

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 05/22/2024	
NAME OF PROVIDER OR SUPPLIER PRIMROSE RETIREMENT COMMUNITY OF KOKOMO		STREET ADDRESS, CITY, STATE, ZIP CODE 329 W RAINBOW DR, KOKOMO, , 46901					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...			(X5) COMPLETION DATE	
R 0000	INITIAL COMMENTS This survey was for a State Residential Licensure Survey. This visit included the Investigation of Complaint IN00434187. Complaint IN00434187-No deficiencies related to the allegations are cited. Survey dates: May 21 and 22, 2024 Facility number: 011555 Residential: 79 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-5. Quality review was completed on May 28, 2024.	R 0000	Please accept this as the Plan of Correction for Primrose Retirement Community of Kokomo.				
R 0092	Administration and Management - Noncompliance 410 IAC 16.2-5-1.3(i)(1-2) (i) The facility must maintain a written fire and disaster	R 0092	1 What Corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice?			06/14/2024	

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preparedness plan to assure continuity of care of residents in cases of emergency as follows:

(1) Fire exit drills in facilities shall include the transmission of a fire alarm signal and simulation of emergency fire conditions, except that the movement of nonambulatory residents to safe areas or to the exterior of the building is not required. Drills shall be conducted quarterly on each shift to familiarize all facility personnel with signals and emergency action required under varied conditions. At least twelve (12) drills shall be held every year. When drills are conducted between 9 p.m. and 6 a.m., a coded announcement may be used instead of audible alarms.

(2) At least every six (6) months, a facility shall attempt to hold the fire and disaster drill in conjunction with the local fire department. A record of all training and drills shall be documented with the names and signatures of the personnel present.

Based on interview and record review, the facility failed to show documentation they attempted to hold a fire and disaster drill in conjunction with the local fire department at least once every six months and failed to show documentation the facility had conducted fire drills quarterly on each shift.

Findings include:

1. During an interview, on

A disaster drill was held on May 30th. The fire chief attended.

[Fire drills are conducted quarterly on each shift.](#)

2 How the facility will identify other residents having the potential to be affected by the same alleged deficient practice?

All residents have the potential to be affected by the alleged deficient practice. A disaster drill was held on May 30th. The fire chief attended.

Fire drills are conducted quarterly on each shift.

3 What measures will be put into place or what systemic changes the facility will make to ensure that the alleged deficient practice does not recur?

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5/22/24 at 1:40 p.m., the Maintenance Director indicated there were no fire and disaster drills completed in conjunction with the local fire department at least once every six months because he did not know he needed to do them.

On 05/22/24 at 2:35 p.m., a record review of the facility's fire drills indicated the monthly fire drill documentation lacked evidence the facility had attempted a fire and disaster drill in conjunction with the local fire department at least once every six months.

2. On 5/22/24 at 2:35 p.m., a review of the facility's fire drills indicated a lack of documentation to show the fire drills were conducted quarterly each shift. The fire drill documentation indicated the following:

On 6/29/23 at 10:30 a.m. to 10:40 a.m., a fire drill was conducted in Room 122 in the wastebasket on 1st shift (dayshift employee's signatures were documented).

On 7/28/23 at 6:25 p.m. to 6:40 p.m., a fire drill was conducted in Room 132 in the wastebasket on 2nd shift (evening shift employee's signatures were documented).

On 8/31/23 at 7:40 a.m. to 7:40 p.m., a fire drill was conducted

Staff will be re-educated on having a fire and disaster drill in conjunction with the local fire department every six months and conducting fire drills quarterly on each shift by June 14th. The Executive Director or her designee will routinely review documentation of fire and disaster drills to ensure documentation is appropriate. If the review does not reach a 95% threshold further education would be completed for the appropriate staff members by the Executive Director or her designee.

4 How the corrective action will be monitored to ensure the alleged deficient practice with not recur, i.e. what quality assurance program will be put into place?

The Preventative Maintenance Director or designee will report to the Quality Assurance committee monthly of their drill results. A percentage of 95% would be the acceptable threshold. The Quality Assurance committee will

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at the kitchen range in the kitchen (dayshift employee's signatures were documented). This report was marked as a night shift fire drill.

On 9/27/23 at 10:00 to 10:15 a.m., a fire drill was conducted in Room 132 in the wastebasket on 1st shift (dayshift employee's signatures were documented).

On 10/19/23 at 9:00 p.m. to 9:15 p.m., a fire drill was conducted in Room 132 in the wastebasket on 2nd shift (evening shift employee's signatures were documented).

On 10/23/23 at 1:15 p.m. to 1:30 p.m., a fire drill was conducted in Room 128 in the wastebasket on 1st shift (dayshift employee's signatures were documented).

On 11/30/23 at 11:15 p.m. to 11:30 p.m., a fire drill was conducted in Room 132 in the wastebasket on 3rd shift (nightshift employee's signatures were documented).

On 12/11/23 at 12:00 p.m. to 12:15 p.m., a fire drill was conducted in the kitchen on 1st shift (dayshift employee's signatures were documented).

On 1/28/24 at 7:00 p.m. to 7:15 p.m., a fire drill was conducted in Room 132 in the wastebasket on 2nd shift (evening shift employee's signatures were

review the findings monthly and take appropriate actions if needed.

5 By what date the systemic changes will be completed?

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documented).

On 2/28/24 at 11:15 p.m. to 11:30 p.m., a fire drill was conducted in Room 132 in the wastebasket on 3rd shift (nightshift employee's signatures were documented).

On 3/28/24 at 10:00 a.m. to 10:15 a.m., a fire drill was conducted in Room 132 in the wastebasket on 1st shift (dayshift employee's signatures were documented).

On 4/30/24 at 3:45 p.m. to 4:00 p.m., a fire drill was conducted in Room 132 in the wastebasket on 2nd shift (evening shift employee's signatures were documented).

According to the facility fire drill documentation:

a. there were 6 fire drills completed on the first shift.

b. there were 4 fire drills completed on the second shift.

c. there were 2 fire drills completed on the third shift.

Each shift should have had four fire drills to be in compliance with the regulation.

During an interview, on 5/22/24 at 1:45 p.m., the Director of Nursing indicated day shift was from 7:00 a.m. to 3:30 p.m., evening shift was 3:00 p.m. to

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11:30 p.m., and night shift was from 11:00 p.m. to 7:30 a.m. The 30-minute layover between shifts allowed the nursing staff to give a report to the next shift coming on and to count the medication carts.

During an interview, on 5/22/24 at 3:25 p.m., the Executive Director indicated the fire and disaster drills not being completed in conjunction with the local fire department at least once every six months was "on her." She did not know there were not enough fire drills completed for the quarterly fire drills. When a fire drill policy was requested, the Executive Director indicated she did not have one and she followed the state regulations for fire drills.

Based on interview and record review, the facility failed to show documentation they attempted to hold a fire and disaster drill in conjunction with the local fire department at least once every six months and failed to show documentation the facility had conducted fire drills quarterly on each shift.

Findings include:

1. During an interview, on 5/22/24 at 1:40 p.m., the Maintenance Director indicated there were no fire and disaster drills completed in conjunction with the local fire department at

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least once every six months because he did not know he needed to do them.

On 05/22/24 at 2:35 p.m., a record review of the facility's fire drills indicated the monthly fire drill documentation lacked evidence the facility had attempted a fire and disaster drill in conjunction with the local fire department at least once every six months.

2. On 5/22/24 at 2:35 p.m., a review of the facility's fire drills indicated a lack of documentation to show the fire drills were conducted quarterly each shift. The fire drill documentation indicated the following:

On 6/29/23 at 10:30 a.m. to 10:40 a.m., a fire drill was conducted in Room 122 in the wastebasket on 1st shift (dayshift employee's signatures were documented).

On 7/28/23 at 6:25 p.m. to 6:40 p.m., a fire drill was conducted in Room 132 in the wastebasket on 2nd shift (evening shift employee's signatures were documented).

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On 8/31/23 at 7:40 a.m. to 7:40 p.m., a fire drill was conducted at the kitchen range in the kitchen (dayshift employee's signatures were documented). This report was marked as a night shift fire drill.

On 9/27/23 at 10:00 to 10:15 a.m., a fire drill was conducted in Room 132 in the wastebasket on 1st shift (dayshift employee's signatures were documented).

On 10/19/23 at 9:00 p.m. to 9:15 p.m., a fire drill was conducted in Room 132 in the wastebasket on 2nd shift (evening shift employee's signatures were documented).

On 10/23/23 at 1:15 p.m. to 1:30 p.m., a fire drill was conducted in Room 128 in the wastebasket on 1st shift (dayshift employee's signatures were documented).

On 11/30/23 at 11:15 p.m. to 11:30 p.m., a fire drill was conducted in Room 132 in the wastebasket on 3rd shift (nightshift employee's signatures were documented).

On 12/11/23 at 12:00 p.m. to 12:15 p.m., a fire drill was conducted in the kitchen on 1st shift (dayshift employee's signatures were documented).

On 1/28/24 at 7:00 p.m. to 7:15 p.m., a fire drill was conducted in Room 132 in the wastebasket

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on 2nd shift (evening shift employee's signatures were documented).

On 2/28/24 at 11:15 p.m. to 11:30 p.m., a fire drill was conducted in Room 132 in the wastebasket on 3rd shift (nightshift employee's signatures were documented).

On 3/28/24 at 10:00 a.m. to 10:15 a.m., a fire drill was conducted in Room 132 in the wastebasket on 1st shift (dayshift employee's signatures were documented).

On 4/30/24 at 3:45 p.m. to 4:00 p.m., a fire drill was conducted in Room 132 in the wastebasket on 2nd shift (evening shift employee's signatures were documented).

According to the facility fire drill documentation:

- a. there were 6 fire drills completed on the first shift.
- b. there were 4 fire drills completed on the second shift.
- c. there were 2 fire drills completed on the third shift.

Each shift should have had four fire drills to be in compliance with the regulation.

During an interview, on 5/22/24 at 1:45 p.m., the Director of Nursing indicated day shift was

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	from 7:00 a.m. to 3:30 p.m., evening shift was 3:00 p.m. to 11:30 p.m., and night shift was from 11:00 p.m. to 7:30 a.m. The 30-minute layover between shifts allowed the nursing staff to give a report to the next shift coming on and to count the medication carts. During an interview, on 5/22/24 at 3:25 p.m., the Executive Director indicated the fire and disaster drills not being completed in conjunction with the local fire department at least once every six months was "on her." She did not know there were not enough fire drills completed for the quarterly fire drills. When a fire drill policy was requested, the Executive Director indicated she did not have one and she followed the state regulations for fire drills.			
R 0300	Pharmaceutical Services - Deficiency 410 IAC 16.2-5-6(c)(4) (4) Over-the-counter medications, prescription drugs, and biologicals used in the facility must be labeled in accordance with currently accepted professional principles and include the appropriate accessory and cautionary instructions and the expiration date. Based on observation, interview and record review, the facility	R 0300	1 What Corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice? Change of order stickers were placed on Resident N & R's medications at the time of survey in front of the surveyor.	06/14/2024

failed to properly label a medication after an order change for 2 of 5 residents observed during medication administration. (Resident N and R)

Finding includes:

1. On 5/22/24 at 11:34 a.m., LPN 1 was observed preparing and administering Resident N's medications. She placed his medications into a plastic medication cup, which included, but were not limited to:

a. Carbidopa (used to treat Parkinson's disease) 25 mg (milligrams).

b. Carbidopa/Levodopa ER (Extended Release) (used to treat Parkinson's disease) 50/200 mg.

The medication bottles provided from the pharmacy indicated the following directions:

a. Carbidopa 25 mg, give one tablet by mouth three times a day for 30 days. The medication started on 4/12/24.

b. Carbidopa/Levodopa 50/200 mg, give two tablets by mouth three times a day. On the bottle in black marker someone had handwritten 7:00 a.m., one at 12 noon. There was no change of direction sticker on either bottle for a change in orders.

2 How the facility will identify other residents having the potential to be affected by the same alleged deficient practice?

All residents have the potential to be affected by the alleged deficient practice.

Medications are properly labeled after any order change. An audit of the medication carts was completed to ensure all medication labels match the orders.

3 What measures will be put into place or what systemic changes the facility will make to ensure that the alleged deficient practice does not recur?

Staff will be re-educated on properly labeling medication after an order change by June 14th. The Director of Nursing or her designee will routinely audit documentation of medication order changes to ensure

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The current physician's orders and Electronic Medication Administration Record, dated May 2024, included, but were not limited to, the following orders:

a. 4/12/24, Carbidopa 25 mg, give one tablet by mouth three times a day at 8:00 a.m., 12:00 p.m., and 5:00 p.m.

b. 2/9/24, Carbidopa/Levodopa ER 50/200 mg, give two tablets by mouth once daily in the morning at 8:00 a.m., one tablet by mouth once a day at 12:00 p.m., and two tablets by mouth once a day at 5:00 p.m.

The medication bottles lacked a change of direction label to alert the nurses and QMAs the medication orders were changed.

At that time, LPN 1 indicated there should have been a change of order sticker on both medication bottles and someone should have called the physician to clarify if the Carbidopa 25 mg order was for the 30 days. She placed a change of order sticker on the medication bottles at that time.

During an interview, on 5/22/24 at 11:40 a.m., the Director of Nursing indicated she did not find an order in Resident N's chart for the Carbidopa for 30 days. She was calling the resident's physician to get the

documentation is appropriate. If the review does not reach a 95% threshold further education would be completed for the appropriate staff members by the Director of Nursing or her designee.

4 How the corrective action will be monitored to ensure the alleged deficient practice with not recur, i.e. what quality assurance program will be put into place?

The Director of Nursing or designee will report to the Quality Assurance committee monthly of their audit results. A percentage of 95% would be the acceptable threshold. The Quality Assurance committee will review the findings monthly and take appropriate actions if needed.

5 By what date the systemic changes will be completed?

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original order and to get a clarification of the order.

During an interview, on 5/22/24 at 12:01 p.m., the Director of Nursing indicated Resident N's physician indicated he was to remain taking the Carbidopa 25 mg and there was not to be a 30-day limit.

2. On 5/22/24 at 11:34 a.m., LPN 1 was observed preparing and administering Resident R's medications. She placed her medication into a plastic medication cup, which included, but was not limited to, Requip (used to treat restless leg disorder) 1 mg tablet.

The current physician's order and Electronic Medication Administration Record (EMAR), dated May 2024, on included, but were not limited to, the following order:

2/17/24, Ropinirole Hydrochloride 1 mg, give one tablet by mouth twice daily at 12:00 p.m. and 9:00 p.m.

The EMAR, dated 2/17/24 to 5/21/24, indicated Ropinirole Hydrochloride 1 mg, give one tablet by mouth twice daily at 12:00 p.m. and 5 p.m.

At that time, LPN 1 indicated there should have been a change of order sticker on the Requip 1 mg bottle. She placed a change of order sticker on the

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medication bottle at that time.

A current policy, titled "Pharmacy Policies and Procedures-Prescriber Medication Orders," dated as revised 12/31/2018 and provided by the Director of Nursing on 5/22/24 at 1:45 p.m., indicated "...Prescription medications are dispensed only upon the clear, complete, and signed order (hardcopy or electronic) of a person lawfully authorized to prescribe...Physician/prescriber orders are required for all prescription and non-prescription (i.e., over the counter) medications for those receiving medication assistance from Primrose Retirement Communities staff...Medication orders (prescriptions) contain all the elements required by law...Any dose or order that appears inappropriate, considering the resident's age, allergies, diagnosis, or current medication regimen, is verified with the prescriber..."

A current policy, titled "Administration of Medications-General Guidelines," dated as revised 12/31/2018 and provided by the Director of Nursing on 5/22/24 at 1:45 p.m., indicated "...Prior to administration, the medication and dosage schedule on the resident's Medication Administration Record (MAR) is

compared with the medication label. If the label and the Medication Administration Record (MAR) are different, or if there is any other reason to question the dosage or directions, the current order should be verified with the physician/prescriber prior to administration of the medication...Steps in Medication Administration...Review the resident's Medication Administration Record (MAR) and note the first medication to administer. Note any discontinued or changed orders...Read prescription label three times before preparing medication...."

Based on observation, interview and record review, the facility failed to properly label a medication after an order change for 2 of 5 residents observed during medication administration. (Resident N and R)

Finding includes:

1. On 5/22/24 at 11:34 a.m., LPN 1 was observed preparing and administering Resident N's medications. She placed his medications into a plastic medication cup, which included, but were not limited to:

a. Carbidopa (used to treat Parkinson's disease) 25 mg (milligrams).

b. Carbidopa/Levodopa ER (Extended Release) (used to treat Parkinson's disease) 50/200 mg.

The medication bottles provided from the pharmacy indicated the following directions:

a. Carbidopa 25 mg, give one tablet by mouth three times a day for 30 days. The medication started on 4/12/24.

b. Carbidopa/Levodopa 50/200 mg, give two tablets by mouth three times a day. On the bottle in black marker someone had handwritten 7:00 a.m., one at 12 noon. There was no change of direction sticker on either bottle for a change in orders.

The current physician's orders and Electronic Medication Administration Record, dated May 2024, included, but were not limited to, the following orders:

a. 4/12/24, Carbidopa 25 mg, give one tablet by mouth three times a day at 8:00 a.m., 12:00 p.m., and 5:00 p.m.

b. 2/9/24, Carbidopa/Levodopa ER 50/200 mg, give two tablets by mouth once daily in the morning at 8:00 a.m., one tablet by mouth once a day at 12:00 p.m., and two tablets by mouth once a day at 5:00 p.m.

The medication bottles lacked a

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FORM APPROVED

OMB NO. 0938-0391

change of direction label to alert the nurses and QMAs the medication orders were changed.

At that time, LPN 1 indicated there should have been a change of order sticker on both medication bottles and someone should have called the physician to clarify if the Carbidopa 25 mg order was for the 30 days. She placed a change of order sticker on the medication bottles at that time.

During an interview, on 5/22/24 at 11:40 a.m., the Director of Nursing indicated she did not find an order in Resident N's chart for the Carbidopa for 30 days. She was calling the resident's physician to get the original order and to get a clarification of the order.

During an interview, on 5/22/24 at 12:01 p.m., the Director of Nursing indicated Resident N's physician indicated he was to remain taking the Carbidopa 25 mg and there was not to be a 30-day limit.

2. On 5/22/24 at 11:34 a.m., LPN 1 was observed preparing and administering Resident R's medications. She placed her medication into a plastic medication cup, which included, but was not limited to, Requip (used to treat restless leg disorder) 1 mg tablet.

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The current physician's order and Electronic Medication Administration Record (EMAR), dated May 2024, on included, but were not limited to, the following order:

2/17/24, Ropinirole Hydrochloride 1 mg, give one tablet by mouth twice daily at 12:00 p.m. and 9:00 p.m.

The EMAR, dated 2/17/24 to 5/21/24, indicated Ropinirole Hydrochloride 1 mg, give one tablet by mouth twice daily at 12:00 p.m. and 5 p.m.

At that time, LPN 1 indicated there should have been a change of order sticker on the Requip 1 mg bottle. She placed a change of order sticker on the medication bottle at that time.

A current policy, titled "Pharmacy Policies and Procedures-Prescriber Medication Orders," dated as revised 12/31/2018 and provided by the Director of Nursing on 5/22/24 at 1:45 p.m., indicated "...Prescription medications are dispensed only upon the clear, complete, and signed order (hardcopy or electronic) of a person lawfully authorized to prescribe...Physician/prescriber orders are required for all prescription and non-prescription (i.e., over the counter) medications for those

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receiving medication assistance from Primrose Retirement Communities staff...Medication orders (prescriptions) contain all the elements required by law...Any dose or order that appears inappropriate, considering the resident's age, allergies, diagnosis, or current medication regimen, is verified with the prescriber..."			
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A current policy, titled "Administration of Medications-General Guidelines," dated as revised 12/31/2018 and provided by the Director of Nursing on 5/22/24 at 1:45 p.m., indicated "...Prior to administration, the medication and dosage schedule on the resident's Medication Administration Record (MAR) is compared with the medication label. If the label and the Medication Administration Record (MAR) are different, or if there is any other reason to question the dosage or directions, the current order should be verified with the physician/prescriber prior to administration of the medication...Steps in Medication Administration...Review the resident's Medication Administration Record (MAR) and note the first medication to administer. Note any discontinued or changed orders...Read prescription label three times before preparing medication...."

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.)

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

TITLE

(X6) DATE