1 time per week weeks, then 1 time per month 3 months to ensure all are fre obstructions. Any discrepanci found will be immediately corrected and re-education will provided. The results of these reviews will be discussed at the monthly facility Quality Assura Committee meeting monthly fithree months and then quarte thereafter once full compliance has been achieved for a total months of monitoring. Freque and duration of reviews will be increased as needed, if areas noncompliance exist.	for e of es ill be ene ance or rrly e of 6 ncy
SS=E Bldg. 01	Protection - Other Protection - Other Protection - Other List in the REMAR Section 18.3 and requirements that provided K-tags, be information, along Safety Code or NR should be included Based on observation failed to ensure 60 dalarms in resident re 101 in 4.6.12.3 state obvious to the publishall be maintained and Signaling Code states fire-warning and tested in according published instruction of Chapter 14. Section 18.3 and 18.3 a	2KS section any LSC 19.3 Protection are not addressed by the out are deficient. This with the applicable Life EPA standard citation, d on Form CMS-2567. on and interview; the facility of 80 battery operated smoke coms were maintained. NFPA as existing life safety features c, if not required by the Code, NFPA 72, National Fire Alarm c, 2010 Edition, Section 29.10 equipment shall be maintained ance with the manufacturer's and per the requirements ion 14.2.1.1.1 Inspection, hance programs shall satisfy	K 0300	What corrective action will be accomplished for those residents found to have bee affected by the alleged deficient practice: No resident was harmed by the facilities alleged deficient practice. Factoreplaced all 60 smoke detection 11/14/23. How other residents having potential to be affected by the same deficient practice will	nt cillity ors the

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	WIEDICAKE & MEDIC		770. 3 77	and the second s	OMB NO. 0938-039
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO		(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	01	COMPLETED
		155222	B. WING		11/13/2023
N	DOLUBER OF STATE	`	STREET A	ADDRESS, CITY, STATE, ZIP COD	
NAME OF I	PROVIDER OR SUPPLIEF	(429 W	LINCOLN RD	
KOKOM	O HEALTHCARE C	ENTER	KOKON	MO, IN 46902	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	the requirements of	this Code and conform to the		identified and what correctiv	е
	equipment manufac	cturer's published instructions.		action will be taken: This	
	Section 14.4.8.1 sta	ates unless otherwise		alleged deficient practice has	the
	recommended by the	ne manufacturer's published		potential to affect 60 residents	in
	instructions, single-	- and multiple-station smoke		the facility. Facility replaced al	1 60
	alarms shall be repl	aced when they fail to respond		smoke detectors on 11/14/23.	
	to operability tests	but shall not remain in service		What measures will be put in	nto
	longer than 10 year	s from the date of manufacture.		place or what systemic	
	This deficient pract	ice could affect 60 residents.		changes will be made to	
				ensure that the deficient	
	Findings include:			practice does not recur:	
				Education was completed with	ı
	Based on observation	on and interview; the facility		maintenance staff on NFPA 72	2
	failed to ensure all	battery operated smoke alarms		section 14.4.8.1. with an	
	in resident rooms w	vere manufactured within the		emphasis on replacing battery	,
	past 10 years. Base	d on observation at 02:20 p.m.		operated smoke detectors eve	ery
	on 11/13/23, two ba	attery operated smoke alarms		10 years.	
	pressented by the M	Maintenance Supervisor from		How the corrective action wi	II
	resident rooms for i	inspection, had a manufacture		be monitored to ensure the	
	date of 01/25/2012	which is more than 10 years old		deficient practice will not	
	. Based on interview	w with the Maintenance		recur: The Maintenance	
	Supervisor, he state	ed that he was working to		Director/Designee will audit	
	replace all of the sn	noke alarms in the resident		battery operated smoke detec	tors
	sleeping rooms. The	e Maintenance Supervisor		3 times per week for 4 weeks,	1
	indicated he had rep	placed about 20 battery		time per week for 8 weeks, the	
		rms in the residents' rooms		time per month for 3 months to	
	with about 60 more	to replace at the time of this		ensure all have been manufac	ctured
	survey.			within the last 10 years. Any	
				discrepancies found will be	
	This deficiency was	s discussed with Maintenance		immediately corrected and	
		ministrator at the exit		re-education will be provided.	The
	conference.			results of these reviews will be	
			1	discussed at the monthly facili	ty
	3.1-19(c)		1	Quality Assurance Committee	•
				meeting monthly for three mor	
			1	and then quarterly thereafter of	
				full compliance has been achie	
			1	for a total of 6 months of	
			1	monitoring. Frequency and	
				duration of reviews will be	

CENTERS FOR MEDICARE & MEDICAID SERVICES						OM	B NO. 0938-039
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155222	ľ í	JILDING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 11/13/2023	
	PROVIDER OR SUPPLIEF			429 W	ADDRESS, CITY, STATE, ZIP COD LINCOLN RD MO, IN 46902		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) increased as needed, if areas of the component		(X5) COMPLETION DATE
K 0321 SS=E Bldg. 01	barrier having 1-h (with 3/4 hour fire automatic fire exti accordance with 8 approved automa option is used, the from other spaces partitions and doc Doors shall be se automatic-closing nonrated or field-ado not exceed 48 the door. Describe the floor	are protected by a fire our fire resistance rating rated doors) or an inguishing system in 3.7.1 or 19.3.5.9. When the tic fire extinguishing system areas shall be separated as by smoke resisting or in accordance with 8.4. If-closing or and permitted to have applied protective plates that inches from the bottom of that are deficient in					
	b. Laundries (larg c. Repair, Mainter d. Soiled Linen Ro gallons) e. Trash Collectio (exceeding 64 gal f. Combustible Sto (over 50 square fo	r-Fired Heater Rooms er than 100 square feet) nance, and Paint Shops coms (exceeding 64 In Rooms Hons) crage Rooms/Spaces eet) classified as Severe					

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Based on observation and interview, the facility

failed to ensure the corridor doors to 2 of 2

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K 0321

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What corrective action will be

accomplished for those

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12/15/2023

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			JRVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPLE	ГЕD
		155222	B. W	ING		11/13/2	023
				CENTER	ADDRESS STEW STATE STR COD		
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD		
KOKOM	0 LIE AL TUO A DE O	ENTED			LINCOLN RD		
KOKOMO	O HEALTHCARE C	ENTER		KOKON	MO, IN 46902		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROWINED'S DEAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	' ⁻	DATE
	hazardous rooms w	ere provided with a			residents found to have been	1	
		which would cause the door to			affected by the alleged		
		and latch into the door frame.			deficient practice: No resider	nt I	
	1	ice could affect 15 residents in			was harmed by the facilities	·	
	two smoke compart				alleged deficient practice. Fac	ility	
	•				immediately repaired the laun	-	
	Findings include:				door during the survey and	u.,	
	1 maniga marata				Activities door was completed		
	Based on observations during a tour of the facility				12/7/23.		
	with the Maintenance Supervisor (MS) on				How other residents having	the	
	11/13/23 between 02:25 p.m. and 02:55 p.m., the				potential to be affected by th		
	corridor doors to the following hazardous areas				same deficient practice will be		
	did not meet the requirements for protection of a				identified and what correctiv		
	hazardous area:				action will be taken: This	·	
	a) Both doors to the Activity room which was				alleged deficient practice has	tho	
	· ·	re feet and contained over 20			potential to affect 15 residents		
		ad self-closing devices but the			1 *		
		and latch when tested.			the facility. Facility completed audit of all hazardous area do		
						ors	
		om larger than 100 square feet,			to ensure all latched properly.		
		ish and dirty linen did not latch			What measures will be put in	ito	
		use the closer arm was			place or what systemic		
	disconnected.				changes will be made to		
	.				ensure that the deficient		
		at the time of observation, the			practice does not recur:		
	~	oms were hazardous storage			Education was completed with		
		to the rooms were self-closing			activities and housekeeping st		
	but did not latch int	to the frame.			on TELS system to ensure the		
					know how to report if the door	s do	
	I -	viewed with the Administrator			not latch.		
	and MS 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 audit all		
					hazardous area doors 3 times	per	
					week for 4 weeks, 1 time per v	week	
					for 8 weeks, then 1 time per		
					month for 3 months to ensure		
					latch properly. Any discrepand	ies	
					found will be immediately		

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER					(X3) DATE COMPL	
		155222	B. WI	NG		11/13/	/2023
	PROVIDER OR SUPPLIE			429 W I	ADDRESS, CITY, STATE, ZIP COD LINCOLN RD MO, IN 46902		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	TE	(X5) COMPLETION
TAG	•	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	IE.	DATE
K 0324	NFPA 101				corrected and re-education wi provided. The results of these reviews will be discussed at the monthly facility Quality Assura Committee meeting monthly for three months and then quarted thereafter once full compliance has been achieved for a total months of monitoring. Frequel and duration of reviews will be increased as needed, if areas noncompliance exist.	ne ince or rly e of 6 ncy	
SS=E Bldg. 01	Cooking Facilities Cooking equipme accordance with Ventilation Contro Commercial Cool * residential cook appliances such a toasters) are used cooking in accord 19.3.2.5.2 * cooking facilities smoke compartm patients comply v 18.3.2.5.3, 19.3.2 * cooking facilities with 30 or fewer p conditions under Cooking facilities NFPA 96 per 9.2. enclosed as haza be open to the co 18.3.2.5.1 throug through 19.3.2.5. Based on observati	int is protected in NFPA 96, Standard for ol and Fire Protection of king Operations, unless: ing equipment (i.e., small as microwaves, hot plates, d for food warming or limited ance with 18.3.2.5.2, sopen to the corridor in ents with 30 or fewer with the conditions under 1.5.3, or so in smoke compartments the patients comply with 18.3.2.5.4, 19.3.2.5.4. protected according to 3 are not required to be redous areas, but shall not pridor. In 18.3.2.5.4, 19.3.2.5.1 of 9.2.3, TIA 12-2 on and interview, the facility	K 03	324	What corrective action will b	e	12/15/2023
		on and interview, the facility ff were instructed in the use of	K 03	324	What corrective action will b accomplished for those	е	12/15/2023

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	IULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	01	COMPL	ETED
		155222	B. W	'ING		11/13/	2023
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIER	8			LINCOLN RD		
кокомо	O HEALTHCARE C	ENTER			MO, IN 46902		
	1		1		T	1	OV.5
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		S LSC IDENTIFYING INFORMATION stem in 1 of 1 Kitchen. NFPA		TAG	residents found to have been		DATE
		structions for manually				n	
	· ·	ctinguishing system shall be			affected by the alleged deficient practice: No resider	nt.	
		ly in the kitchen and shall be			was harmed by the facilities	ıı	
		loyees by management. This			alleged deficient practice. Fac	ility	
	_	ould affect staff in the kitchen			immediately educated dietary	-	
	and 25 residents in				during survey to ensure they		
					instructed in the use of UL 300		
	Findings include:				hood system.	-	
					How other residents having	the	
	Based on observation	on with the Maintenance			potential to be affected by th		
	Supervisor (MS) on	11/13/23 at 03:05 p.m., the			same deficient practice will be		
	kitchen was provided with a UL 300 hood system				identified and what correctiv		
	and a K-class fire ex	xtinguisher with posted			action will be taken: This		
	instructions. Based	on interview, the Cook was			alleged deficient practice has	the	
	asked; what is the c	orrect response if there was a			potential to affect 25 residents	s in	
	grease fire undernea	ath the hood. The employee			the dining room and staff in th	е	
	replied; I would use	the fire extinguisher. The			kitchen. Facility completed		
		indicate activating the UL 300			education with all dietary staff	to	
		system first and then using			ensure they were instructed in	the	
		nguisher for a hood grease fire.			use of UL 300 hood system.		
		ged the Cooks response and			What measures will be put ir	nto	
	educated the cook of	on the proper procedure.			place or what systemic		
					changes will be made to		
		viewed with the Administrator			ensure that the deficient		
	and MS at the exit of	conference.			practice does not recur: Fac	ility	
	2.1.10(1)				completed education with all		
	3.1-19(b)				dietary staff to ensure they we		
					instructed in the use of UL 300	J	
					hood system. How the corrective action wi		
					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	.51 1	
					weeks, then 1 time per month	for	
					3 months to ensure they have		
					been instructed in the use of l		

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

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155222	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 11/13/2023
	PROVIDER OR SUPPLIER O HEALTHCARE C		429 W	ADDRESS, CITY, STATE, ZIP COD LINCOLN RD MO, IN 46902	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL 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
				300 hood system. Any discrepancies found will be immediately corrected and re-education will be provided. results of these reviews will be discussed at the monthly facil Quality Assurance Committee meeting monthly for three mo and then quarterly thereafter full compliance has been achifor a total of 6 months of monitoring. Frequency and duration of reviews will be increased as needed, if areas noncompliance exist.	e ity e nths once eved
K 0345 SS=F Bldg. 01	in accordance with complying with the National Electric C National Fire Alari Records of system and testing are respected on observation failed to ensure 1 of continuously in pro NFPA 72, National 2010 Edition, Section	n - Testing and m is tested and maintained n an approved program e requirements of NFPA 70, Code, and NFPA 72, m and Signaling Code. n acceptance, maintenance adily available.	K 0345	What corrective action will be accomplished for those residents found to have bee affected by the alleged deficient practice: No resident was harmed by the facilities	n
		ould affect all residents, staff		alleged deficient practice. Fac already had Koorsen schedul repair panel the next day, as stated in the 2567. Koorsen completed the repair as	-

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	IULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	01	COMPLETED	
		155222	B. W	ING		11/13/2023	
				STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIER	2			LINCOLN RD		
кокомо	O HEALTHCARE C	ENTER			MO, IN 46902		
			1		T		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	03.1
PREFIX	· ·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		ON
TAG		on of the fire alarm control	+	TAG		DATE	
		at 03:00 p.m. during a tour of the			scheduled.	ha	
	_	intenance Supervisor (MS),			How other residents having to		
		trouble light illuminated on the			potential to be affected by the same deficient practice will be		
		anel. At the time of			identified and what corrective		
	-	e alarm system panel display			action will be taken: This		
		able light was due to the			alleged deficient practice has	he	
		monitor. During an interview			potential to affect all residents		
		vation, the Maintenance			staff, and visitors. Facility had		
		ated that the Fire Alarm Panel			panel repaired the next day, a	s	
		e repaired tomorrow.			scheduled.		
					What measures will be put ir	to	
	This finding was re	viewed with the Administrator			place or what systemic		
	and MS at the exit of				changes will be made to		
	3.1-19(b)				ensure that the deficient		
					practice does not recur: Faci	lity	
					completed education with		
					maintenance staff on ensuring	the	
					fire alarm system is continuou	sly	
					in proper operating condition.		
					How the corrective action wi	I	
					be monitored to ensure the		
					deficient practice will not		
					recur: The Maintenance		
					Director/Designee will audit th	e fire	
					panel 3 times per week for 4		
					weeks, 1 time per week for 8	.	
					weeks, then 1 time per month		
					3 months to the fire alarm sys		
					is continuously in proper opera	aurig	
					condition. Any discrepancies		
					found will be immediately corrected and re-education wi	l be	
					provided. The results of these	ı ne	
					reviews will be discussed at th	_	
					monthly facility Quality Assura		
					Committee meeting monthly for		
					three months and then quarte		
					thereafter once full compliance	-	
					has been achieved for a total		
			1		I had book dorneved for a total	·· ~	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION (X3) DATE S A. BUILDING 01 COMPLI					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155222	A. BUILI B. WING		01	COMPL 11/13/	
		199222	B. WINC			11/13/	2023
	PROVIDER OR SUPPLIEI O HEALTHCARE C		4	429 W L	DDRESS, CITY, STATE, ZIP COD INCOLN RD O, IN 46902		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROWIDERIC BY AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PR	EFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	1	ΓAG	DEFICIENCY)		DATE
					months of monitoring. Frequer and duration of reviews will be increased as needed, if areas noncompliance exist.		
K 0355	NFPA 101						
SS=E Bldg. 01	installed, inspected accordance with I Portable Fire Exti 18.3.5.12, 19.3.5.	nguishers guishers are selected, ed, and maintained in NFPA 10, Standard for nguishers.	K 035	5	What corrective action will be	Đ	12/15/2023
	failed to ensure 1 of pressure gauge read range. LSC section wherever any device condition, arranger other feature shall the Code exempts in the Code exempts in the Extinguishers, Chaperiodic monthly of gauge reading is in Chapter 7.2.3 requifire extinguisher reconditions listed in action shall be take affect 5 residents. Findings include: Based on observation with the Maintenant 11/13/23 at 02:15 properties was below the oper extinguisher locate interview at the times.	f 20 Portable Fire Extinguishers ding was in the acceptable 4.5.8 requires whenever or te, equipment, system, nent, level of protection, or any thereafter be maintained, unless			accomplished for those residents found to have been affected by the alleged deficient practice: No resident was harmed by the facilities alleged deficient practice. Facilimmediately replace fire extinguisher with low pressure during the survey. How other residents having to potential to be affected by the same deficient practice will be identified and what corrective action will be taken: This alleged deficient practice has to potential to affect 5 residents. Facility completed whole hous audit on fire extinguishers to ensure all 20 were within acceptable pressure ranges. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur: Facil	the e e the e	

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

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	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	l í		ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	01	COMPL	
		155222	B. W	NG		11/13/	2023
	ROVIDER OR SUPPLIER		•	429 W I	ADDRESS, CITY, STATE, ZIP COD LINCOLN RD MO, IN 46902	•	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID			(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	*	LISC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
		for the fire extinguisher located			maintenance staff on ensuring		
	in the boiler room.	5			replacing fire extinguishers	•	
					immediately if they are not wit	hin	
	This finding was re	viewed with the Administrator			acceptable ranges.		
	and MS at the exit of				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 audit th	e fire	
					extinguishers 3 times per wee		
					4 weeks, 1 time per week for 8	3	
					weeks, then 1 time per month	for	
					3 months to ensure the pressu	ıre	
					gauges are within acceptable		
					ranges. Any discrepancies fou	ınd	
					will be immediately corrected	and	
					re-education will be provided.	The	
					results of these reviews will be	•	
					discussed at the monthly facili	ty	
					Quality Assurance Committee		
					meeting monthly for three mor		
					and then quarterly thereafter o		
					full compliance has been achi	eved	
					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	NEDA 404						
K 0363 SS=D	NFPA 101						
88-D Bldg. 01	Corridor - Doors Corridor - Doors						
ום. טום	_	corridor oponings in other					
		corridor openings in other					
	-	losures of vertical openings, s areas resist the passage					
		made of 1 3/4 inch					
		wood or other material					
		ng fire for at least 20					
		fully sprinklered smoke only required to resist the					
	companinents are	only required to resist the					I

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

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	of correction identification number 155222	A. BUILDING B. WING	01	COMPLETED 11/13/2023
	PROVIDER OR SUPPLIER O HEALTHCARE CENTER	429 W I	ADDRESS, CITY, STATE, ZIP COD LINCOLN RD MO, 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
	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 beer affected by the alleged deficient practice: No resident was harmed by the facilities alleged deficient practice. Fac repaired room 425 and the Be	n it ility

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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	NG		11/13/	2023
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP COD		
					LINCOLN RD		
KOKOMO HEALTHCARE CENTER				KOKOMO, IN 46902			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	DROWINED'S DEAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	Findings include:				Shop doors on 11/15/23.		
					How other residents having	the	
	1. Based on observa	ation with the Maintenance			potential to be affected by th		
	Supervisor (MS) or	n 11/13/23 at 02:35 p.m., the			same deficient practice will b		
	corridor door to res	ident sleeping room 425 would			identified and what correctiv		
	not close and latch	into the frame when tested.			action will be taken: This		
	Based on interview	at the time of observation, the			alleged deficient practice has	the	
	MS agreed the corr	idor door to room 425 would			potential to affect 2 residents.		
	not close and latch	into the door frame.			Facility completed whole hous	e	
					audit on all corridor doors to		
	The finding was rev	viewed with the Administrator			ensure all latch properly.		
	and MS during the exit conference.				What measures will be put ir	ito	
					place or what systemic		
	3.1-19(b)				changes will be made to		
					ensure that the deficient		
	Findings include:				practice does not recur: Faci	lity	
					completed education with		
	2. Based on observation with the Maintenance				maintenance staff on ensuring	ı all	
		n 11/13/23 at 02:35 p.m., the			corridor doors are provided wi	th	
	1	Shop was equipped with a			the means suitable for keeping		
	_	but the self-closing device			door closed, has no impedime	ent to	
	1	se and latch to keep the door in			closing, latching, and would re	esist	
	_	Based on interview at the time			the passage of smoke.		
		MS agreed the self-closing			How the corrective action wi	II	
		to the Beauty Shop was not			be monitored to ensure the		
		y as it did not allow the door			deficient practice will not		
	to self latch when to	ested.			recur: The Maintenance		
					Director/Designee will audit 5		
		viewed with the Administrator			doors per week for 4 weeks, 3		
	and MS during the exit conference.				doors per week for 8 weeks, the		
					3 doors per month for 3 month		
	3.1-19(b)				ensure the pressure gauges a		
					within acceptable ranges. Any	'	
					discrepancies found will be		
					immediately corrected and		
					re-education will be provided.		
					results of these reviews will be	· I	
					discussed at the monthly facili	-	
					Quality Assurance Committee		
				meeting monthly for three mor	nths I		

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CENTERS FO	R MEDICARE & MEDIC	AID SERVICES				OM	B NO. 0938-039
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155222		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 11/13/2023	
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	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
K 0511 SS=E	NFPA 101 Utilities - Gas and	Flectric			and then quarterly thereafter of full compliance has been achie for a total of 6 months of monitoring. Frequency and duration of reviews will be increased as needed, if areas noncompliance exist.	eved	
Bldg. 01	Utilities - Gas and Equipment using a complies with NFF Code, electrical w complies with NFF Code. Existing ins service provided r 18.5.1.1, 19.5.1.1	Electric gas or related gas piping PA 54, National Fuel Gas iring and equipment PA 70, National Electric stallations can continue in no hazard to life.	K 0	£1.1	What corrective action will b		12/15/2022
	failed to ensure 2 or interrupter (GFCI) protection against e 2011 Edition at 210 Circuit-Interrupter states, ground-fault personnel shall be protection against e this deficient pract. 1. Based on observation Supervisor (MS) or 02:05 p.m. when the feet from the sink in station West was te electric receptacle of the electrical circuit.	f over 20 ground fault circuit was properly maintained for lectric shock. NFPA 70, NEC	K 0	511	accomplished for those residents found to have been affected by the alleged deficient practice: No resident was harmed by the facilities alleged deficient practice. Factobypassed both circuits in room 303 and at West's nurse's state to outlets that are more than 3 away from the sink on 12/8. The West nurse's station electric panel was immediately correct 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 affected by the same deficient practice has alleged deficient practice alleged deficient practice has alleged deficient practice alleged	nt ility ntion feet he tted the e oe	12/15/2023

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protected..

receptacle 3 feet from the sink was not GFCI

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potential to affect 4 residents in

the facility. Facility completed an

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 01 COMPLETED	
AND LEARN OF CONNECTION IDENTIFICATION NOWIDER A. BUILDING UI CONNECTED	
155222 B. WING 11/13/2023	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP COD	
429 W LINCOLN RD	
KOKOMO HEALTHCARE CENTER 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 COMPLET	ON
TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE	
audit of outlets on West unit to	
This finding was reviewed with the Administrator ensure there are no others that are	
and the MS during the exit conference. within 3 feet of a sink. Facility also	
completed an audit of all electric	
3.1-19(b) panels to ensure all are properly	
secured with no concerns noted	
2. Based on observation and interview, the facility on 11/14.	
failed to ensure 1 of 5 electrical panels in the West What measures will be put into	
nurses station was secured from non-authorized place or what systemic	
personnel. NFPA 70, 2011 edition states 230.62 changes will be made to	
Energized parts of service equipment shall be ensure that the deficient	
enclosed as specified in 230.62(A) or guarded as practice does not recur:	
specified in 230.62(B).	
(A) Enclosed. Energized parts shall be enclosed maintenance staff to ensure all	
so that they will not be exposed to accidental GFCI are properly maintained for	
contact or shall be guarded as in 230.62(B).	
(B) Guarded. Energized parts that are not enclosed and that electrical panels are	
shall be installed on a switchboard, panelboard, or secured from non-authorized	
control board and guarded in accordance with personnel.	
110.18 and 110.27. Where energized parts are How the corrective action will	
guarded as provided in 110.27(A)(1) and (A)(2), a be monitored to ensure the	
means for locking or sealing doors providing deficient practice will not	
access to energized parts shall be provided. This recur: The Maintenance	
deficient practice could affect 10 residents in the Director/Designee will audit 3	
vicinity of the West Nurses station. GFCI outlets per week for 4	
weeks, 2 GFCI outlet per week for	
Findings include: 8 weeks, then 1 GFCI outlet per	
month for 3 months to ensure they	
Based on observation with Administrator and MS are properly maintained. The	
on 11/13/23 at 02:05 p.m., the electrical panel in the Maintenance Director/Designee	
West nurses station was unlocked when tested. will audit 3 electric panels per	
The panel included breakers to the lights, week for 4 weeks, 2 electric	
emergency lighting, and outlets in the West Hall. panels per week for 8 weeks, then	
Based on interview at the time of observation, the 1 electric panel per month for 3	
MS stated the electrical panel will need to be months Any discrepancies found	
locked. will be immediately corrected and	
re-education will be provided. The	
This finding was reviewed with the Administrator results of these reviews will be	
and MS at the exit conference.	
Quality Assurance Committee	

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

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AND PLAN OF CORRECTION IDENTIF		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155222	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 11/13/2023		
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 429 W LINCOLN RD KOKOMO, IN 46902				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R 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		
TAG	3.1-19(b)	LISC IDENTIFYING INFORMATION	TAU	meeting monthly for three mor and then quarterly thereafter of full compliance has been achie for a total of 6 months of monitoring. Frequency and duration of reviews will be increased as needed, if areas noncompliance exist.	onths once eved		
K 0712 SS=F Bldg. 01	alarm signal and s conditions. Fire dr and unexpected ti conditions, at leas The staff is familia aware that drills at routine. Where dr 9:00 PM and 6:00	ay be used instead of					
	Based on record rev failed to conduct fir quarters. LSC 19.7. conducted quarterly facility personnel (rengineers, and admissignals and emerger varied conditions. Tall staff and residen Findings include: Based on records re Supervisor (MS) on documentation was	view and interview, the facility re drills on each shift for 1 of 2 1.6 states drills shall be von each shift to familiarize nurses, interns, maintenance inistrative staff) with the next action required under This deficient practice affects atts.	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	n e or the		
	fire drill for the seco	ond quarter of 2023 was		same deficient practice will be	oe e		

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STATEMENT OF DEFICIENCIES X1) PROVID		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFY		IDENTIFICATION NUMBER	a. building <u>01</u>		COMPLETED		
155222		B. WING 11/13/2023			11/13/2023		
		<u> </u>	'	STREET A	ADDRESS, CITY, STATE, ZIP COD		_
NAME OF I	PROVIDER OR SUPPLIER	t .	l		LINCOLN RD		
КОКОМ	O HEALTHCARE C	ENTER	l		10, IN 46902		
	1				-,	<u> </u>	
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	CY MUST BE PRECEDED BY FULL	I F	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		i
TAG		R LSC IDENTIFYING INFORMATION		TAG		DATE	—
		n interview at the time of			identified and what correctiv	e	
	drill was not conduc	MS stated the aforementioned			action will be taken: This	ile e	
	driff was not conduc	cied.			alleged deficient practice has t		
	This finding was re	viewed with the Administrator			potential to affect all residents the facility. All other fire drills h		
	and MS during the				appropriate documentation for		
	and wis during the	ean comerciae.			drill completion.	iii G	
	3.1-19(b)				What measures will be put in	to	
	3.1-51(c)				place or what systemic		
					changes will be made to		
					ensure that the deficient		
					practice does not recur:		
					Education was completed with	1	
					maintenance staff with an		
					emphasis on LSC 19.7.1.6 to		
					ensure facility is in compliance	;	
					with documentation required for	or	
					fire drills.		
					How the corrective action wi	II	
					be monitored to ensure the		
					deficient practice will not		
					recur: The Executive		
					Director/Designee will audit fin	е	
					drills monthly for 6 months to		
					ensure follow up documentation	on is	
					added to conducted fire drills.		
					Any discrepancies found will b immediately corrected and	E	
					re-education will be provided.	The	
					results of these reviews will be		
					discussed at the monthly facili		
					Quality Assurance Committee	٠,	
					meeting monthly for three mor	nths	
					and then quarterly thereafter of		
					full compliance has been achie		
					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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		X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
		IDENTIFICATION NUMBER	A. BUILDING <u>01</u>		COMPLETED			
		155222	B. W	ING		11/13/	2023	
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	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE	
K 0754 SS=E Bldg. 01	NFPA 101 Soiled Linen and Toolled Linen are shall not exceed 3 average density of room or space shall gallons/square feet capacity of 32 gall within any 64 squal linen or trash colled capacities greater located in a room area when not atted. Containers used spermitted to be extended in a room area when not atted and containers for and listed as meet 6921 or equivalent 18.7.5.7, 19.7.5.7. Based on observation failed to ensure trast in accordance with could affect staff and Activity office. Findings include: Based on observation with the Maintenant 11/13/23 at 02:25 periodiction receptable in K321 tag of this staff and doors (2) did not sell based on interview MS agreed there was shall be soiled to be a sell doors (2) did not sell based on interview MS agreed there was shall be soiled to be a sell doors (2) did not sell based on interview MS agreed there was shall be soiled to be a sell doors (2) did not sell based on interview MS agreed there was shall be soiled to be a sell doors (2) did not sell based on interview MS agreed there was shall be soiled to be a sell doors (2) did not sell based on interview MS agreed there was shall be soiled to be a sell doors (2) did not sell based on interview MS agreed there was shall be soiled to be a sell doors (2) did not sell based on interview MS agreed there was shall be soiled to be a sell doors (2) did not sell based on interview MS agreed there was shall be soiled to be a sell doors (3) did not sell based on interview MS agreed there was shall be soiled to be a sell doors (4) did not sell based on interview MS agreed there was shall be soiled to be a sell doors (4) did not sell based on interview MS agreed there was shall be soiled to be a sell doors (4) did not sell based on interview MS agreed there was shall be soiled to be a sell doors (4) did not sell based on interview MS agreed there was shall be soiled to be a sell doors (4) did not sell based on the sell doors (5) did not sell based on	Frash Containers Frash Containers Sh collection receptacles 2 gallons in capacity. The f container capacity in a fall not exceed 0.5 Set. A total container fons shall not be exceeded fare feet area. Mobile soiled fection receptacles with finh 32 gallons shall be fortected as a hazardous finded. Folely for recycling are folded from the above free each container is less find gallons unless attended, from the standard	K 0	754	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. Factimmediately removed the 40 get trash container from the activit room on 11/13/23. How other residents having to potential to be affected by the same deficient practice will be identified and what corrective action will be taken: This alleged deficient practice has potential to affect 5 residents. Facility completed whole hous	nt illity jallon ties the e e the	12/15/2023	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

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Facility ID: 000127

If continuation sheet

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

PRINTED: 12/12/2023 FORM APPROVED OMB NO. 0938-039

		L			
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING <u>01</u>		COMPLETED	
		155222	B. WING		11/13/2023
NAME OF D	PROVIDER OR SUPPLIEI		STREET	ADDRESS, CITY, STATE, ZIP COD	
TARME OF F	NO VIDER OR BUILDED		429 W	LINCOLN RD	
KOKOMO	O HEALTHCARE C	ENTER	KOKOI	MO, IN 46902	
	Τ			1	
(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 APPROPRIATE DEFICIENCY)	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	self close and latch	when tested.		audit all hazardous area doors	to
				ensure all latched properly.	
	The finding was re-	viewed with the Administrator		What measures will be put int	0
	_	the exit conference.		place or what systemic	
	and the ivid during	me compromee.		changes will be made to	
	3.1-19(b)			<u> </u>	
	3.1-19(0)			ensure that the deficient	. .
				practice does not recur: Facili	ıy
				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 p	
				week for 4 weeks, 1 time per w	еек
				for 8 weeks, then 1 time per	
				month for 3 months to ensure	
				latch properly. Any discrepancie	es
				found will be immediately	
				corrected and re-education will	be
				provided. The results of these	
				reviews will be discussed at the	
				monthly facility Quality Assuran	ce
				Committee meeting monthly for	
				three months and then quarterly	
				thereafter once full compliance	
				<u>'</u>	f G
				has been achieved for a total of	
				months of monitoring. Frequence	cy
				and duration of reviews will be	
				increased as needed, if areas of	of
				noncompliance exist.	

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