STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155819	A. BUILDING -- B. WING	01/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WELLBROOKE OF KOKOMO	2200 SOUTH DIXON ROAD 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: 01/17/2023 Facility Number: 013153 Provider Number: 155819 AIM Number: 201254360 At this Emergency Preparedness survey, Wellbrooke of Kokomo was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has a capacity of 70 and had a census of 53 at the time of this survey. Quality Review completed on 01/18/23	E 0000	The submission of this plan of correction does not indicate any admission by Wellbrooke of Kokomo that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and the living environment provided to the residents of Wellbrooke of Kokomo. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests desk review or substantial compliance.	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 01/17/2023 Facility Number: 013153 Provider Number: 155819 AIM Number: 201254360	K 0000	The submission of this plan of correction does not indicate any admission by Wellbrooke of Kokomo that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and the living environment provided to the residents of Wellbrooke of Kokomo. The facility recognizes its obligation to provide legally and	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Amorette Dunkle	Executive Director	02/02/2023

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

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	At this Life Safety Code survey, Wellbrooke of Kokomo 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 V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, areas open to the corridors and hard wired smoke detectors in the resident rooms. The facility has a capacity of 70 and had a census of 53 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 01/18/23		medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests desk review or substantial compliance.	
K 0341 SS=C Bldg. 01	NFPA 101 Fire Alarm System - Installation Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for			

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	integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 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: Based on observation of the fire alarm control panel with the Director of Plant Operations (DPO) and Facilities Management Support (FMS) on 01/17/23 at 11:30 a.m., the time on the display of the fire alarm control panel indicated the time to be 1555 when checked at 11:30 a.m. Based on interview at the time of observation, the DPO and FMS agreed the fire alarm control panel had the wrong time. The finding was reviewed with the DPO and FMS during the exit conference. 3.1-19(b)	K 0341	Residents affected: No residents, staff, or visitors affected Corrective action: Director of Plant Operations corrected time on fire alarm control panel. The Director of Plant Operations was educated by the Executive Director on NFPA 72, National Fire Alarm and Signaling Code, 2010 Edition, Section 14.2.1.2.2 states system defects and malfunctions shall be corrected. Monitoring: Director of Plant Operations or designee will monitor fire alarm control panel weekly during rounds. Director of Plant Operations or designee will bring monitoring tool to QAPI monthly x3 months.	02/01/2023
K 0353 SS=C Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked			

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	b) Who provided system test c) Water system supply source Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on observation and interview, the facility failed to ensure 1 of 1 sprinkler systems were provided with spare sprinklers, a spare sprinkler cabinet and a sprinkler wrench on the premises. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.4.1.4 states a supply of spare sprinklers shall be maintained on the premises so that any sprinklers that have been operated or damaged in any way can be promptly replaced. The sprinklers shall correspond to the types and temperature ratings of the sprinklers on the property. The sprinklers shall be kept in a cabinet located where the temperature in which they are subjected will at no time exceed 100 degrees Fahrenheit. A special sprinkler wrench shall be provided and kept in the cabinet to be used in the removal and installation of sprinklers. This deficient practice could affect all residents and staff in the facility. Findings include: Based on observations during a tour of the facility with the Director of Plant Operations and Facilities Management Support on 01/17/23 at 11:20 am., there was a spare sprinkler cabinet in the riser room that included spare sprinklers; 1 of which was not in their own protected slot, being stored inside the sprinkler box. Based on interview at the time of the observation, the Director of Plant	K 0353	Residents affected: No residents, staff, or visitors affected Corrective action: Director of Plant Operations placed spare sprinkler in protected slot in spare sprinkler cabinet. The Director of Plant Operations was educated by the Executive Director on NFPA 25, Standard for the inspection, and Maintenance of Water based Fire Protection Systems, 2011 Edition, Section 5.4.1.4 states a supply of spare sprinklers shall be maintained on the premises so that any sprinklers that have been operated or damaged in any way can be promptly replaced. Monitoring: Director of Plant Operations or designee will monitor items and placement in spare sprinkler cabinet weekly during rounds. Director of Plant Operations or designee will bring monitoring tool to QAPI monthly x3 months.	01/18/2023

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	Operations agreed the spare sprinkler cabinet had one spare sprinkler not in protected slot. This finding was reviewed with the Director of Plant Operations at the time of discovery and again at the exit conference with the Director of Plant Operations and Facilities Management Support present. 3.1-19(b)			
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 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			

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	frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. Based on observation and interview, the facility failed to ensure 1 of about 35 resident room corridor doors were provided with a means suitable for keeping the door closed, had no impediment to closing, latching and would resist the passage of smoke. This deficient practice could affect 2 residents in resident room 222. Findings include: Based on observation with the Director of Plant Operations (DPO) and Facilities Management Support (FMS) on 01/17/23 at 11:50 a.m., the corridor door to resident room 222 did not latch into the frame when tested. Based on interview at the time of observation, the FMS stated the corridor door would not latch into the door frame because there was a problem with the hinge. The finding was reviewed with the DPO and FMS during the exit conference. 3.1-19(b)	K 0363	Residents affected: No residents, staff, or visitors affected Corrective action: Director of Plant Operations attempted to repair door, however unable to do so. Call placed to Hayes Brothers general contractors to repair door for room 222 on 1/26/23. Hayes Brothers scheduled to service door on 2/3/23 at 9:00am, at earliest available appointment. The Director of Plant Operations was educated by the Executive Director on Corridor – Doors, NFPA 101 Corridor doors and doors. Monitoring: Director of Plant Operations or designee will monitor doors in facility for proper closure 5x/week during rounds. Director of Plant Operations or designee will bring monitoring tool to QAPI monthly x3 months.	01/26/2023

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K 0374 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 Based on observation and interview, the facility failed to ensure 1 of 1 set of smoke barrier doors would restrict the movement of smoke for at least 20 minutes. LSC 19.3.7.8 requires doors in smoke barriers shall comply with LSC Section 8.5.4. LSC 8.5.4.1 requires doors in smoke barrier shall close the opening leaving only the minimum clearance necessary for proper operation. This deficient practice could affect about 25 residents in the affected hall. Findings include: Based on observation during a tour of the facility with the Director of Plant Operations (DPO) and Facilities Management Support (FMS) on 01/17/23 at 11:55 a.m., the set of smoke barrier doors in the corridor by resident room 217 would not close due to it getting stopped midway by the carpeting under it on one of the smoke doors. This condition would leave the door half open upon activation of the fire alarm. Based on interview	K 0374	Residents affected: No residents, staff, or visitors affected Corrective action: Director of Plant Operations adjusted the speed of the smoke barrier door closer by room 217 to allow door to close fully without being stopped by carpet. The Director of Plant Operations was educated by the Executive Director on NFPA 101 – Subdivision of building Spaces – Smoke Barrier Doors, LSC 19.3.7.8 requires doors in smoke barriers shall comply with LSC section 8.5.4. LSC 8.5.4.1 requires doors in smoke barrier shall close the opening leaving only the minimum clearance necessary for proper operation. Monitoring: Director of Plant Operations or designee will	01/18/2023

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	during the time of observation, the FMS stated the door that was part of a smoke barrier, was blocked from closing by the carpeting under it. This finding was reviewed during the exit conference. 3.1-19(b)		monitor all smoke barrier doors for proper closure in facility weekly during rounds. Director of Plant Operations or designee will bring monitoring tool to QAPI monthly x3 months.	
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 quarterly fire drills at unexpected times under varying conditions on all shifts for 4 of 4 quarters. This deficient practice could affect all residents, staff and visitors in the facility. Findings include: Based on records review with the Director of Plant Operations (DPO) and Facilities Management Support (FMS) on 01/17/23 at 10:00 a.m., the following shifts did not have fire drills at unexpected times: a. All first shift (6:00 a.m. to 2:00 p.m.) fire drills took place around the last week of the month. b. All second shift (2:00 p.m. to 10:00 p.m.) fire	K 0712	Residents affected: No residents, staff, or visitors affected Corrective action: Director of Plant Operations created schedule for fire drills for 2023 to ensure drills are held at unexpected times that vary monthly for all staff on all shifts. The Director of Plant Operations was educated by the Executive Director on NFPA 101 – Fire Drills. Fire Drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. Monitoring: Director of Plant	01/31/2023

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	drills took place around the last few days of the month. c. All third shift (10:00 p.m. to 6:00 a.m.) fire drills took place around the last few days of the month. Based on interview at the time of record review, the DPO and FMS did not realize the fire drills for all three shifts were not held at unexpected times. The findings were reviewed with the DPO and FMS during the exit conference. 3.1-19(b)		Operations or designee will monitor fire drill schedule monthly to ensure drills are held at unexpected and varying times. Director of Plant Operations or designee will bring monitoring tool to QAPI monthly x3 months.	
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 (plastic totes) in 1 of 6 corridors were maintained in accordance with 19.7.5.7. This deficient practice could affect staff and up to 20 residents in the affected hall.	K 0754	Residents affected: No residents, staff, or visitors affected Corrective action: Director of Plant Operations placed soiled linen/trash receptables in soiled	01/18/2023

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	Findings include: Based on observations during a tour of the facility with the Director of Plant Operations (DPO) and Facilities Management Support (FMS) on 01/17/23 at 12:05 p.m., there were two 30-gallon soiled linen/trash barrels (plastic totes) in the corridor next to resident room 134 doorway. Based on interview at the time of observation, the DPO and FMS observed there were two 30-gallon barrels of soiled linen/trash (plastic totes) totaling 60 gallons in a 64 square foot area in the hall. The finding was reviewed with the DPO and FMS during the exit conference. 3.1-19(b)		utility room and provided staff education. The Director of Plant Operations was educated by the Executive Director on NFPA 101 – Soiled Linen and Trash Containers. Soiled linen or trash collection receptacle shall not exceed 32 gallons in capacity. Monitoring: Director of Plant Operations or designee will monitor corridors 5x/week during rounds to ensure soiled linen/trash receptables are stored properly in soiled utility rooms. Director of Plant Operations or designee will bring monitoring tool to QAPI monthly x3 months.	
K 0920 SS=D Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension			

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	cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 Based on observation and interview, the facility failed to ensure 1 of 1 power strips for non-PCREE (patient-care-related electrical equipment) in resident rooms (outside of resident care vicinity) meet UL 1363. This deficient practice affects two residents. Findings include: Based on observation with the Director of Plant Operations (DPO) on 01/17/22 at 11:50 a.m., in resident room 222 there was a power strip in use outside of the resident care area that did not meet UL-1363. Based on interview at the time of observation, the DPO agreed a power strip was in use in a resident room and did not meet UL-1363. The findings were reviewed with the DPO and Facilities Management Support during the exit conference. 3.1-19(b)	K 0920	Residents affected: No residents, staff, or visitors affected Corrective action: Director of Plant Operations removed power strip from resident room 222 and plugged resident electrical devices into wall outlet. The Director of Plant Operations was educated by the Executive Director on NFPA 101, Electrical Equipment – Power Cords and Extension cords. Power strips for non-PCREE in the patient rooms meet UL 1363. Monitoring: Director of Plant Operations or designee will monitor resident rooms for power strips that do not meet UL-1363 criteria weekly during rounds. Director of Plant Operations or designee will bring monitoring tool to QAPI monthly x3 months.	01/18/2023
K 0923 SS=E Bldg. 01	NFPA 101 Gas Equipment - Cylinder and Container Storag Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet			

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	Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99)			
	1. Based on observation and interview, the facility failed to ensure empty cylinders are segregated from full cylinders and are marked to avoid confusion. This deficient practice could affect up to 30 residents in two smoke compartments.	K 0923	Residents affected: No residents, staff, or visitors affected Corrective action: Director of Plant Operations posted signage in oxygen room above racks to distinguish where full tanks are	01/18/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155819	A. BUILDING 01 B. WING	01/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WELLBROOKE OF KOKOMO	2200 SOUTH DIXON ROAD KOKOMO, IN 46902

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	Findings include: Based on observations with the Director of Plant Operations (DPO) and Facilities Management Support (FMS) on 01/17/23 at 11:50 a.m., the oxygen storage rooms contained two racks that did separate full cylinders from empty cylinders and no signage to identify which cylinders were empty. Based on interview at the time of observation, the DPO stated that there were empty and full cylinders in the racks but no way to identify the empty ones in both oxygen storage rooms. The findings were reviewed with the DPO and FMS during the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of about 20 cylinders of nonflammable gases such as oxygen were properly secured from falling. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 11.3.2 states storage for nonflammable gases greater than 8.5 cubic meters (300 cubic feet) but less than 85 cubic meters (3000 cubic feet) shall comply with 11.3.2.1 through 11.3.2.3. NFPA 99, Section 11.3.2.6 states cylinder or container restraints shall comply with 11.6.2.3. Section 11.6.2.3(11) states freestanding cylinders shall be properly chained or supported in a proper cylinder stand or cart. This deficient practice could affect 10 residents in one smoke compartment. Findings include: Based on observations during a tour of the facility with the Director of Plant Operations (DPO) and		located and where empty tanks are located. Director of Plant Operations chained 'E' type oxygen cylinder to wall for proper storage. The Nursing staff was educated by the Executive Director on NFPA 101, Gas Equipment – Cylinder and container storage. Empty cylinders are segregated from full cylinders. Monitoring: Director of Plant Operations or designee will monitor oxygen rooms weekly during rounds. Director of Plant Operations or designee will bring monitoring tool to QAPI monthly x3 months.	

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	155819	A. BUILDING 01 B. WING	01/17/2023

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	Facilities Management Support (FMS) on 01/17/23 at 11:50 a.m., one 'E' type oxygen cylinder was standing upright on the floor of the oxygen storage/trans-filling room and not properly chained or supported in a proper cylinder stand or cart. Based on interview at the time of observation, the DPO acknowledged one 'E' type oxygen cylinders in the oxygen storage/trans-filling room and not properly chained or supported in a proper cylinder stand or cart. The finding was reviewed with the DPO and FMS during the exit conference. 3.1-19(b)			