STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155222	A. BUILDING -- B. WING	06/13/2024

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
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 06/13/24 Facility Number: 000127 Provider Number: 155222 AIM Number: 100291430 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 completed on 06/14/24	E 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.	
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: 06/13/24 Facility Number: 000127 Provider Number: 155222 AIM Number: 100291430 At this Life Safety Code survey, Kokomo Healthcare Center was found not in compliance with Requirements for Participation in	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
Sydnie Reed	Executive Director	06/27/2024

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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	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 II (000) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, areas open to the corridors and battery powered smoke detectors in the resident sleeping rooms. The facility has a capacity of 80 and had a census of 70 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 06/14/24			
K 0293 SS=E Bldg. 01	NFPA 101 Exit Signage Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) Based on observation and interview, the facility failed to ensure 1 of over 10 exit signs were continuously illuminated. NFPA 101 2012 Edition - Life Safety Code at 7.10 states "Exit and directional signs are displayed in accordance with 7.10 with continuous illumination, also served by the emergency lighting system." This deficient	K 0293	**What corrective action will be 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	07/03/2024

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	practice could affect as many as 14 residents, 4 staff and 2 visitors in the smoke compartment. Findings include: Based on observations made on 06/13/24 during a tour of the facility with the Executive Director and the Maintenance Director, the 400 Hall exit sign above the barrier doors nearest to resident room #425 was not illuminated. Based on an interview at the time of observation, the Maintenance Director verified that the bulbs in the exit light were indeed burnt out and added that he would have one of his staff replace the bulbs immediately. This item was discussed with the Executive Director and the Maintenance Director at the exit conference held on 06/13/24 at 2:45 p.m. 3.1.19(b)		barrier doors near room 425 to ensure the sign is continuously illuminated in accordance with Life Safety Code 7.10. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:** The alleged deficient practice has the potential to affect up to 14 residents, 4 staff, and 2 visitors. A whole house audit of all exit signs above barrier doors was completed during the survey with no other discrepancies noted in the 2567. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** Education was completed with maintenance staff with an emphasis on NFPA 101 2012 Edition – Life Safety Code at 7.10 to ensure facility is in compliance. **How the corrective action will be monitored to ensure the deficient practice will not recur:** The Maintenance Director/Designee will conduct weekly rounds for 12 weeks, then monthly rounds for 12 weeks to ensure all fire exit signs are continuously luminated. Any discrepancies found will be immediately corrected. The results	

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			of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for three months and then quarterly thereafter once full compliance has been achieved for a total of 6 months of monitoring. Frequency and duration of reviews will be increased as needed, if areas of noncompliance exist.	
K 0761 SS=E Bldg. 01	Based on record review and interview, the facility failed to maintain annual testing for 1 of 1 oxygen storage and transfilling room door in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives, 2010 Edition. LSC 4.5.8 requires any device, equipment, system, condition, arrangement, level of protection, or any other feature is required for compliance with the provision of this Code, such device, equipment, system, condition, arrangement, level of protection, or other feature shall thereafter be maintained unless the Code exempts such maintenance. NFPA 80 5.2.1 requires fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. This deficient practice could affect as many as 14 residents, 4 staff and 2 visitors in the smoke compartment. Findings include: Based on record review on 06/13/24 with the Executive Director and the Maintenance Director present at 11:49 a.m., the annual fire door inspection documentation was requested. After	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 and transfilling room door to ensure it is in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives, 2010 Edition. LSC 4.5.8. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:** The alleged deficient practice has the potential to affect up to 14 residents, 4 staff, and 2 visitors. A whole house audit of all annual testing for fire doors was completed during the survey with no other discrepancies noted in the 2567.	07/03/2024

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	the documentation was provided, it was noted that the oxygen storage and transfilling room door was not a part of the aforementioned inspection. Based on interview at the time of record review, the Maintenance Director that he was unaware that the door to the oxygen storage and transfilling room was required to be inspected as a part of this testing but added that he would have this door inspected as soon as possible. This item was discussed with the Executive Director and the Maintenance Director at the exit conference held on 06/13/24 at 2:45 p.m. 3.1.19(b)		**What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** Education was completed with maintenance director with an emphasis on NFPA 80, Standard for Fire Doors and Other Opening Protectives, 2010 Edition. LSC 4.5.8 to ensure facility is in compliance. **How the corrective action will be monitored to ensure the deficient practice will not recur:** The Maintenance Director/Designee will conduct monthly audits to ensure annual inspection is completed in compliance with NFPA 80, Standard for Fire Doors and Other Opening Protectives, 2010 Edition. LSC 4.5.8. Any discrepancies found will be immediately corrected. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for three months and then quarterly thereafter once full compliance has been achieved for a total of 6 months of monitoring. Frequency and duration of reviews will be increased as needed, if areas of noncompliance exist.	