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	12/28/2022

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 the Investigation of Complaints IN00396010, IN00396088, IN00397441 and IN00397922. Complaint IN00396010 - Unsubstantiated due to lack of evidence. Complaint IN00396088 - Substantiated. Federal/State deficiency related to the allegations is cited at F921. Complaint IN00397441 - Substantiated. No deficiencies related to the allegations were cited. Complaint IN00397922 - Substantiated. No deficiencies related to the allegations were cited. Survey dates: December 27 and 28, 2022 Facility number: 000127 Provider number: 155222 AIM number: 100291430 Census bed type: SNF/NF: 76 Total: 76 Census payor type: Medicare: 3 Medicaid: 66 Other: 7 Total: 76 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1. Quality review was completed on January 5, 2023.	F 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
Sydnie Reed	Executive Director	01/19/2023

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.

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	12/28/2022

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 0921 SS=D Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation, interview and record review, the facility failed to ensure personal care equipment was properly stored to promote a safe, clean, and comfortable environment for 5 of 10 resident rooms observed for environment. (Residents F, G, H, and K) Findings include: During a tour of the facility with the ED (Executive Director) in attendance, on 12/27/22 at 2:27 p.m., the following observations were made: 1. Resident F's bathroom was observed at 2:28 p.m. There was an uncovered pink fractured bedpan placed in between the handicapped safety rail going around the back of the toilet and the toilet. At that time, the ED indicated the bedpan could be placed there for storage, but it was to be covered with a bag. 2. Resident G's bathroom was observed at 2:30 p.m. There was an uncovered pink wash basin sitting directly on the floor, under the sink, and another uncovered pink wash basin was sitting on the edge of the sink leaning against the wall to stop it from falling on the floor. The wash basin sitting on the sink had personal care items observed in it. At that time, the ED indicated the wash basins should not be sitting on the floor or the sink. 3. Resident H's bathroom was observed at 2:53 p.m. There was an uncovered large blue bedpan	F 0921	F921 **Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:** Facility immediately addressed personal care equipment for the affected residents to ensure a safe, functional, sanitary, and comfortable environment. **Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken:** All residents that use personal care equipment have the potentially to be affected. Facility completed a whole house sweep to ensure all personal care equipment was properly stored to promote a safe, functional, sanitary, and comfortable environment. **Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:** Education on Routine Resident Care policy was provided to all direct care employees with the focus being on personal care equipment storage. **How the corrective measures**	01/23/2023

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	12/28/2022

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
	sitting on its side on the floor between the left side of the toilet and the wall. At that time, the ED indicated the bedpan was to be bagged and it should not be sitting on the floor. 4. Resident K's bathroom was observed at 2:59 p.m. There was an uncovered urinal sitting on the back of the toilet. At that time, the ED indicated the urinal should have been placed into a plastic bag. At the end of the tour, the ED indicated all the personal care equipment must be placed in a bag to be stored. These items were reused if they were stored properly. A current policy, titled "Routine Resident Care," undated and provided by the Regional Director of Clinical Operations (RDCO) on 12/27/22 at 2:15 p.m., indicated "...Definition: Routine Resident Care: care that is not necessarily medically or clinically based but necessary for quality of life promoting dignity and independence, as appropriate...Procedure...3. Unlicensed Staff: a. Provide routine daily care by a certified nursing assistant under the supervision of a licensed nurse. b. Routine care by a nursing assistant includes but is not limited to the following...iv. Assisting in maintenance of belongings and immediate environment of residents...vi. Providing privacy and personal space...." This Federal tag relates to Complaint IN00396088. 3.1-19(f)(5)		**will be monitored to ensure the alleged deficient practice does not recur**: The Director of Nursing/Designee will conduct audits of 5 residents per week for 4 weeks, then 3 residents for 4 weeks, then 1 resident for 4 months to ensure personal care equipment is being stored properly. Any deficiencies identified will be immediately corrected and re-education will be provided by the Director of Nursing/Designee. The results of the audit observations will be reported, reviewed and trended for compliance thru the facility Quality Assurance Committee for a minimum of six months then randomly thereafter for further recommendation.	