PRINTED: 07/01/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING		COMPLETED			
		155222	B. W	ING		06/13/	/2024	
		<u>I</u>		STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>		
NAME OF PROVIDER OR SUPPLIER					LINCOLN RD			
кокомо	) HEALTHCARE CI	ENTER	_	KOKOMO, IN 46902				
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	``	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
E 0000								
Bldg								
Diag	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in		E 00	000	Please accept this plan of correction as the provider's			
				300				
	accordance with 42	-			credible allegation of complian	ice.		
					The provider respectfully requi			
	Survey Date: 06/13	5/24			a desk review with paper			
					compliance to be considered i	n		
	Facility Number: 00				establishing that the provider i	s in		
	Provider Number: 1			substantial compliance.				
	AIM Number: 1002	291430						
	A 4 41. i.a. 15	D						
	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 a capacity of 80 and had a census of 70 at the time							
	of this survey.							
	Quality Review con	npleted on 06/14/24						
K 0000								
Dida 04								
Bldg. 01	A Life Sefety Code	Recertification and State	17.0	000	Diagon accept this plan of			
	<u> </u>	ras conducted by the Indiana	K 0	UUU	Please accept this plan of correction as the provider's			
		th in accordance with 42 CFR			credible allegation of compliar	nce		
	483.90(a).	in in accordance with 72 Cr K			The provider respectfully requi			
	130130(4).				a desk review with paper	-510		
	Survey Date: 06/13	5/24			compliance to be considered i			
	Facility Number: 0	00127			establishing that the provider is in substantial compliance.			
	Provider Number: 1				Castaniai compilance.			
	AIM Number: 1002							
	At this Life Safety (	Code survey, Kokomo						
		vas found not in compliance						
	with Requirements	for Participation in						

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Sydnie Reed Executive Director 06/27/2024

Any defiency statement 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 disclodays 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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## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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		IDENTIFICATION NUMBER  155222	A. BUILDING B. WING	01	COMPLETED 06/13/2024	
NAME OF PROVIDER OR SUPPLIER  KOKOMO HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 429 W LINCOLN RD KOKOMO, IN 46902				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
K 0293 SS=E Bldg. 01	Medicare/Medicaid, Life Safety from Fir National Fire Protect Life Safety Code (L Health Care Occupa This one-story facilit Type II (000) constr sprinklered. The fact with smoke detection to the corridors and detectors in the resid facility has a capacit 70 at the time of this  All areas where the access were sprinkle facility services were  Quality Review com  NFPA 101 Exit Signage Exit Signage Exit Signage Exit Signage 2012 EXISTING Exit and directional accordance with 7 illumination also se lighting system. 19.2.10.1 (Indicate N/A in on occupancies with I where the line of e Based on observation failed to ensure 1 of continuously illumin Life Safety Code at directional signs are 7.10 with continuously	A2 CFR Subpart 483.90(a), re and the 2012 edition of the stion Association (NFPA) 101, SC), Chapter 19, Existing ancies and 410 IAC 16.2.  Aty was determined to be of ruction and was fully ility has a fire alarm system on in the corridors, areas open battery powered smoke dent sleeping rooms. The try of 80 and had a census of a survey.  All areas providing re sprinklered.  All areas providing re sprinklered.  All signs are displayed in all signs are displayed in and with continuous reved by the emergency	K 0293	What corrective action will b accomplished for those residents found to have been affected by the alleged deficient practice: The facility immediately replaced the light bulb in the exit sign above the	e 07/03/2024	

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i '		X1) PROVIDER/SUPPLIER/CLIA	` ′		ONSTRUCTION	(X3) DATE SURVEY	
		IDENTIFICATION NUMBER	A. BUILDING <u>01</u>		COMPLETED		
155222		B. WING 06/13/2024			024		
NAME OF E	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF FROVIDER OR SUFFLIER					LINCOLN RD		
KOKOMO	O HEALTHCARE C	ENTER		KOKON	ЛО, IN 46902		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE (	COMPLETION
TAG		t as many as 14 residents 4		TAG			DATE
	_	t as many as 14 residents, 4 in the smoke compartment.			barrier doors near room 425 to ensure the sign is continuousl		
	starr and 2 visitors i	in the smoke compartment.		illuminated in accordance with Life		•	
	Findings include:				Safety Code 7.10.		
	Based on observation	ons made on 06/13/24 during a			How other residents having	the	
		vith the Executive Director and			potential to be affected by th		
		rector, the 400 Hall exit sign			same deficient practice will I		
		oors nearest to resident room			identified and what correctiv	e	
		inated. Based on an interview at			action will be taken: The		
		tion, the Maintenance Director			alleged deficient practice has	the	
		bs in the exit light were indeed			potential to affect up to 14	^	
	burnt out and added that he would have one of his staff replace the bulbs immediately.				residents, 4 staff, and 2 visitor		
	his starr replace the	butos ininediately.			whole house audit of all exit si above barrier doors was comp	-	
	This item was discu	assed with the Executive			during the survey with no other		
	Director and the Maintenance Director at the exit				discrepancies noted in the 250		
		06/13/24 at 2:45 p.m.			alouropariolog flotog ili tilo 200	٠٠. ا	
					What measures will be put ir	nto	
	3.1.19(b)				place or what systemic		
					changes will be made to		
					ensure that the deficient		
					practice does not recur:		
					Education was completed with	1	
					maintenance staff with an emphasis on NFPA 101 2012		
					Edition – Life Safety Code at 7		
					to ensure facility is in complian		
					How the corrective action wi		
					be monitored to ensure the		
					deficient practice will not		
					recur: The Maintenance		
					Director/Designee will conduc		
					weekly rounds for 12 weeks, t		
					monthly rounds for 12 weeks to ensure all fire exit signs are	io	
					continuously luminated. Any		
					discrepancies found will be		
					immediately corrected. The re	sults	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155222	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 06/13/2024		
NAME OF PROVIDER OR SUPPLIER  KOKOMO HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP COD 429 W LINCOLN RD KOKOMO, IN 46902				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
				of these reviews will be discuss at the monthly facility Quality Assurance Committee meetin monthly for three months and quarterly thereafter once full compliance has been achieve a total of 6 months of monitori Frequency and duration of revisible will be increased as needed, i areas of noncompliance exist.	g then ed for ing. views f		
K 0761 SS=E Bldg. 01	failed to maintain a storage and transfill with NFPA 80, Star Opening Protective requires any device condition, arrangem other feature is required provision of this Cosystem, condition, a protection, or other maintained unless the maintenance. NFPA assemblies shall be than annually, and a inspection shall be by the AHJ. This domany as 14 resident smoke compartment.	view and interview, the facility innual testing for 1 of 1 oxygen ling room door in accordance indard for Fire Doors and Other is, 2010 Edition. LSC 4.5.8, equipment, system, ment, level of protection, or any streed for compliance with the ode, such device, equipment, arrangement, level of feature shall thereafter be the Code exempts such in a 80 5.2.1 requires fire door inspected and tested not less a written record of the signed and kept for inspection efficient practice could affect as its, 4 staff and 2 visitors in the t.	K 0761	What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice: The facility immediately completed annual testing for the oxygen storage transfilling room door to ensur is in accordance with NFPA 8 Standard for Fire Doors and COpening Protectives, 2010 Ed LSC 4.5.8.  How other residents having potential to be affected by the same deficient practice will be identified and what corrective action will be taken: The alleged deficient practice has potential to affect up to 14 residents, 4 staff, and 2 visitor whole house audit of all annual testing for fire doors was	n  y al and re it 0, Other dition.  the ne be ye the		
	Executive Director	and the Maintenance Director		completed during the survey v			

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inspection documentation was requested. After

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the 2567.

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>01</u> COM		COMPL	ETED	
		155222	B. WING		06/13/	06/13/2024	
		1					
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP COD		
					LINCOLN RD		
KOKOMO	O HEALTHCARE C	ENTER		KOKON	MO, IN 46902		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID			(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
TAG	`	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
		was provided, it was noted					
		rage and transfilling room door			What measures will be put in	ıto.	
		e aforementioned inspection.			place or what systemic	110	
	-	at the time of record review,			changes will be made to		
		irector that he was unaware			_		
	that the door to the				ensure that the deficient		
		as required to be inspected as a			practice does not recur:		
	_	•			Education was completed with	I	
	-	out added that he would have			maintenance director with an		
	this door inspected	as soon as possible.			emphasis on NFPA 80, Stand		
	TEN 1 1	i sid n			for Fire Doors and Other Oper	-	
		ussed with the Executive			Protectives, 2010 Edition. LSC	;	
		aintenance Director at the exit			4.5.8 to ensure facility is in		
	conference held on	06/13/24 at 2:45 p.m.			compliance.		
	3.1.19(b)				How the corrective action wi	II	
					be monitored to ensure the		
					deficient practice will not		
					recur: The Maintenance		
					Director/Designee will conduct	t	
					monthly audits to ensure annu	ıal	
					inspection is completed in		
					compliance with NFPA 80,		
					Standard for Fire Doors and C	)ther	
					Opening Protectives, 2010 Ed	ition.	
					LSC 4.5.8. Any discrepancies		
					found will be immediately		
					corrected. The results of these	•	
					reviews will be discussed at th		
					monthly facility Quality Assura		
					Committee meeting monthly for		
					three months and then quarter		
					thereafter once full compliance	-	
					has been achieved for a total		
					months of monitoring. Frequer		
					and duration of reviews will be		
					increased as needed, if areas	OI	
					noncompliance exist.		

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