CL. TLIGHTON	THE WINDS		OHB 10.00000				
STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	<del></del>	COMPL	ETED
		155678	B. W	NG	<del></del>	03/17/	/2025
				_			-
NAME OF P	ROVIDER OR SUPPLIER	3			ADDRESS, CITY, STATE, ZIP COD		
					JOSEPH DR		
WATERF	ORD PLACE HEAL	_TH CAMPUS		KOKON	MO, IN 46901		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
E 0000							
Bldg							
Ü	An Emergency Pres	paredness Survey was	E 00	000	The submission of this plan of	:	
		idiana Department of Health in		700	correction does not indicate a		
	accordance with 42	_			admission by Waterford Place		
	ascordance with 42	0110 103.73.			Health Campus that the findin		
	Survey Date: 03/17	7/25			and allegations contained her	-	
	Survey Date. 03/1/	1123			_		
	Eggility Nyambar 00	12667			are accurate, true representat		
	Facility Number: 00 Provider Number: 1				of the quality of care provided		
					the living environment provide		
	AIM Number: 2003	800090			the residents of Waterford Pla		
					Kokomo. The facility recogniz		
		Preparedness survey,			its obligation to provide legally		
		ealth Campus was found in			medically necessary care and		
	-	nergency Preparedness			services to its residents in an		
	-	Iedicare and Medicaid			economic and efficient manne	r.	
	Participating Provide	ders and Suppliers, 42 CFR			The facility hereby maintains i	t is	
	483.73. The facility	has a capacity of 103 and had a			in substantial compliance with	all	
	census of 73 at the	time of this survey.			state and federal requirement	S	
					governing the management of	f this	
	Quality Review con	mpleted on 03/20/25			facility. It is thus submitted as		
	` ,	•			matter of statute only. The fac		
					respectfully requests desk rev	-	
					for substantial compliance.		
					lor substantial compliance.		
K 0000							
Bldg. 01							
Diag. 01	A Life Sefety Cada	Decertification and State	17.0	000	The authorises of this plan at	:	
	-	Recertification and State	K 0	UUU	The submission of this plan of		
	-	vas conducted by the Indiana			correction does not indicate a		
	-	Ith in accordance with 42 CFR			admission by Waterford Place		
	483.90(a).				Health Campus that the findin	_	
					and allegations contained her		
	Survey Date: 03/17/25				are accurate, true representat		
					of the quality of care provided		
	Facility Number: 0				the living environment provide	d to	
	Provider Number: 1	155678			the residents of Waterford Pla	ce of	
	AIM Number: 2003	300090			Kokomo. The facility recognize	es	
					its obligation to provide legally	/ and	
			1		l ,		I

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

(X6) DATE

TITLE

Justin RifeArea Executive Director04/04/2025

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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: WQ5P21 Facility ID: 002667 If continuation sheet Page 1 of 16

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	E CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	<u>01</u>	COMPLETED		
		155678	B. WING		03/17/2025		
	PROVIDER OR SUPPLIER		800	STREET ADDRESS, CITY, STATE, ZIP COD 800 ST JOSEPH DR KOKOMO, IN 46901			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		(X5)		
PREFIX		CY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR			
TAG	`	LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	DATE		
	At this Life Safety (	Code survey, Waterford Place		medically necessary care an	d		
	Health Campus was found not in compliance with Requirements for Participation in			services to its residents in an			
				economic and efficient mann	er.		
	Medicare/Medicaid	, 42 CFR Subpart 483.90(a),		The facility hereby maintains	it is		
	Life Safety from Fir	re and the 2012 edition of the		in substantial compliance wit	h all		
	National Fire Protect	ction Association (NFPA) 101,		state and federal requiremen	ts		
	•	SC), Chapter 19, Existing		governing the management of	of this		
	Health Care Occupa	ancies and 410 IAC 16.2.		facility. It is thus submitted as	3 a		
				matter of statute only. The fa	-		
		ity was determined to be of		respectfully requests desk re	view		
	• • • •	uction and was fully		for substantial compliance.			
	_	cility has a fire alarm system					
		on in the corridors, areas open					
		in the resident sleeping					
		has a capacity of 103 and had e time of this survey.					
	a census of 75 at the	e time of this survey.					
	All areas where the	residents have customary					
		ered. All areas providing					
	facility services wer	re sprinklered.					
	Quality Review con	npleted on 03/20/25					
K 0161	NFPA 101						
SS=E Bldg. 01		tion Type and Height					
	Based on record rev	view, observation and	K 0161	K161 - Building Construction	Type 04/04/2025		
	interview; the facili	ty failed to maintain the		and Height	,, , , , , , , , , , , , , , , , , , , ,		
	building construction	on type for a facility with Type					
	V(111) construction	n. This deficient practice could		Compliance Date: 04/04/202	5		
	affect over 20 reside	ents, staff and visitors in the					
	vicinity of the Main	Dining Room.		Corrective Action:			
				The Director of Plant Operati			
	Findings include:			replaced the striker and strike			
				plate on 90-min door separat	_		
	Based on review of			the main dining room from th	e		
		the Facilities Management		restorative dining room.			
		on 03/17/25, the construction		Exhibit A – Photo			
		was Type V(111). In addition,					
	a two-hour fire barr	ier wall is constructed from the		The Director of Plant Operati	ons		

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Event ID:

WQ5P21 Facility ID: 002667

If continuation sheet Page 2 of 16

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
	OF CORRECTION	IDENTIFICATION NUMBER	l í	JILDING	01	COMPLETED		
ANDILAN	OI CORRECTION	155678	B. W		<u>01</u>	03/17		
		133076	B. W.	_		03/17/	72023	
NAME OF F	PROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD			
				800 ST JOSEPH DR				
WATERF	FORD PLACE HEAL	TH CAMPUS		KOKOMO, IN 46901				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	F CORRECTION (X5)		
PREFIX	,	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY		DATE	
		de of the roof in the wall			was educated by the Executiv			
		Dining Room from the Health			Director K161 – NFPA 101, 20			
		rative Dining Room. Based on			edition Building Construction	Гуре		
		ne Facilities Management			and Height 19.1.6.1, 19.1.6.2			
		ant Director of Plant			through 19.1.6.7, 19.1.6.4,			
	_	Maintenance Assistant at 2:20			10.1.6.5			
	_	he door separating the Main			Exhibit B - Inservice			
	_	the Restorative Dining Room is						
		barrier wall noted in the			The Director of Plant Operation			
		The door was equipped with a			designee will audit 90 min doo	ors in		
		and was held in the fully open			facility daily x 4 weeks then			
	*	l mounted magnetic holding			weekly x 3 months, assuring t			
		e with fire alarm activation. A			each door properly self-closes	and		
		tance rating label was affixed to			latch.			
	_	e door. The door failed to fully			Exhibit C – Audit tool			
		into the door frame when						
		iple times. Based on interview			Results of this audit will be			
		oservations, the Assistant			presented by the Executive			
		perations and the Maintenance			Director to the QAPI committe	e for		
	_	e aforementioned door in the			further recommendations and			
		er wall failed to fully self-close			continue until the Quality			
		oor frame which did not			Assurance Team determines			
	maintain the buildir	ng construction type.			substantial compliance has be	een		
					achieved.			
		e reviewed with the			This deficient practice could a			
		he Facilities Management			over 20 residents, staff and vi			
	Support during the	exit conference.			in the vicinity of the Main Dinir	ng		
	2.1.10(1.)				Room.			
	3.1-19(b)							
K 0251	NFPA 101							
SS=D		ors and Common Path of						
Bldg. 01	Travel							
5.4g. 01		on and interview, the facility	$ _{K0}$	251	K251 – Dead end Corridors a	nd	04/04/2025	
		f 7 exit access corridors did not	1 1 1	4J I	common Path of Travel		04/04/2023	
		ceeding 30 feet. This deficient			Common Facility Flaver			
	practice could affect	_			Compliance Date 04/04/2025			
	ratate coala alloc				35.11pilatios Bate 04/04/2020			
	Findings include:				Corrective Action			
					Exit signage was installed			

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

PRINTED: 04/08/2025 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155678		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 03/17/2025		
	ROVIDER OR SUPPLIER	-	STREET ADDRESS, CITY, STATE, ZIP COD 800 ST JOSEPH DR KOKOMO, IN 46901				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	Based on interview conference at 10:00 Administrator state added to the facility. The Administrator residents have custocenter which adjoin portion of the facilities Massistant Director of Maintenance Assist six resident sleeping 100 Hall had been of The former resident 109 through 114 nowhich is at the sout entrance to the dialywas not marked as a door to the dialywas not marked as a code to unlock the door was not posted Hall consists of the self-closing 20-min by Room 101 and 1 door frame. As a resleeping rooms 103 have only one exit a for two of those root 2:45 p.m. on 03/17/Operations used a femasured the distant door to the corridor feet. Based on interest and the Assistant Dagreed that a dead-of-green and the Assistant Dagreed the distant dead-o				indicating egress pathway the keypad code to enter Dialysis posted above the keypad to all entrance additional signage ware added to the door to indicate emust be staff assisted.  Exhibit D – Photo Exhibit E – Photo  The director of plant operation was educated by the Executive Director on K251 of the NFPA code Section 19.2.5.2 as it pertains to dead end corridors means of egress.  Exhibit B – Inservice  The director of Plant Operation will conduct a visual inspection exit lighting to ensure proper location and illumination week 4 then monthly X 3.  Exhibit F- Audit Tool  Results of this audit will be presented by the Executive Director to the QAPI committee further recommendations and continue until the Quality Assurance Team determines substantial compliance has be achieved.  This deficient practice could af 2 residents.	was low as entry  s e 101 and as of ly x	
	and 108 by the con-	version of the south end of the is center which was not marked					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

 $WQ5P21 \quad \text{ Facility ID: } \quad 002667$ 

If continuation sheet

Page 4 of 16

		X1) PROVIDER/SUPPLIER/CLIA	ì í	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  01			(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155678	A. BU B. W.		<u>U1</u>	03/17/2		
		133076	D. W.	_		03/11/2	2023	
NAME OF P	ROVIDER OR SUPPLIER	1			ADDRESS, CITY, STATE, ZIP COD			
WATERF	ORD PLACE HEAL	TH CAMPUS		KOKOMO, IN 46901				
(X4) ID		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 DEFICIENCY)	TE	COMPLETION	
TAG	as a facility exit for	the 100 Hell		TAG	BETEIENCT		DATE	
	as a facility exit for	the 100 Hall.						
	These findings were	e reviewed with the						
		he Facilities Management						
	Support during the	_						
	3.1-19(b)							
K 0281	NFPA 101							
SS=E	Illumination of Mea	ans of Egress						
Bldg. 01								
		on and interview, the facility	K 0	281	K281 - Illumination of Means of	of	04/04/2025	
	_	ess lighting for 1 of 8 exit			Egress			
	_	s arranged so the failure of			Compliance Date: 04/04/2025	'		
		fixture (bulb) would not leave						
		LSC 7.8.1.4 requires			O - man attinua A attinua			
		e arranged so that that the elighting unit does not result			Corrective Action:			
		evel of less than 0.2 foot-candle			The Director of Plant Operation replaced the missing light bulk	I		
		rea. This deficient practice			fixture near exit discharge for			
		residents, staff and visitors if			600 hall, by room 617	uie		
		facility from the 600 Hall by			Exhibit G - Photo			
	Room 617.	acting from the 600 fram by			The DPO (Director of Plant			
					Operations) was educated by	the		
	Findings include:				Executive Director on K281			
	_				Illumination of Means of Egres	SS		
	Based on observation	ons with the Facilities			LSC 7.8.1.4 requires illuminat	ion		
	Management Suppo	ort, the Assistant Director of			shall be arranged so that the			
	Plant Operations an	d the Maintenance Assistant			failure of any single lighting ur	nit		
	•	7/25, the exit discharge for the			does not result in an illuminati	on		
	_	617 was equipped with one			level of less than 0,2 foot-cand	dle in		
		two light bulb sockets for the			designated area.			
	_	light bulb was in the fixture.			Exhibit B - Inservice			
	Based on interview				The Director of Plant Operatio			
		acilities Management Support			Assignee will audit exterior light			
		ntioned exit discharge was not			weekly x 4wks then monthly X	.3		
	arranged with the m lighting fixtures (bu	ninimum number of operable			mths.			
	ngnung nxtures (bu	iius).			Exhibit H – Audit tool			
	These findings were	e reviewed with the			Results of this audit will be			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

WQ5P21 Facility ID: 002667

If continuation sheet Page 5 of 16

		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	01	COMPL	
		155678	B. WI	NG		03/17/	ZUZ5
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 800 ST JOSEPH DR KOKOMO, IN 46901				
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	Administrator and the Support during the state of the sta	he Facilities Management exit conference.			presented by the Executive Director to the QAPI committe further recommendations and continue until the Quality Assurance Team determines substantial compliance has be achieved.  This deficient practice could at over 10 residents, staff and vis if needing to exit the facility fro	en ffect sitors	
					the 600 Hall by Room 617.	7111	
K 0291 SS=F Bldg. 01	NFPA 101 Emergency Lightir						
	Based on observation and interview, the facility failed to ensure 1 of 6 battery powered emergency lighting systems was maintained in accordance with LSC Section 7.9. LSC 7.9.2.6 states battery operated emergency lights shall use only reliable types of rechargeable batteries provided with suitable facilities for maintaining them in properly charged condition. Batteries used in such lights or units shall be approved for their intended use and shall comply with NFPA 70, National Electric Code. This deficient practice could affect all residents, staff and visitors.  Findings include:  Based on observations with the Facilities Management Support, the Assistant Director of Plant Operations and the Maintenance Assistant at 1:51 p.m. on 03/17/25, the battery operated lighting system installed on the ceiling above the emergency generator transfer switches in the facility's main electrical room by the employee break room failed to illuminate when its respective		K 0.	291	K291 Emergency Lighting Compliance date 04/04/2025  Corrective Action: The Director of Plant Operations replaced one battery operated emergency light in the main mechanical room.  Exhibit I - Photo The Director of Plant Operations was educated by the Executive Director on Emergency Lighting, Emergency Lighting of at least 1-1/2 hour duration is provided automatically in accordance with 7.9.18.2.9.1 19.2.9.1  Exhibit B - Inservice  The Director of Plant operations will test the operation of the emergency lighting in the mechanical 1 X per week X 2		04/04/2025

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SU			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155678	B. W	NG		03/17/	/2025
				STREET /	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIEF	₹			JOSEPH DR		
WATERF	FORD PLACE HEAL	LTH CAMPUS		KOKOMO, IN 46901			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	-	hed multiple times. Based on			Exhibit J – Audit Tool		
		e of the observations, the					
		tant agreed the battery			Results of this audit will be		
		stem failed to illuminate when			presented by the Executive		
	it was tested multip	le times.			Director to the QAPI committe	e for	
					further recommendations and		
	These findings were				continue until the Quality		
		the Facilities Management			Assurance Team determines		
	Support during the	exit conference.			substantial compliance has be	en	
					achieved.		
	3.1-19(b)				This deficient practice could a	ffect	
					staff in the facility.		
K 0345	NFPA 101						
SS=F	Fire Alarm Systen	n - Testing and					
Bldg. 01	Maintenance						
J		on and interview, the facility	K 0	345	K345: FIRE ALARM SYSTEM	_	04/04/2025
		f 1 fire alarm systems was	110		TESTING & MAINTENANCE		0 1/0 1/2025
		rdance with LSC 9.6.1.3. LSC					
		re alarm system to be installed,			Compliance Date: 4/04/2025		
	-	ned in accordance with NFPA			'		
	70, National Electri	ical Code and NFPA 72,			Corrective Action:		
	National Fire Alarn	n Code. NFPA 72, Section			The Director of Plant Operatio	ns	
	14.2.1.2.2 requires	that system defects and			has contacted Safe Care and		
	malfunctions shall l	be corrected. This deficient			remedy the trouble signal on t	he	
	practice could affec	et all residents, staff and			fire alarm control panel.		
	visitors.				·		
					The Director of Plant Operatio	ns	
	Findings include:				was educated by the Executiv	е	
					Director on Fire Alarm System		
	Based on observation	ons with the Facilities			testing and maintenance 9.6.1	.3,	
	Management Suppo	ort at 9:50 a.m. on 03/17/25			9.6.1.5, NFPA 70, NFPA 72,		
	during the entrance	to the facility, which			Section 14.2.1.2.2 requires that	at	
	comprised a part of	the initial walk through of the			system defects and malfunction	ns	
	facility, the remote	fire alarm control panel at the			shall be corrected.		
	main entrance door	for the health care portion of			Exhibit B - Inservice		
	the facility was in the	he trouble mode and was			The Director of Plant Operatio	ns or	
	silenced. The remo	te panel did not state the			Designee will audit fire panel t	.0	
		. Based on interview at the			ensure panel does not display		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155678		(X2) MULTIPLE CONSTRUCTION       (X3) DATE SUR         A. BUILDING       01       COMPLETE         B. WING       03/17/202			ETED		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 800 ST JOSEPH DR KOKOMO, IN 46901				
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE  CY MUST BE PRECEDED BY FULL  LEG IDENTIFYING INFORMATION	F	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION
TAG  K 0355 SS=E	time of the observat Management Suppor facility that day and trouble mode or the on interview at the Facilities Managem contact the fire alar- immediately for a si observations with th Support at 2:26 p.m fire alarm control pi nurse's station was si was silenced. Base the observations, th Support stated the f had come to repair to duct detector in the needed repair or add corrected at the time These findings were	ort stated he was visiting the did not know it was in the cause of the trouble. Based time of the observations, the ent Support stated he would minspection contractor it visit for repair. Based on the Facilities Management at on 03/17/25, the facility's main anel at the Health Center still in the trouble mode and don interview at the time of the Facilities Management for alarm system contractor the system and found that a Health Club more than likely ditional parts and was not the of the survey.  The reviewed with the the Facilities Management exit conference.		TAG	trouble signals once daily X 4 weeks, then 1 X per day every other week X 2 months.  Exhibit K – Audit tool  Results of this audit will be presented by the Executive Director to the QAPI committe further recommendations and continue until the Quality Assurance Team determines substantial compliance has be achieved.  This deficient practice could a all residents, staff and visitors.	e for een ffect	DATE
Bldg. 01	Based on observation failed to ensure 1 of in the facility were NFPA 10, Standard 2010 Edition. Section extinguishers other shall be installed us means. (1) Securely extinguishers. (2) Ir extinguisher manufactures.	on and interview, the facility of 19 portable fire extinguishers installed in accordance with for Portable Fire Extinguishers, on 6.1.3.4 states portable fire than wheeled extinguishers ing any of the following on a hanger intended for the on the bracket supplied by the acture. (3) In a listed bracket purpose. (3) In a cabinet or wall	K 03	55	K 355 - Fire Extinguishers Compliance date: 4/04/2025  Corrective Action The Director of Plant Operatio Immediately removed the spail fire extinguisher from the mechanical room and mounte on the wall off the floor in the sprinkler riser room. Exhibit L – Photo	re	04/04/2025

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	LETED
		155678	B. W	ING		03/17	/2025
				_	_		
NAME OF I	PROVIDER OR SUPPLIEI	R			ADDRESS, CITY, STATE, ZIP COD		
					JOSEPH DR		
WATER	FORD PLACE HEA	LTH CAMPUS		KOKON	MO, IN 46901		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	recess. This deficie	ent practice could affect over					
	10 residents, staff a	and visitors in the vicinity of			The Director of Plant Operation	ns	
	the 600 Hall sprink	ler riser room.			was educated by the Executiv		
	Findings include:				Director on NFPA 101, Portab		
					Fire Extinguishers. Portable F	ire	
					Extinguishers are selected,		
	Based on observati	on with the Facilities			installed, inspected, and		
	Management Supp	ort, the Assistant Director of			maintained in accordance with	ı	
	Plant Operations ar	nd the Maintenance Assistant			NFPA 10, Standard for Portab	ole	
	at 3:02 p.m. on 03/	17/25, the ABC portable fire			Fire Extinguishers. 18.3.5.12.		
	extinguisher locate	d in the 600 Hall sprinkler riser			19.3.5.12, NFPA 10		
	room was not supp	orted and was free standing on			Exhibit B - Inservice		
	top of the water sof	ftener storage bin. The			The Director of Plant Operation	ns or	
	portable fire exting	uisher inspection contractor			designee will audit the Portab	le	
	had affixed an annu	al maintenance tag indicating			Fire Extinguishers located in t	he	
	annual maintenance	e was performed in November			sprinkler riser room, assuring	that	
	2024. The facility	had documented monthly			it remains securely mounted to	0	
	inspections on the t	ag through March 2025.			the wall 1 X per week X 6 wee	eks.	
	Based on interview	at the time of the observation,			Exhibit M – Audit tool		
	the Facilities Mana	gement Support agreed the fire					
	extinguisher was fr	eestanding on top of the bin			Results of this audit will be		
	and was not proper	ly installed.			presented by the Executive		
					Director to the QAPI committe	e for	
	These findings wer	e reviewed with the			further recommendations and		
	Administrator and	the Facilities Management			continue until the Quality		
	Support during the	exit conference.			Assurance Team determines		
					substantial compliance has be	en	
	3.1-19(b)				achieved.		
					This deficient practice could a	ffect	
					over 10 residents, staff and		
					visitors, in the vicinity of the 6	00	
					Hall sprinkler riser room.		
							1
K 0363	NFPA 101						
SS=E	Corridor - Doors						
Bldg. 01							
		on and interview, the facility	K 0	363	K363 Corridor - Doors		04/04/2025
	failed to ensure 1 o	f over 50 corridor doors to			Compliance date 04/04/2025		

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

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		l ′	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	01	COMPL	
		155678	B. WI	ING		03/17/	2025
	PROVIDER OR SUPPLIER		-	STREET ADDRESS, CITY, STATE, ZIP COD 800 ST JOSEPH DR KOKOMO, IN 46901			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROVIDED'S DI AN OE CORRECTION	OVIDER'S PLAN OF CORRECTION (2	
PREFIX	(EACH DEFICIEN	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
		oms had no impediment to					
		g into the door frame and			Corrective Action		
	_	sage of smoke. This deficient			The Director of Plant Operation		
	practice could affect over 20 residents, staff and				has removed the wedge that v		
		ity or resident sleeping Room			propping open resident sleepi	ng	
	308.				Room 308.		
	Findings include:				The Director of Plant Operation	ons	
					was educated by the Executiv		
	Based on observation	on with the Facilities			Director on NFPA 101, 2012		
	Management Suppo	ort, the Assistant Director of			edition, Corridor – Doors		
	Plant Operations an	d the Maintenance Assistant			19.3.6.3.10. Doors shall not be	е	
	at 1:56 p.m. on 03/1	17/25, the corridor door to			held open by devices other that	an	
	resident sleeping Ro	oom 308 was propped in the			those that release when the d	oor	
	fully open position	with a wedge placed on the			is pushed or pulled.		
		r. Based on interview at the			Exhibit B - Inservice		
	time of the observat						
		ort stated the resident's family			The Director of Plant Operation	ns	
		in to the facility and agreed			will audit all Resident room do	ors	
		corridor door had an			1 x per week x 4 weeks		
	impediment to latch would not resist the	ning into the door frame and passage of smoke.			Exhibit N – Audit tool		
					Results of this audit will be		
	These findings were	e reviewed with the			presented by the Executive		
	Administrator and t	he Facilities Management			Director to the QAPI committe	e for	
	Support during the	exit conference.			further recommendations and		
					continue until the Quality		
	3.1-19(b)				Assurance Team determines		
					substantial compliance has be	en	
					achieved.		
					This deficient practice could a	ffect	
					over 20 residents, staff and		
					visitors, in the vicinity of reside	ent	
					room 308.		
K 0712	NFPA 101						
SS=F	Fire Drills						

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155678		lì í	JILDING	onstruction 01	(X3) DATE COMPL <b>03/17</b> /	LETED	
	PROVIDER OR SUPPLIER			800 ST	ADDRESS, CITY, STATE, ZIP COD JOSEPH DR MO, IN 46901	•	
(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)	TE.	(X5) COMPLETION DATE
Bldg. 01	failed to document of shift for 1 of 4 quaraffects all residents,  Findings include:  Based on review of documentation and Drills" documentation of a most recent twelve in the fourth quarter December) 2024 was facility documented the second shift at 4 2:30 p.m. on 12/30/a.m. on 03/17/25, th Support stated the fiper day and confirm drill was a second so Management Support provided defire drill conducted he agreed was not confirm quarter of 2024. Based additional firms available for review a fire drill conducte fourth quarter 2024.  These findings were affected to the second support provided defired and the second support provided defired agreed was not confirm the second support provided defired fill conducted the agreed was not confirm the second support provided defired and the second support provided defired agreed was not confirm the second support provided defired fill conducted the second support provided defined fill the second support provided defined	"Fire Drill Report" Direct Supply TELS "Fire on with the Facilities art and the Assistant Director at 11:05 a.m. on 03/17/25, fire drill conducted within the month period on the third shift (October, November, as not available for review. The two fire drills conducted on :19 p.m. on 11/30/24 and at 24. Based on interview at 11:05 are Facilities Management acility operates three shifts need the 11/30/24 4:19 p.m. fire hift fire drill. The Facilities becomentation of a third shift on 01/06/25 at 5:41 a.m. which conducted during the fourth ased on interview at the time of facilities Management Support and agreed documentation of d on the third shift in the was not available for review.	KO	712	K712 Fire Drills Compliance Date: 04/04/2025 Corrective action: Director of Plant Operations created schedule for fire drills 2025 to ensure drills are held unexpected times that vary monthly for all staff on all shift The Director of Plant Operation was educated by the Executive Director on NFPA 101 – Fire Drills. Fire Drills are held at expected and unexpected time under varying conditions, at least quarterly on each shift.  Exhibit B - Inservice The Director of Plant Operation will monitor fire drill schedule monthly to ensure drills are held unexpected and varying times.  Results of the monitoring will presented by the Executive Director to the QAPI committed further recommendations and continue until the Quality Assurance Team determines substantial compliance has be achieved.  This deficient practice could a all residents, staff and visitors	for at s. ons re es east ons be defor	04/04/2025

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155678	B. W	ING		03/17	
NAME OF P	PROVIDER OR SUPPLIER	t e e e e e e e e e e e e e e e e e e e			ADDRESS, CITY, STATE, ZIP COD		
\4/4 TEDE		THEOAMBLIC		800 ST JOSEPH DR			
WATERF	FORD PLACE HEAL	TH CAMPUS		KUKUI	MO, IN 46901		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	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
	3.1-51(c)						
K 0911	NFPA 101						
SS=F	Electrical Systems	s - Other					
Bldg. 01							
		on and interview, the facility	K 0	911	K911 Electrical System-Other		04/04/2025
		otected branch circuits for 2 of			Compliance Date: 4/04/2025		
	_	anels in the facility in			Corrective Action:		
		FPA 70. NFPA 99, Health Care			The Director of Plant Operation	ns	
		2 Edition, Section 6.3.2.1 states			has contacted and scheduled		
		n shall be in accordance with			Houston Electric to trace Brea	kers	
	i i	Electric Code. NFPA 70, 2011			and label them inside 2 of 10		
	· ·	0.5(A) states the grounded			electric panels in the facility.		
		ch circuit shall be identified in					
		ticle 200.6. This deficient			The Director of Plant Operation		
	1 -	t all residents, staff and			was educated by the Executiv	е	
	visitors.				Director on Electrical		
					Systems-Other NFPA 70, 201		
	Findings include:				edition article 210.5(A) state the		
					grounded conductor of a bran	ch	
		ons with the Facilities			circuit shall be identified in		
		ort, the Assistant Director of			accordance with Article 200.6		
		d the Maintenance Assistant			Exhibit B - Inservice		
	· -	17/25, most all of the					
		that were in the "On"			The Director of plant Operatio	ns	
	1 ^	mounted electrical panel			will perform an audit of the 2		
		Critical" in the main electrical			electrical panels assuring that	the	
	I	oom were not identified. The			ground conductor of a branch		
	1	vices identified in the panel			circuit remains identified.		
		rough 20 which were identified					
		The "A.D. Critical" electrical			Results of this audit will be		
	1 -	ne facility's emergency			presented by the Executive	. <b>.</b>	
		cal conduits for the panel were			Director to the QAPI committee		
		joining Russell Electric			further recommendations and		
		Switch in the room. Based on			continue until the Quality		
		e of the observations, the			Assurance Team determines		
		ant agreed the electrical panel			substantial compliance has be	en	
		ergency generator with most all			achieved.	ffoot	
		not identified. In addition,			This deficient practice could a		
1	ine mam electrical s	shut offs in the room also	I		all residents, staff and visitors		I

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155678	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction  01	(x3) date survey COMPLETED 03/17/2025
	PROVIDER OR SUPPLIER		800 ST	ADDRESS, CITY, STATE, ZIP COD  JOSEPH DR  MO, IN 46901	
(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 APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
	located in the facilities Massistant Director of Maintenance Assist most all of the over the "On" position in panel identified as "riser room were not overcurrent device panel was breaker 2 Alarm Booster". The panel had "Emergenthe panel. Based or observations, the Action Operations and the agreed all overcurre panel did not identified evice except for brother the panel.	e reviewed with the he Facilities Management			
K 0914 SS=F Bldg. 01	Testing Based on record rev failed to ensure doc	riew and interview, the facility umentation of electrical outlet	K 0914	K914 Electrical Systems- Maintenance and Testing	04/04/2025
	was completed in ac NFPA 99, Health C Edition, Section 6.3 listed as hospital-gr and in locations wh anesthesia shall be t exceeding 12 month	are Facilities Code, 2012 .4.1.3 states receptacles not ade at patient bed locations ere deep sedation or general rested at intervals not as. NFPA 99, Health Care 2 Edition, Section 6.3.4.1.1		Compliance Date: 4/04/2025 Corrective Action: The Director of Plant Operation has Re-Tested all receptacles ensure that the Ground Retent tests were performed.  Director of Plant Operations we educated by Facilities	to ion

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

PRINTED: 04/08/2025 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155678	(X2) MULTIPLE C A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 03/17/2025		
NAME OF PROVIDER OR SUPPLIER WATERFORD PLACE HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP COD 800 ST JOSEPH DR KOKOMO, IN 46901				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETION DATE		
	states hospital-grade receptacles testing shall be performed after initial installation, replacement or servicing of the device. Section 6.3.3.2, Receptacle Testing in Patient Care Rooms requires the physical integrity of each receptacle shall be confirmed by visual inspection. The continuity of the grounding circuit in each electrical receptacle shall be verified. Correct polarity of the hot and neutral connections in each electrical receptacle shall be confirmed; and retention force of the			Management Support on NF 99, 2012 edition, 6.3.4.1.3 st receptacles not listed as hos – grade at patient bed locations shall be tested at intervals not exceeding 12 months.  Exhibit B - Inservice  The Director of Plant Operation will audit outlets in the Camp	ates pital ons ot		
	(except locking-typ than 115 grams (4 c states, at a minimur	each electrical receptacle e receptacles) shall be not less nunces). Section 6.3.4.2.1.2 n, the record shall contain the ureas tested, and an indication		assuring that each non- Hos Grade electrical receptacle h been inspected and not exce 12 months	pital – nas		
	the performance red	e met, or have failed to meet, quirements of this chapter. I residents, staff and visitors.		Results of this audit will be presented by the Executive Director to the QAPI committ further recommendations and continue until the Quality	d		
	"Receptacle Testing October 2024 with	Direct Supply TELS g" documentation dated the Facilities Management sistant Director of Plant		Assurance Team determines substantial compliance has bachieved.  This deficient practice could	peen		
	receptacle inspection for all resident sleep recent twelve month October 2024 inspendocumentation listed not itemize receptace.	p.m. on 03/17/25, electrical on and testing documentation oing rooms within the most he period was incomplete. The ction and testing defined the room locations but diducted to the locations in each room. In and Retention" column of the		all residents, staff and visitor	s		
	inspection documer room. Based on int review, the Facilitie the facility does per testing for the recep force retention testi	atation was left blank for each serview at the time of record es Management Support stated form ground force retention stacles but agreed ground ng documentation for the available for review and					

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155678		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 03/17/2025	
	ROVIDER OR SUPPLIER		800 S	T ADDRESS, CITY, STATE, ZIP COD ST JOSEPH DR OMO, IN 46901	
(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 CROSS-REFERENCED TO THE APPROLIDERICIENCY)	BE COMPLETION
K 0918 SS=F Bldg. 01	agreed "Receptacle not itemized by rece resident sleeping root the time of record room.  Management Suppose sleeping room may and non-hospital graroom.  These findings were Administrator and the Support during the control of the support during the grand of the support during the prime in the support of the support of the support of the support of the grand of the gran	Testing" documentation was eptacle location within the oms. Based on interview at eview, the Facilities out stated each resident have a mix of hospital grade ade receptacles installed in the extremely desired and interview, the facility on and interview, the facility of the emergency generators was perly located remote stop in tor caught fire. NFPA 110, ency and Standby Power on, Section 5.6.5.6, requires all have a remote manual stop or event inadvertent or the confidence of the prime mover in the p	K 0918	K918 - Electrical Systems- Essential Electric Style Compliance Date: 04/04/20 Corrective Action: The Director of Plant Opera contacted Houston Electric 3/20/2025 to install remote Emergency Shut-Off Switch inside mechanical room for Generator.  The Director of Plant Opera was educated by the Exect Director on NFPA 110, Sta for Emergency and Standb Power Systems 2010 edition Section 5.6.5.6, requires al installations shall have a re manual stop station of a typ prevent inadvertent or unin operation located outside the	04/04/2025  025  ations on  In to the  ations ative Indard y on, I emote oe to tentional he room
	could affect all fest	lents, staff and visitors in the	1	housing of the prime mover	i, where

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

PRINTED: 04/08/2025 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 <u>01</u>		01	COMPLETED	
155678		B. WIN	G		03/17/	2025	
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD				
\\\\\		TH CAMPUS			JOSEPH DR		
WATER	ORD PLACE HEAI	LTH CAMPUS	KOKOMO, IN 46901				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL	P	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  DA'		COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	+	TAG			DATE
	facility.			so installed, or elsewhe			
	Piudius indude				premises where the prime mo		
	Findings include:				is located outside the building		
	Dagad on abaamiati	Based on observations with the Facilities			Section 5.6.5.6.1 requires the		
		ort, the Assistant Director of			remote manual stop station to be		
					labeled.		
	Plant Operations and the Maintenance Assistant at 1:52 p.m. on 03/17/25, the facility has one diesel				Exhibit B – Inservice		
	-				The Director of Plant Operation	ne	
	fired emergency generator located outside of the building in a weatherproof shell on the north side				will audit the newly installed		
	of the property. Manufacturer's nameplate				remote manual stop station the		
	documentation affixed to the emergency generator				this device remains visible,		
	stated it was rated at 100 kW and was			unblocked, and as appropriate			
	manufactured 04/20/23. No remote stop for the		signage.			-	
	emergency generator could be located on the				signage.		
	exterior of the weatherproof shell or in a remote				Results of this audit will be		
	location inside or outside the facility. Based on interview at the time of the observations, the Facilities Management Support and the Maintenance Assistant stated the generator was a replacement generator for their old generator and agreed no remote stop switch was installed for this new generator.				presented by the Executive		
					Director to the QAPI committee	e for	
					further recommendations and		
					continue until the Quality		
					Assurance Team determines		
					substantial compliance has be	en	
					achieved.		
	These findings were reviewed with the				This deficient practice could affect		
	Administrator and the Facilities Management			all residents, staff and visitors.			
	Support during the exit conference.  3.1-19(b)						
5.1 15(0)							