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	07/11/2022

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
K 0000 Bldg. 01	A Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted on 05/11/22 was conducted by the Indiana Department of Health in accordance 42 CFR Subpart 483.90(a). Survey Date: 07/11/22 Facility Number: 000127 Provider Number: 155222 AIM Number: 100291430 At this PSR survey, Kokomo Healthcare Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type 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 07/13/22	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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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 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			

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	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. 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	K 0222	1) Vendor repaired maglock on 7/12/22 for the 100-hall exit door and Maintenance director performed a house wide sweep with no further concerns noted. 2) This deficient practice could affect 25 residents in the 100-hall. 3) An audit of all doors was completed to ensure doors release in 15 seconds on 7/11/2022. All egress doors were checked and the one on 100-hall was the only one not releasing properly. After the maglock was repaired on the	07/12/2022

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	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 07/11/22 at 2:15 p.m., the 100-hall exit door by therapy was equipped with a 15 second delayed egress. When the exit door was tested the 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. This deficiency was cited on 05/11/22. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-19(b)		100-hall door, all doors are now releasing properly. The maintenance director will perform rounds 1x per day for 5 days per week to ensure facility is in compliance. 4)The Maintenance Director/Designee will ensure completion of the audit of the secured doors. Results of the audit 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 7/12/2022	
K 0741 SS=E 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			

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	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 smoking is permitted. 18.7.4, 19.7.4 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 device. This deficient practice could affect staff and 10 residents in the courtyard. Findings include: Based on observation during a tour of the facility with the Maintenance Director on 07/11/22 at 2:30 p.m., in the courtyard resident smoking area there were over 30 cigarette butts disposed on the ground in and around the smoking area. Also, in the staff smoking hut there were over 20 cigarette butts on the floor of the hut and around the hut on the ground. Based on interview at the time of observations, the Maintenance Director agree there were cigarette butts on the ground in the	K 0741	1) The maintenance director/designee removed all cigarette butts and disposed of properly on 7/11/2022. Education provided to all staff on smoking policy. 2) This could affect staff and 10 residents in the courtyard. 3) The maintenance director/designee will perform rounds to ensure facility is in compliance and that all cigarette butts are disposed of properly. 4) The maintenance director/designee will perform rounds 2x per day 5 days per week for one month then then 1x	07/11/2022

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	aforementioned locations. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. This deficiency was cited on 05/11/22. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-19(b)		per day for 5 days per week to observe smoking areas. The 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 7/11/2022.	