STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155222	A. BUILDING 00 B. WING	04/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KOKOMO HEALTHCARE CENTER	429 W LINCOLN RD KOKOMO, IN 46902

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00349822, IN00350159 and IN00352562. Complaint IN00349822 - Unsubstantiated due to lack of evidence. Complaint IN00350159 - Unsubstantiated due to lack of evidence. Complaint IN00352562 - Substantiated. Federal/State deficiencies related to the allegations are cited at F757. Survey dates: April 28, 29 and 30, 2021 Facility number: 000127 Provider number: 155222 AIM number: 100291430 Census bed type: SNF: 2 NF: 54 SNF/NF: 10 Total: 66 Census payor type: Medicare: 2 Medicaid: 54 Other: 10 Total: 66 This deficiency reflects state findings cited in accordance with 410 IAC 16.2-3.1. Quality review was completed on May 11, 2021.	F 0000	Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during a complaint survey on April 30, 2021. 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

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F 0757 SS=D Bldg. 00	483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. Based on interview and record review, the facility failed to recognize when a resident had a duplicate drug therapy of the Proton Pump Inhibitor drug classification, failed to ensure the resident had an adequate indication for the use of an antipsychotic medication and an anticonvulsant medication, and failed to ensure monitoring for the presence of adverse consequences in the resident's psychotropic medication regimen was reviewed and adjusted to reduce or discontinue sedating medications for 1 of 1 respite resident being reviewed for unnecessary medications (Resident B).	F 0757	F757- Drug Regimen is Free from Unnecessary Drugs 1. Resident B was not harmed by the alleged deficient practice and no longer resides in the facility. 2. All residents in the facility have the potential to be affected by the same alleged deficient practice. The Clinical Management Team completed medication reviews on all residents. Any resident found to be on duplicate PPI therapy, have inadequate indication for use of an antipsychotic and/or	05/28/2021

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	Finding includes: During an phone interview, with Resident B's Guardian along with Resident B in attendance, on 4/29/21 at 3:02 p.m., the Guardian indicated Resident B was at the facility for a few days for a Respite stay after being discharged from the hospital for seizure activity. The Guardian supplied the current medications the resident was taking when she was discharged from the hospital at the end of March. The resident was able to walk into the facility by herself without any assistive devices and was talking the day she was admitted on 4/15/21. The day she was discharged on 4/20/21, she had to be transferred to the new facility on a gurney by an ambulance because she could not walk and she was not able to talk. When she called to speak to the resident during her stay at the facility, she was told by the facility staff the resident was sleeping, which was not normal for her to be napping during the day. The resident was prescribed medications at the facility, which she was not taking at home such as; Zyprexa (an antipsychotic medication) and Depakote (a medication used to treat seizures). She indicated the Zyprexa caused the resident to have seizures and the Depakote did not stop her seizures, so when she was hospitalized at the end of March, these medications were stopped and she was started on Keppra (a medication used to treat seizures). The Guardian brought the medication bottles from home the resident needed while being a respite stay in the facility. After Resident B got out of the facility through an exit door, the guardian received a call from a facility staff member explaining to her they could no longer keep the resident in the facility because she needed a locked unit. The Guardian indicated the admission person from the new		anticonvulsant, and/or failed to have appropriate monitoring in place, had their physician notified and orders updated as appropriate. 3. The facility will conduct inservicing with all licensed nurses by the Director of Nursing or designee on unnecessary drug use with emphasis on monitoring, indications for use, and duplicate therapies. 4. DON/Designee will review new admission charts on next business day after admission to ensure that all PCC alerts for duplicate therapy have been addressed with MD and all psychoactive medications have appropriate indications and side effect monitoring in place. Director of Nursing or Designee will review the order listing report daily, Monday-Friday, to determine any residents with new medication orders to ensure they have appropriate indications for use, are not duplicate therapy and have side effect monitoring in place, if applicable. This will occur 5 times weekly x4 weeks, twice weekly x4 weeks, and monthly x4 months. The results of the audit observations will be reported, reviewed, and trended for compliance thru the facility Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendations.	

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	facility came to assess the resident the day she was dismissed (4/20/21), and she called her after she assessed the resident. She was told by the new facility admission's person, the resident was sitting in a wheelchair at the nurses' station with a male staff member and she was non-responsive and unable to talk. After the resident was moved to the new facility, she told the new facility staff the resident was not to be on the Zyprexa and Depakote and they stopped those medications and the resident's mental status began to improve. Since getting off the medication she was not supposed to be on, she has improved and she was talking and able to get up to the bedside commode now. During an interview, on 4/29/21 at 11:20 a.m., the DON and the Unit Manager were in attendance. The DON indicated when the resident admitted to the facility she was ambulating by herself and she talked. The Responsible Party brought in all the resident's pill bottles she was taking except the Zyprexa, Klonopin and the Hydrocodone because she indicated she had to get them refilled. The Guardian indicated once she got them refilled she would bring those in also, but she never brought those in, so those medications had to be ordered from the facility pharmacy. The only new medication the resident was started on was the 1 mg (milligram) dose of Klonopin, which the medication was not new, only the dose had been increased and the Guardian indicated she had not gotten it filled yet. The DON indicated Resident B's admission orders for her medication were written from the last visit progress note from her primary care physician, dated 2/25/21. They requested her primary care physician to fax her last visit progress note to them prior to her admission, so they could obtain her "current" medications from		5. Date of Compliance: May 28, 2021 Please review for paper compliance.	

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	the last visit note dated 2/25/21. When she was admitted to the facility, they called the facility physician and went over those medications from her last visit note with him to verify he wanted those "current" medications and those were the medications he ordered for her. The facility did not verify with Resident B's primary care physician if the medications listed on the last visit note dated 2/25/21, were accurate or not, they "assumed" they were accurate. During an interview, on 4/29/21 at 11:45 a.m., LPN 5, DON and Unit Manager were in attendance. LPN 5 indicated she was Resident B's nurse on the last day she was in the facility and she was very lethargic this day. She sat in a wheelchair behind the nurses' station with a male staff member sitting with her for one on one supervision until she was discharged by stretcher in an ambulance to the new facility around 5:00 p.m. She indicated she was especially lethargic right after she took her medications in the morning, then she woke up a little in the afternoon. During an interview, on 4/29/21 at 11:59 a.m., the Admissions Coordinator at the new facility indicated when she came to assess Resident B, in the early afternoon on 4/20/21, she was sitting in a wheelchair at the nurses' station with a male staff member. She was slumped over and leaning in her wheelchair and she could barely hold her head up. She could not get a response from her when she tried to talk to her. She could not visibly connect to people with her eyes. She had a cup of pudding in front of her, but she had missed her mouth several times while trying to feed herself because she had pudding falling from the side of her mouth and on her clothes. She was drooling pudding out of her mouth. She			

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	had the appearance of being "oversedated." During an interview, on 4/29/21 at 2:31 p.m., the DON and the Unit Manager were in attendance. The DON indicated the Guardian did not bring in the Zyprexa, Hydrocodone or the Klonopin, so the facility obtained these medications from their pharmacy. The progress visit note from Resident B's primary physician indicated she was taking all three of these medications. The DON indicated the facility's policy for admitting a resident was to contact the resident's primary care physician to get the last visit note and they went by this to get the current medications. They verified the current medications with the facility physician and he decided what medications to keep or delete. The last visit progress note was supposed to have a "current" list of the residents' current medications they were taking. She had no idea the resident had been hospitalized at the end of March because the Guardian had not told her this information. The list of medications on the facility physician's note dictated on 4/15/21, listed the medications she was taking while hospitalized not what she was currently on and the DON indicated the facility physician was noting this in his notes for informational purposes only. The facility did not call the primary care physician prior to a respite admission to verify the last visit progress note was accurate as far as the resident's "current" medications unless it had been a few months since the resident had been seen by the doctor. When they asked for the last visit progress note, they were getting the most "current" medication list unless they were informed by someone the resident had his or her medication list updated. During an interview, on 4/29/21 at 4:27 p.m., the DON, Unit Manager and the facility physician			

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	were in attendance. The facility physician indicated he assessed the resident. She had a history of seizures. He would not have started her on Zyprexa if she had not already been on it because of the category the medication fell into. It was an atypical medication and he would not start this type of medication on a resident in a long term care facility if they had not already been on it prior to admission. The record review for Resident B was completed on 4/29/21 at 1:15 p.m. Diagnoses included, but were not limited to, dementia with behavioral disturbance, epilepsy intractable with status epilepticus, anxiety disorder and cognitive communication deficit. A facility document, titled "Reason for Visit," dated 4/15/21, indicated the facility physician assessed the resident on this date. She was hospitalized, from 3/27/21 to 3/31/21, after having two seizures at home. He reviewed and documented the medications she was currently prescribed according to her discharge summary from the hospital on 3/31/21. The resident's hospital discharge medications, dated 3/31/21, included, but were not limited to, the following: Keppra 500 mg by mouth, give 1 tablet twice a day. Klonopin 0.5 mg by mouth, give 1 tablet at bedtime. Proton 40 mg by mouth, give 1 tablet daily. Vimpat 100 mg by mouth, give 1 tablet twice a day. Zyprexa and Depakote were not listed on hospital discharge summary.			

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	A facility document, titled "Personal Effects Inventory," dated 4/15/21 and signed by LPN 4 on 4/29/21, did not list any medication bottles left at the facility for the resident during her admission. The EMAR (Electronic Medication Administration Record), dated April 1, 2021 to April 30, 2021, and the Order Summary Report, dated April 30, included, but were not limited to, the following orders: 4/15/21--Famotidine Tablet (a medication used to treat heart burn), give 20 mg one time a day for GERD (Gastroinstinal Esophageal Reflux Disease) 4/15/21--Omerprazole Capsule Delayed Release (a medication used to treat heart burn), give 20 mg tablet by mouth one time a day for GERD. 4/15/21--Pantoprazole Sodium tablet Delayed Release (a medication used to treat heart burn), give 40 mg by mouth one a day for GERD. 4/15/21--Depakote Tablet Delayed Release 500 mg (a medication used to treat seizures), give one tablet by mouth two times a day for seizures. 4/15/21--Keppra Tablet (a medication used to treat seizures), 250 mg give one tablet by mouth two times a day for seizures. 4/15/21--Olanzapine (Zyprexa) tablet (a medication used to treat mental disorders), 5 mg give one tablet by mouth two times a day for dementia with behavioral disturbance. 4/15/21--Vimpat Tablet (a medication used to treat seizures), 50 mg by mouth two times a day			

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	for dementia with behavioral disturbance. 4/17/21--Clonzapam (Klonopin) tablet (a medication used to treat anxiety), 1 mg by mouth at bedtime for increased anxiety/insomnia. Resident B's record lacked these items: a. Monitoring for duplication of medication classifications which included, but were not limited to, the multiple Proton Pump Inhibitors and seizure medications. b. Adequate indication for the use of Vimpat and Olanzapine (Zyprexa). c. Adequate monitoring for adverse consequences in the resident's psychotropic medication regimen such as; antipsychotic or antianxiety medications to determine if these medications required a decrease in dosage. During an interview, on 4/30/21 at 2:39 p.m., the Unit Manager indicated she would have to verify the medication lists from 2/25/21, 3/31/21 and 4/15/21 to find out how this resident was prescribed three Proton Pump Inhibitors (Famotidine, Omerprazole and Pantoprazole Sodium) at the same time and investigate why pharmacy did not catch this. The indication for use for Vimpat was for seizures. She was not sure what the indication was for the use of the Zyprexa. An MD Exam report received from a hospital, dated 4/24/21 at 8:02 p.m., indicated the resident was brought to the emergency room (ER) by an ambulance from a facility she had been residing in for the past four days due to she was "acting differently" according to her Guardian. The facility she was transferred from to the hospital indicated there had been no changes in her			

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	condition since admission four days prior, but the family indicated when the resident checked into the first facility prior to this one, she ambulated into the facility by herself, unassisted and checked herself into the facility. The Neurologist spoke to the resident in the ER, then asked to have the resident transferred down to the hospital where he was located and he would admit her and take over her care. The Emergency Room Physician's concern, as well as the Neurologist's concern, which might be the cause of the resident's problems was polypharmacy (the use of more medications than were medically necessary). This Federal tag relates to Complaint IN00352562. 3.1-48(a)(1) 3.1-48(a)(3) 3.1-48(a)(4) 3.1-48(a)(5)			