STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155222	A. BUILDING 00 B. WING	01/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
KOKOMO HEALTHCARE CENTER	429 W LINCOLN RD KOKOMO, IN 46902

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a COVID-19 Focused Infection Control Survey. Survey date: January 5, 2022 Facility number: 000127 Provider number: 155222 AIM number: 100291430 Census Bed Type: SNF/NF: 68 Total: 68 Census Payor Type: Medicare: 7 Medicaid: 55 Other: 6 Total: 68 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review was completed on January 11, 2022.	F 0000	Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during a COVID-19 Focused Infection Control Survey on 1/5/2022. Please accept this plan of correction as the provider's credible allegation of compliance. The provider respectfully requests a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program.			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155222	A. BUILDING 00 B. WING	01/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
KOKOMO HEALTHCARE CENTER	429 W LINCOLN RD KOKOMO, IN 46902

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155222	A. BUILDING 00 B. WING	01/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
KOKOMO HEALTHCARE CENTER	429 W LINCOLN RD KOKOMO, IN 46902

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.			
	Based on observation, interview and record review, the facility failed to develop and implement written policies and procedures for infection control, to contain the spread of the Covid-19 virus, when the facility failed to dispose of used PPE (personal protective equipment), properly store unused PPE and put soiled laundry in containers for two of four halls observed for infection control. (100 hall and 400 hall) Finding includes: During an ongoing observation, on 1/5/22 starting at 2:00 p.m., the following was observed: a. One blue disposable gown was hanging on the outside of the door to room 104. b. One blue disposable gown was hanging on the door knob of room 111. c. One white disposable gown hanging at the	F 0880	**F 880** **Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:** The disposable gowns were removed from rooms 104 and 111 and from the Nurses Station. The pair of gloves in the card board box next to the exit were properly disposed of. The towel and hoyer that were hanging on the handrail were transported to laundry as soiled linen to be washed. **Identification of other residents having the potential to be affected by the same alleged**	01/06/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155222	A. BUILDING 00 B. WING	01/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
KOKOMO HEALTHCARE CENTER	429 W LINCOLN RD KOKOMO, IN 46902

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	nurses station on the 100 hall. d. The hallway next to an exit door, on the 400 hall, had several empty boxes stacked on top of unopened boxes. There was one pair of gloves rolled together and inside out, in the empty cardboard box on top. e. The handrail next to the exit door had a white, wrinkled towel hanging on it. f. The dirty linen room across from the exit door, on the 400 hall, with the card board boxes had a Hoyer pad hanging from the handrail. g. The door to room 426 had a red sign on it to designate a positive Covid room. The door was opened into the resident room. The door had a hanging pocket on it with exposed and opened N95 masks hanging from the top pocket. Since the door was opened into the resident room, the masks were in the resident room. During an interview, starting at 2:05 p.m., the DON (Director of Nursing) indicated the facility was not in crisis capacity for PPE and was only using gowns once before disposal. She did not know why the gown was on the door to room 104 as the resident from the room was currently on the Covid unit. The gown was not on the doorknob of room 111 in the morning. The resident from 111 was currently on the Covid unit. The white disposable gown had been at hanging at the nurse station for a while and she was not sure if it was just there today or had also been there yesterday. She was not sure if the Hoyer pad was dirty and should have been placed inside the dirty linen room. She could not tell if the white towel on the handrail was dirty or clean. The masks hanging from room 426 should not have been left open to the air in the Covid positive room. A current facility policy, titled "Infection Prevention Program," dated as revised on 3/5/2021		**deficient practice and corrective actions taken**: All residents have the potential to be affected by this alleged deficient practice. The DON or designee will complete the following: Ensure staff involved are educated or appropriate way to dispose of contaminated items with potentially infectious agents. Ensure the potentially infectious agents are transported in biohazard containers and disposed of according to policy. Follow CDC and facility policy. Policy: Infection Control Practices for Laundy Linens Policy: Criteria for Covid 19 Requirements and Placement Ensure staff involved are educated on how and when to don and doff PPE with return demonstration, including, but not limited to, mask, respirator devices, gloves, gown, and eye protection. Follow CDC and facility policy. Policy: Criteria for Covid 19 Requirements and Placement CDC: PPE sequence Competency: AAPACN Personal-Protective-Equipment-PPE-Donning-and-Doffing,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155222	A. BUILDING 00 B. WING	01/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
KOKOMO HEALTHCARE CENTER	429 W LINCOLN RD KOKOMO, IN 46902

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	and received from the Executive Director (ED) on 1/5/2022 at 2:40 p.m., indicated "...The facility infection prevention program is comprehensive in that it addresses detection, prevention and control of infections among residents and employees...The facility will utilize current CDC guidelines for infection control monitoring and guidance...Prevention and spread of infections is accomplished by education and implementation for the use of hand hygiene, standard precautions, and transmission based precautions as appropriate...Staff and resident education focuses on risk of infection and practices to decrease risk including but not limited to hand hygiene compliance and cough/sneeze etiquette to break the chain of infection. Education to staff on donning and doffing of personal protective equipment is a focus of the infection prevention program..." The CDC guidelines on how to safely remove personal protective equipment (PPE), indicated "...GOWN...Gown front and sleeves are contaminated...Unfasten gown ties, taking care that sleeves don't contact your body when reaching for ties...Pull gown away from neck and shoulders, touching inside of gown only...turn gown inside out...Fold or roll into a bundle and discard in a waste container...." 3.1-18(b)		**Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:** A Root Cause Analysis (RCA) was conducted with the Infection Preventionist (IP) and input from the IDT and the facility Medical Director/IP/DON. The root cause was identified resulting in the facility's failure. Solutions were developed and systemic changes were identified that need to be taken to address the root cause. The Infection Preventionist and IDT reviewed the LTC infection control self-assessment and identified changes to make accurate **How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:** After the IDT and Infection Preventionist completed the RCA and LTC infection control assessment, training identified above was implemented to facility staff. The training will be conducted by the DON, IP or Medical Director with documentation of completion. To ensure Infection Control	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155222	A. BUILDING 00 B. WING	01/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
KOKOMO HEALTHCARE CENTER	429 W LINCOLN RD KOKOMO, IN 46902

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			Practices are maintained, the following monitoring will be implemented. 1. The IP nurse/DON/Designee will monitor each solution and systemic change identified in RCA and as noted above, daily or more often as necessary for 6 weeks and until compliance is maintained. Ensure staff execute the appropriate way to dispose of contaminated items with potentially infectious agents. Ensure the potentially infectious agents are transported in biohazard containers and disposed of according to policy Ensure staff execute appropriate donning and doffing of PPE Ensure N95s are stored / covered / sealed when in PPE storage compartments 2. The IP nurse/DON/Designee will complete daily visual rounds throughout the facility to ensure staff are practicing appropriate Infection Control Practices and complying with the solutions identified as above. This will occur for 6 weeks and until compliance is maintained. Ensure staff execute the appropriate way to dispose of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155222	A. BUILDING 00 B. WING	01/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
KOKOMO HEALTHCARE CENTER	429 W LINCOLN RD KOKOMO, IN 46902

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			contaminated items with potentially infectious agents. Ensure the potentially infectious agents are transported in biohazard containers and disposed of according to policy Ensure staff execute appropriate donning and doffing of PPE Ensure N95s are covered / sealed when in PPE storage compartments **Quality Assurance and Performance Improvement (QAPI):** The facility through the QAPI program, will review, update and make changes to the DPOC as needed for sustaining substantial compliance for no less than 6 months.	