STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155819	A. BUILDING -- B. WING	04/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WELLBROOKE OF KOKOMO	2200 SOUTH DIXON ROAD KOKOMO, IN 46902

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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: 04/10/25 Facility Number: 013153 Provider Number: 155819 AIM Number: 201254360 At this Emergency Preparedness survey, Wellbrooke of Kokomo was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. Due to the lack of a two-hour separation (which was determined by facility construction prints and physical inspection) between assisted living and health care, the whole facility was surveyed. The facility has a capacity of 70 health care beds with a census of 56, 33 beds in assisted living with a census of 27, and a total census of 83. Quality Review completed on 04/15/25	E 0000	The submission of this plan of correction does not indicate and admission by Wellbrooke of Kokomo that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and the living environment provided to the residents of Wellbrooke of Kokomo. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. 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: 04/10/25 Facility Number: 013153 Provider Number: 155819	K 0000	The submission of this plan of correction does not indicate and admission by Wellbrooke of Kokomo that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and the living environment provided to the residents of Wellbrooke of	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Amorette Dunkle	Executive Director	04/25/2025

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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	AIM Number: 201254360 At this Life Safety Code survey, Wellbrooke of Kokomo 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. 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, spaces open to the corridors, carbon dioxide detectors by gas fireplaces, and hard-wired smoke detectors in all the resident sleeping rooms. The facility is partly protected by a type II EES diesel powered generator. Due to the lack of a two-hour separation (which was determined by facility construction prints and physical inspection) between assisted living and health care, the entire facility was surveyed. The facility has a capacity of 70 health care beds with a census of 56, 33 beds in assisted living with a census of 27, and a total census of 83. All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered. Quality Review completed on 04/15/25		Kokomo. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests from the department a desk review for substantial compliance.	
K 0324 SS=E Bldg. 01	NFPA 101 Cooking Facilities Based on observation and interview, the facility failed ensure 2 of 2 commercial cooking equipment open to the corridor was in accordance LSC	K 0324	1 1. No residents were affected. No adverse effects noted. 2 2.All residents have the	04/14/2025

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	18.3.2.5.3 witch states within a smoke compartment, where residential or commercial cooking equipment is used to prepare meals for 30 or fewer persons, one cooking facility shall be permitted to be open to the corridor, provided that all of the following conditions are met: LCS TIA 12-2 18.3.2.5.3 states within a smoke compartment, where residential or commercial cooking equipment is used to prepare meals for 30 or fewer persons, one cooking facility shall be permitted to be open to the corridor, provided that all of the following conditions are met: (1) The portion of the health care facility served by the cooking facility is limited to 30 beds and is separated from other portions of the health care facility by a smoke barrier constructed in accordance with 18.3.7.3, 18.3.7.6, and 18.3.7.8. (2) The cooktop or range is equipped with a range hood of a width at least equal to the width of the cooking surface, with grease baffles or other grease-collecting and clean-out capability. (3)* The hood systems have a minimum airflow of 500 cfm (14,000 L/min). (4) The hood systems that are not ducted to the exterior additionally have a charcoal filter to remove smoke and odor. (5) The cooktop or range complies with all of the following: (a) The cooktop or range is protected with a fire suppression system listed in accordance with UL 300, or is tested and meets all requirements of UL 300A, in accordance with the applicable testing document's scope. (b) A manual release of the extinguishing system is provided in accordance with NFPA 96, Section 10.5. (c) An interlock is provided to turn off all sources of fuel and electrical power to the cooktop or range when the suppression system is activated. (6)* The use of solid fuel for cooking is		potential to be affected. Cooking appliances removed from Assisted Living and Health Center kitchenettes. Ventilation hood removed from Assisted Living kitchenette. House wide audit completed to ensure all cooking appliances in correct locations and locks installed on cooking appliances with wheels. Staff educated on correct placement of cooking appliances. 3 3. As a measure of ongoing compliance, the Director of Plant Operations (DPO) or designee will audit placement of cooking appliances. Audit to consist of three cooking appliances, if available, weekly x4 weeks, then twice monthly x2 months, then monthly x3 months. 4 4. As a quality measure, the ED or designee will review any findings and corrective action at least quarterly in the campus Quality Assurance Performance Improvement meetings. The plan will be revised and updated as warranted.	

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	prohibited. (7)* Deep-fat frying is prohibited (8) Portable fire extinguishers in accordance with NFPA 96 are located in all kitchen areas. (9)* A switch meeting all of the following is provided: (a) A locked switch, or a switch located in a restricted location, is provided within the cooking facility that deactivates the cooktop or range. (b) The switch is used to deactivate the cooktop or range whenever the kitchen is not under staff supervision. (c) The switch is on a timer, not exceeding a 120-minute capacity that automatically deactivates the cooktop or range, independent of staff action. (10) Procedures for the use, inspection, testing, and maintenance of the cooking equipment are in accordance with Chapter 11 of NFPA 96 and the manufacturer's instructions and are followed. (11)* Not less than two AC-powered photoelectric smoke alarms with battery backup, interconnected in accordance with 9.6.2.10.3, and equipped with a silence feature are located not closer than 20 ft (6.1 m) and not further than 25 ft (7.6 m) from the cooktop or range. (12)* The smoke alarms required by 18.3.2.5.3(11) are permitted to be located outside the kitchen area where such placement is necessary for compliance with the 20- ft (7.6-m) minimum distance criterion. (13)* A single system smoke detector is permitted to be installed in lieu of the smoke alarms required in 18.3.2.5.3(11) provided the following criteria are met: (a) The detector is located not closer than 20 ft (6.1 m) and not further than 25 ft (7.6 m) from the cooktop or range. (b) The detector is permitted to initiate a local audible alarm signal only. (c) The detector is not required to initiate a			

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	building-wide occupant notification signal. (d) The detector is not required to notify the emergency forces. (e) The local audible signal initiated by the detector is permitted to be silenced and reset by a button on the detector or by a switch installed within 10 ft (3.0 m) of the system smoke detector. (14) System smoke detectors that are required to be installed in corridors or spaces open to the corridor by other sections of this chapter are not used to meet the requirements of 18.3.2.5.3(11) and are located not closer than 25 ft (7.6 m) to the cooktop or range. This deficient practice could affect 60 residents in two smoke compartments. Findings include: Based on observation with the Maintenance Director and Direct Management Support (DMS) on 04/10/25 at 11:40 a.m. and 11:55 a.m., the following was observed: (a) In the AL dining room, there was a grill underneath a suppression system that was open to the corridor, but the suppression system was not inspected and was not equipped with a manual release of the extinguishing system. (b) In the main dining room, there was a grill in use that was open to the corridor but there was no suppression system provided and it did not meet all other listed requirements. Based on an interview at 11:40 a.m. and 11:55 a.m., the Maintenance Director stated the AL dining kitchen's suppression system has never been inspected, did not contain a manual release for the extinguishing system, and the main dining room grill was not protected with the listed requirements. This finding was reviewed with the Maintenance			

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	Director, DMS, and the Administrator during the exit conference at 1:30 p.m. 3.1-19(b)			
K 0781 SS=E Bldg. 01	NFPA 101 Portable Space Heaters Based on record review, observation, and interview; the facility failed to enforce the portable space heater policy to ensure heaters are inspected and did not exceed 212 degrees for 1 of 1 portable space heaters used in staff areas. This deficient practice could affect 50 residents in the main dining room and staff in the kitchen. Findings include: Based on observation with the Maintenance Director and Direct Management Support (DMS) on 04/10/25 at 11:47 a.m., there was a portable space heater in use in the Dietary office. Based on records review at 12 :50 p.m., the space heater policy does allow space heaters in staff areas with proper maintenance and testing, but there was no documentation available to ensure the space heater does not exceed 212 degrees and receive proper testing and maintenance. Based on interviews at 11:47 a.m. and 12:50 p.m., the DMS and the Maintenance Director stated space heaters are allowed in staff areas but the portable space heater in the Dietary office was not inspected and tested before use. This finding was reviewed with the Maintenance Director, DMS, and the Administrator during the exit conference at 1:30 p.m. 3.1-19(b)	K 0781	1 1.No residents were affected. No adverse effects noted. 2 2.All residents have the potential to be affected. Housewide audit completed to ensure no space heaters being used in campus. Staff educated on the portable heaters policy. 3 3. As a measure of ongoing compliance, the Director of Plant Operations (DPO) or designee will audit offices to ensure space heaters are not present. Audit to consist of three offices, if available, weekly x4 weeks, then twice monthly x2 months, then monthly x3 months. 4 4. As a quality measure, the ED or designee will review any findings and corrective action at least quarterly in the campus Quality Assurance Performance Improvement meetings. The plan will be revised and updated as warranted.	04/14/2025

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K 0927 SS=E Bldg. 01	NFPA 101 Gas Equipment - Transfilling Cylinders Based on observation and interview, the facility failed to ensure 2 of 2 liquid oxygen storage/transfer rooms were provided with a sign indicating when oxygen transfilling is occurring. NFPA 99 11.5.2.3.1(3) states, the area is posted with signs indicating that trans-filling is occurring and that smoking is the immediate area is not permitted. This deficient practice could affect 40 residents in two smoke compartments. Findings include: Based on observation with the Maintenance Director and Direct Management Support (DMS) on 04/10/25 at 12:24 p.m. and 12:39 p.m., the 100-hall and 200-hall oxygen transfilling rooms contained liquid oxygen tanks. The doors to the rooms were not provided with signs indicating when oxygen transfilling is occurring. Based on an interview at 12:24 p.m. and 12:39 p.m., the Maintenance Director stated there were no signs on the transfilling room doors indicating when oxygen transfilling is occurring. This finding was reviewed with the Maintenance Director, DMS, and the Administrator during the exit conference at 1:30 p.m. 3.1-19(b)	K 0927	1. No residents were affected. No adverse effects noted. 2. All residents that have the potential to be affected. House wide audit completed to ensure all oxygen rooms have appropriate signage in place on door. Staff educated on using signage to indicate when oxygen transfer is in process. 3. As a measure of ongoing compliance, the Director of Plant Operations (DPO) or designee, will complete audits of 2 oxygen rooms to ensure oxygen transfer sign is in place and being used appropriately 3x weekly x4 weeks, then weekly x 4 weeks, then every other week x 4 weeks, then monthly x3 months 4. As a quality measure, the Executive Director (ED) or designee will review any findings and corrective action at least quarterly in the campus Quality Assurance Performance Improvement meetings. The plan will be revised and updated as warranted.	04/14/2025