STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155678	A. BUILDING -- B. WING	12/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERFORD PLACE HEALTH CAMPUS	800 ST JOSEPH DR KOKOMO, IN 46901

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E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 12/29/2022 Facility Number: 002667 Provider Number: 155678 AIM Number: 200300090 At this Emergency Preparedness survey, Waterford Place Health Campus 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 103 and had a census of 61 at the time of this survey. Quality Review completed on 01/03/23	E 0000	Waterford Place Health Campus POC due: 01-15-23 Date of Compliance: 01-28-23 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 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 the survey visit with exit on December 29. 2022. The facility respectfully requests from the department a desk review for 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: 12/29/2022 Facility Number: 002667 Provider Number: 155678 AIM Number: 200300090 At this Life Safety Code survey, Waterford Place	K 0000	Waterford Place Health Campus POC due: 01-15-23 Date of Compliance: 01-28-23 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 it is required by the	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Rachel Bishir	Executive Director	01/12/2023

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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	Health Campus 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 103 and had a census of 61 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 01/03/23		position of Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during the survey visit with exit on December 29. 2022. The facility respectfully requests from the department a desk review for substantial compliance.	
K 0222 SS=D 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			

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	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. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS			

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	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 30 residents in the Transitional Care area. Findings include: Based on observation during a tour of the facility with the Facility Operations Manager and Senior Manager on 12/29/22 at 11:00 a.m. and 12:15 p.m., the Transitional Care hall exit door 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	K 0222	**K-222 – Egress Doors** Compliance Date – 1/28/23 **Immediate Intervention** The Transitional Care exit door was immediately repaired by the DPO and re-tested, is now functioning properly. The DPO was educated by the Facility Operations Manager on LSC 7.2.1.5.10. The TCS exit door in question was repaired, tested and is now functioning properly. As a measure of ongoing compliance, the DPO (Director of Plant Operations) or designee will test the proper egress operation of the exit doors weekly and document tests. The testing records will be audited weekly to ensure compliance X one month, then monthly X 3 months or until 100% compliance is maintained. As a quality measure, The Executive Director or designee will review findings and any corrective actions for at least 6 months or until 100% compliance is maintained in the campus QAA meetings. This plan will be reviewed and updated as warranted.	01/28/2023

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	the time of observation, the Facilities Operations Manager tried 4 times to activate the delay egress and stated the delayed egress is not working and will need to be repaired. This finding was reviewed with the Facilities Operations Manager and Senior Manager during the exit conference. 3.1-19(b)		TCS residents (30) have the potential to be affected by alleged deficient practice.	
K 0321 SS=D Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons)			

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	e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) 1.Based on observation and interview, the facility failed to ensure the 2 of 2 corridor doors to the laundry room, which is a hazardous area greater than 100 square feet, was provided with a self-closing device which would cause the door to automatically close and latch into the door frame. This deficient practice could affect staff in the service hall. Findings include: Based on observations during a tour of the facility with the Facility Operations Manager (FOM) and Senior Manager on 12/29/22 at 12:05 p.m., the laundry room, a hazardous room that was greater than 100 square feet, was equipped with a self-closing device on the in and out corridor doors, but both doors did not latch into the frame when tested. Based on interview at the time of observation, the Facility Operations Manager and Senior Manager agreed the room was larger than 100 square feet, and stated the doors are scheduled to be replaced. This finding was reviewed with the FOM and Senior Manager at the exit conference. 2.Based on observation and interview, the facility failed to ensure 1 of 1 Consultation room with large amounts of combustible storage and greater than 50 square feet was protected as a hazardous area. This deficient practice could affect 6 residents in the Consultant room area.	K 0321	**K-321 – Hazardous Areas – Enclosure** Compliance Date – 1/28/23 **Immediate Intervention** The Laundry Room door will be repaired to ensure proper closure. A closure was ordered for the consultant room door and supplies have now been moved to another enclosed storage unit. The DPO was educated by the Facility Operations Manager on NFPA 101 Hazardous Areas – Enclosed The Laundry Room doors were scheduled for replacement to ensure proper closure. A closure was ordered for the consultant room door and supplies have now been moved to another enclosed storage unit. As a measure of ongoing compliance, the DPO (Director of Plant Operations) or designee will audit weekly the laundry room door function and the consultant room door closure and document results. The auditing records will be reviewed weekly to ensure compliance X one month, then monthly X 3 months or until 100% compliance is maintained. As a quality measure, The Executive Director or designee will	01/28/2023

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	Findings include: Based on observation during a tour of the facility with the Facilities Operations Manager (FOM) and Senior Manager on 12/29/22 at 1:00 p.m., the Consultation room contained over 30 boxes of supplies and was greater than 50 square feet making this a hazardous area. The storage room was not protected as a hazardous area because the corridor door to the room was not self-closing or automatic closing. Based on interview at the time of observation, the FOM agreed the room contained a large amount of combustible storage, was larger than 50 square feet, and the corridor door to the room was not self-closing. The finding was reviewed with the FOM and Senior Manager during the exit conference. 3.1-19(b)		review findings and any corrective actions for at least 6 months or until 100% compliance is maintained in the campus QAA meetings. This plan will be reviewed and updated as warranted. 6 residents have the potential to be affected by alleged deficient practice.	
K 0345 SS=F Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 Based on record review and interview, the facility failed to ensure 1 of 1 fire alarm systems was maintained in accordance with LSC 9.6.1.3. LSC 9.6.1.3 requires a fire alarm system to be installed, tested, and maintained in accordance with NFPA 70, National Electrical Code and NFPA 72,	K 0345	**K-345 – NFPA 101 Fire Alarm System – Testing and Maintenance.** Compliance Date – 1/28/23 **Immediate Intervention** The Fire Panel was immediately	01/28/2023

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	National Fire Alarm Code. NFPA 72, Section 14.2.1.2.2 requires that system defects and malfunctions shall be corrected. This deficient practice could affect all residents and staff. Findings include: Based on observation with the Facilities Operations Manager (FOM) on 12/29/22 at 12:30 p.m., the fire control panel was found in trouble mode. Based on interview with the Facilities Operations Manager he stated that there was a water leak in the ceiling that was repaired but the system continued to be in trouble mode. The system was tested and confirmed that it is working. The FOM stated that they are on a waiting list to be repaired due to the recent cold temperatures. This finding was reviewed with the FOM and Senior Manager during the exit conference. 3.1-19(b)		addressed, smoke detector serviced, and brought into compliance with the correction of the trouble alarm on 01/06/23 by the ADPO. Is now functioning properly. The DPO was educated by the Facility Operations Manager on NFPA 101, Fire Alarm System – Testing and Maintenance. The Fire Panel was immediately serviced and brought into compliance with the correction of the trouble alarm. Is now functioning properly. As a measure of ongoing compliance, the DPO (Director of Plant Operations) or designee will audit the fire panel 3 X weekly and document audits. The auditing records will be reviewed weekly to ensure compliance X one month, then monthly X 3 months or until 100% compliance is maintained. As a quality measure, The Executive Director or designee will review findings and any corrective actions for at least 6 months or until 100% compliance is maintained in the campus QAA meetings. This plan will be reviewed and updated as warranted. All residents have the potential to be affected by alleged deficient practice.	
K 0712 SS=E Bldg. 01	NFPA 101 Fire Drills Fire Drills			

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	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 fire drills on each shift for 5 of 12 drills. 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. This deficient practice affects all staff and residents. Findings include: Based on records review with the Facilities Operations Manager and Senior Manager on 12/29/22 at 11:30 a.m., the following shifts were missing documentation of a completed fire drill: a) A first shift fire drill in the first quarter of 2022. b) Second shift and third shift fire drills in the third quarter of 2022. c)Second shift and third shift fire drills in the fourth quarter of 2022. Based on interview at the time of record review, the Senior Manager stated they could not find the documentation to show the aforementioned drills were conducted. This finding was reviewed at the exit conference.	K 0712	K-712 – **Fire Drills** Compliance Date – 1/28/23 **Immediate Intervention** The DPO/Assistant were in-serviced by the Facilities Operations Manager on the requirements for conducting fire drills. The schedule of drills was completed for the 2023 year. As a measure of ongoing compliance, the DPO (Director of Plant Operations) or designee will audit monthly the conducting of drills per the established schedule and document results. The auditing records will be reviewed weekly to ensure compliance X one month, then monthly X 3 months or until 100% compliance is maintained. As a quality measure, The Executive Director or designee will review findings and any corrective actions for at least 6 months or until 100% compliance is maintained in the campus QAA meetings. This plan will be reviewed and updated as	01/28/2023

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	3.1-19(b)		warranted. All residents have the potential to be affected by the alleged deficient practice.	
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 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 flexible cords were not used as a substitute for fixed wiring. NFPA-70/2011, 400.8 state unless specifically permitted in 400.7 flexible cords and cables shall not be used for (1) as a substitute for fixed wiring. This deficient practice could affect up to 2 residents in resident	K 0920	**K-920 – Electrical Equipment - Power Cords and Extension Cords** Compliance Date – 1/28/23 **Immediate Intervention** The extension cord in room 607 was immediately removed.	01/28/2023

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	room 607. Findings include: Based on observation during a tour of the facility with the Facilities Operations Manager (FOM) and Senior Manager on 12/29/22 at 12:40 p.m., a cell phone charger was plugged into and supplied power by an extension cord in resident room 607. Based on interview at the time of observation, the FOM and Senior Manager acknowledged an extension cord was in use and removed the extension cord. The finding was reviewed with the FOM and Senior Manager during the exit conference. 3.1-19(b)		The DPO was educated by the Facility Operations Manager NFPA 101, Electrical Equipment - Power Cords and Extension Cords. The extension cord in room 607 was immediately removed and a walk-through audit conducted to ensure no other cords were present. As a measure of ongoing compliance, the DPO (Director of Plant Operations) or designee will round weekly all resident rooms for the presence of unapproved cords or power strips and document results. The auditing records will be reviewed monthly X 3 months to ensure compliance or until 100% compliance is maintained. As a quality measure, The Executive Director or designee will review findings and any corrective actions for at least 6 months or until 100% compliance is maintained in the campus QAA meetings. This plan will be reviewed and updated as warranted. Two residents have the potential to be affected by the alleged deficient practice.	