STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155222	A. BUILDING -- B. WING	05/11/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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: 05/11/22 Facility Number: 000127 Provider Number: 155222 AIM Number: 100291430 At this Emergency Preparedness survey, Kokomo Healthcare Center was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 80 certified beds. At the time of the survey, the census was 68. Quality Review completed on 05/16/22	E 0000	Please accept this plan of correction as the provider's credible allegation of compliance. The provider respectfully requests a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 05/11/22 Facility Number: 000127 Provider Number: 155222 AIM Number: 100291430 At this Life Safety Code survey, Kokomo	K 0000	Please accept this plan of correction as the provider's credible allegation of compliance. The provider respectfully requests a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	

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

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	Healthcare Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and hard wired smoke detectors on 100 hall which do not activate the fire alarm system and battery powered smoke detectors in all other resident rooms. The healthcare portion of the facility has a capacity of 80 and had a census of 68 at the time of this visit. All areas where residents have customary access were sprinklered and all areas providing facility services were sprinkled. Quality Review completed on 05/16/22			
K 0222 SS=E Bldg. 01	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall			

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	be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted.			

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	18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 Based on observation and interview, the facility failed to ensure 1 of 6 delayed egress locking arrangements were installed in accordance with LSC 7.2.1.6.1(3) which states an irreversible process shall release the lock in the direction of egress within 15 seconds, or 30 seconds where approved by the authority having jurisdiction, upon application of a force to the release device required in 7.2.1.5.10 under all of the following conditions: (a) The force shall not be required to exceed 15 lbf (67 N). (b) The force shall not be required to be continuously applied for more than 3 seconds. (c) The initiation of the release process shall activate an audible signal in the vicinity of the door opening. (d) Once the lock has been released by the application of force to the releasing device, relocking shall be by manual means only. This deficient practice could affect 25 residents in the 100-hall Findings include: Based on observation Maintenance Director on 05/11/22 at 12:30 p.m., the 100-hall exit door by therapy was equipped with a 15 second delayed egress. When the exit door was tested the	K 0222	**1) The maintenance director installed new maglock on 5/11/22 for the 100-hall exit door and performed a house wide sweep with no further concerns observed.** **2) This deficient practice could affect 25 residents in the 100-hall.** **3) The maintenance director will perform weekly audits to ensure all egress doors are releasing properly.** **4)The Maintenance Director/Designee will bring results of the audits to QAPI for six months or until 100% compliance is achieved and address any concerns immediately.** **5) Changes will be implemented by 5/27/2022.**	05/27/2022

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	irreversible process to release the lock was not initiated. Based on interview at the time of observation, the Maintenance stated the maglock was broken and will be repaired. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)			
K 0353 SS=E 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 _____ 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 the spray pattern for sprinkler heads were not obstructed in 2 of 4 storage rooms in accordance with LSC 19.3.5.1. NFPA 13, 2010 edition, Section 8.5.5.1 states sprinklers shall be located so as to minimize obstructions to discharge as defined in Section 8.5.5.2 and Section 8.5.5.3 or additional	K 0353	**1. The maintenance director removed boxes in both storage rooms on 5/11/2022 that were within 18 inches from the sprinkler and performed a house wide sweep with no further concerns observed.** **2. This deficient practice could**	05/27/2022

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	sprinklers shall be provided to ensure adequate coverage of the hazard. Sections 8.5.5.2 and 8.5.5.3 do not permit continuous or noncontinuous obstructions less than or equal to 18 inches below the sprinkler deflector or in a horizontal plane more than 18 inches below the sprinkler deflector that prevent the spray pattern from fully developing. This deficient practice could affect 20 residents in one smoke compartment. Findings include: Based on observation with the Maintenance Director on 05/11/22 at 12:20 p.m., the storage closets next to rooms 203 and 211 had boxes stored about 6 to 8 inches away the deflector of the sprinkler head. Based on interview at the time of observation, the Maintenance Director agreed the boxes were less than 18 inches from the sprinkler and would obstruct sprinkler coverage. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		**affect 20 residents in one smoke compartment.3. The maintenance director/designee will perform weekly audits to ensure facility is in compliance.4. The Maintenance Director/Designee will bring results of the audits to QAPI for six months or until 100% compliance is achieved and address any concerns immediately.5) Changes will be implemented by 5/27/2022.**	
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			

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	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 of 15 resident room corridor doors on the 200-hall 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 room 211. Findings include:	K 0363	**1) The maintenance director adjusted the door frame for room 211 on 5/17 22 to ensure latching and performed a house wide sweep with no further concerns observed.** 2) This deficient practice could affect 2 residents in room 211. 3) The maintenance	05/27/2022

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	Based on observation with the Maintenance Director on 05/11/21 at 12:13 p.m., the corridor door to resident room 211 did not latch into the frame when tested. Based on interview at the time of observation, the Maintenance Director stated the corridor door would not latch into the frame because the door needed to be adjusted. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		director/designee will perform weekly audits to ensure facility is in compliance. 4) The Maintenance Director/Designee will bring results of the audits to QAPI for six months or until 100% compliance is achieved and address any concerns immediately. **5) Changes will be implemented by 5/27/2022.**	
K 0372 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. Based on observation and interview, the facility failed to ensure the penetrations caused by the passage of wire and/or conduit through 3 of 4 smoke barriers were protected to maintain the smoke resistance of each smoke barrier. LSC Section 19.3.7.5 requires smoke barriers to be constructed in accordance with LSC Section 8.5 and shall have a minimum ½ hour fire resistive	K 0372	**1) The maintenance director sealed the holes with fireproof caulk in room 226, room 407, and dietary on 5/12/2022 to ensure smoke barrier walls are sealed.** **2) This deficient practice could affect at least 30 residents in 3**	05/27/2022

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	rating. LSC Section 8.5.2.1 requires smoke barriers to be continuous from an outside wall to an outside wall, from a floor to a floor, or from a smoke barrier to a smoke barrier, or by use of a combination thereof. 8.5.6.2 requires penetrations for cables, cable trays, conduits, pipes, tubes, vents, wires, and similar items to accommodate electrical, mechanical, plumbing, and communications systems that pass through a wall, floor, or floor/ceiling assembly constructed as a smoke barrier, or through the ceiling membrane of the roof/ceiling of a smoke barrier assembly, shall be protected by a system or material capable of restricting the movement of smoke. This deficient practice could affect at least 30 residents in 3 smoke compartments. Findings include: Based on observations with the Maintenance Director on 05/11/22 between 12:40 p.m. and 1:00 p.m., above the ceiling tiles of the smoke walls by room 226, room 407, and dietary had a one-inch hole around a wire. Based on interview at the time of observation. the Maintenance agreed the three smoke walls contained unsealed penetrations. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		**smoke compartments.** **3. The maintenance director/designee will perform monthly audits to ensure facility is in compliance.** **4. The Maintenance Director/Designee will bring results of the audits to QAPI for six months or until 100% compliance is achieved and address any concerns immediately.** **5) Changes will be implemented by 5/27/2022.**	
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			

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	fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 Based on record review and interview, the facility failed to conduct fire drills or documented orientation training on each shift for 2 of 4 quarters. LSC 19.7.1.6 states drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions. QSO-20-31 1135 temporary waiver states in lieu of a physical fire drill, a documented orientation training program related to the current fire plan, which considers current facility conditions, is acceptable. The training will instruct employees, including existing, new or temporary employees, on their current duties, life safety procedures and the fire protection devices in their assigned area. This deficient practice affects all staff and residents. Findings include: Based on records review with the Maintenance Director on 05/11/22 at 10:40 a.m., the following shifts were missing documentation of a completed fire drill or documented orientation training: a) Third shift for the third quarter of 2021. b) Third shift for the first quarter of 2022. Based on interview at the time of record review, the Maintenance Director agreed there were two	K 0712	**1) The maintenance staff to be in-service for completing quarterly fire drills for each shift and documenting in TELS.** **2) This deficient practice could affect all staff and residents** **3. The executive director/designee will audit fire drills monthly for 6 months to ensure facility is in compliance.** **4. Results of the audits will be brought to QAPI monthly for six months or until 100% compliance is achieved and address any concerns immediately.** **5) Changes will be implemented by 5/27/2022.**	05/27/2022

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	missing fire drills and staff has not been trained in the fire safety procedures for the first and third quarters. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)			
K 0741 SS=F Bldg. 01	NFPA 101 Smoking Regulations Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where			

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	smoking is permitted. 18.7.4, 19.7.4 1. Based on observation, records review, and interview, the facility failed to enforce 1 of 1 smoking policies. This deficient practice could affect all occupants. Findings include: Based on records review with the Maintenance Director on 05/11/22 at 10:40 a.m., the smoking policy stated smoking is allowed only in designated areas. Based on observation with the Maintenance Director between 9:30 a.m. and 12:00 p.m., smoking in non-designated areas was evident due to at least 200 cigarette butts on the ground in the following areas: a. Service Hall exit. b. Front and back of the garage. c. Kitchen exit. d. By the activity's windows. e. In the front landscaping. f. Along the front sidewalk/curb. Based on interview at the time of observation and records review, the Maintenance Director stated there are only two smoking areas; the resident courtyard and the staff smoking hut. The Maintenance Director confirmed there was smoking in non-designated areas due to the cigarette butts on the ground in the aforementioned locations. 2. Based on observation and interview; the facility failed to ensure 2 of 2 smoking areas were maintained by disposing cigarette butts in a metal or noncombustible container with self-closing cover devices. This deficient practice could affect staff and 10 residents in the courtyard.	K 0741	**1) The maintenance director/designee removed all cigarette butts and disposed of properly on 5/12/2022. Education to be provided to all staff on smoking policy.** **2) This deficient practice could affect all occupants** **3) The maintenance director/designee will perform daily audit to ensure facility is in compliance and that all cigarette butts are disposed of properly.** **4) Results of the audits will be brought to QAPI monthly for six months or until 100% compliance is achieved and address any concerns immediately.** **5) Changes will be implemented by 5/27/2022.**	05/27/2022

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	Findings include: Based on observation during a tour of the facility with the Maintenance Director on 05/11/22 between 9:30 a.m. and 12:00 p.m., in the courtyard resident smoking area there were over 20 cigarette butts disposed on the ground in and around the smoking area. Also, in the staff smoking hut there were over 20 cigarette buts on the floor of the hut. Based on interview at the time of observations, the Maintenance Director agree there were cigarette butts on the ground in the aforementioned locations. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)			
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			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155222	A. BUILDING 01 B. WING	05/11/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	6921 or equivalent. 18.7.5.7, 19.7.5.7 Based on observation and interview, the facility failed to ensure trash receptacles in 2 of 5 corridors were maintained in accordance with 19.7.5.7. This deficient practice could affect staff and up to 20 residents in the 400-hall. Findings include: Based on observations with the Maintenance Director on 05/11/22 at 12:01 p.m. and 12:20 p.m., there were two 33-gallon soiled linen/trash barrels side by side by the soiled utility room on the 100-hall and the 300-hall. Based on interview at the time of observation, the Maintenance Director agreed there were two 33-gallon barrels of soiled linen/trash totaling 66 gallons in a 64 square foot area on the 100-hall and 300-hall. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)	K 0754	**1) The maintenance director removed both 33 gallon barrels from the hall and stored properly on 5/11/2022. Education to be provided to all staff on storage.** **2) This deficient practice could affect staff and up to 20 residents in the 400-hall.3) The maintenance director/designee will perform daily audits to ensure facility is in compliance.** **4) Results of the audits will be brought to QAPI monthly for six months or until 100% compliance is achieved and address any concerns immediately.5) Changes will be implemented by 5/27/2022.**	05/27/2022