STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155367	A. BUILDING 00 B. WING	08/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GOLDEN LIVING CENTER-SYCAMORE VILLAGE	2905 W SYCAMORE ST KOKOMO, IN 46901

(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
F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00360083, IN00359285 and IN00358778. This visit included a COVID-19 Focused Infection Control Survey. Complaint IN00360083- Substantiated. Federal/State deficiencies related to the allegations are cited at F580 and F757. Complaint IN00358778- Substantiated. Federal/State deficiencies related to the allegations are cited at F580 and F695. Complaint IN00359285- Unsubstantiated due to lack of sufficient evidence. Survey dates: August 12, 13 and 16, 2021. Facility number: 000258 Provider number: 155367 AIM number: 100289160 Census Bed Type: SNF/NF: 86 Total: 86 Census Payor Type: Medicare: 12 Medicaid: 48 Other: 26 Total: 86 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review was completed on August 19, 2021.	F 0000	Preparation, submission and implementation of this plan of correction does not constitute an admission of or an agreement with the facts and conclusion set forth on the survey report. Our of plan of correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable State and Federal regulatory requirements. Taking into the consideration the low severity nature of the citations. We hereby request Desk review / paper compliance for our POC. Sincerely, Kaushik Patel	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 0580 SS=D Bldg. 00	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident			

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	representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). Based on interview and record review, the facility failed to notify the physician when the administration of oxygen and medications were given outside of the physician ordered parameters for 4 of 4 residents reviewed for a change in condition. (Residents C, D, E, B). Findings include: 1. The record for Resident C was reviewed on 8/12/2021 at 2:45 p.m. Diagnoses included, but were not limited to, dementia with behavioral disturbance, hypertensive heart disease and Covid 19. A physician's order, dated 4/20/2020, indicated oxygen (02) at 2 LPM (liters per minute) to keep the oxygen saturation (02 sats) above 90% as needed. A progress note, dated 12/2/2020 at 7:31 a.m., indicate the resident's 02 sats were 88% on room air. The resident was placed on 02 at 2 LPM per nasal cannula (NC). The resident's sats were in the 80's so the oxygen was increased to 3 LPM with no improvement in the resident's 02 sats. The oxygen was then increased to 5 LPM per NC and the 02 sats were 94%.	F 0580	· Resident CDEB either no longer resides at the facility or were unable to be identified. · Progress notes reviewed for the past 30 days of all residents with O2 orders to ensure O2 was administered within the Physician ordered parameters. MD was notified of those residents who received O2 outside of Physician ordered parameters. The vital signs exception report reviewed for the past 30 days of all residents with medication orders with hold parameters to identify any abnormal Vital signs and then verified with the MAR to ensure medications are not administered outside the Physicians ordered parameters. The MD was notified of any resident who received medications outside of hold parameters. · Education provided to all licensed staff regarding ensuring Medications are held per MD parameters and O2 is being administered within the Physician	09/10/2021

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	A progress note, dated 12/2/2020 at 9:40 a.m., indicated the resident's 02 sats were 90% on 5 LPM of 02. This was not the prescribed 02 at 2 LPM and the progress notes did not include notification to the physician of the resident's condition which required the need to increase the oxygen to 5 LPM. 2. The record for Resident D was reviewed on 8/12/21 at 1:57 p.m. Diagnoses included, but were not limited to, Alzheimer's disease, peripheral vascular disease and Covid 19. A physician's order, dated 11/21/2020, indicated 02 at 2-4 LPM per NC to keep 02 sats greater than 95%. A progress note, dated 12/3/2020 at 8:41 a.m., indicated the resident's 02 sat was 91% on 5 LPM per NC. The progress note did not include a notification to the physician for the change in the resident's condition or the need to increase the 02 to 5 LPM. A progress note, dated 12/6/2020 at 8:31 p.m., indicated the resident remained on continuous oxygen at 10 LPM. The progress notes did not include a notification to the physician for the change in the resident's condition or the need to increase the 02 to 10 LPM. 3. The record for Resident E was reviewed on 8/13/21 at 2:00 p.m. Diagnoses included, but were not limited to, dementia with Lewy bodies, chronic		ordered parameters and notifying MD when administered outside of parameters. · During Clinical start up, DON/ designee will review progress notes to ensure O2 is administered within the Physician ordered parameters and the MD is notified when administered outside of the ordered parameters to obtain new O2 parameter orders. DON/ designee will review the vital signs exception report to identify any abnormal Vital signs and then verify with the MAR to ensure medications are not administered outside the Physicians ordered parameters. These reviews will be completed 5 times weekly x 30 days, the 3 times weekly x 60 days, then 2 x weekly x 60 days then weekly x 30 days. · Any issues or concerns will be monitored through QAPI process on an ongoing basis for a minimum of 6 months to track trends. If any trends are identified, then audits are to be completed on QAPI recommendations. If no trends are identified, then reviews will be completed on a PRN basis	

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	obstructive pulmonary disease, type 2 diabetes, schizophrenia, psychotic disorder with hallucinations, Parkinson's disease and visual hallucinations. A physician's order, dated 7/27/21, indicated 02 at 1-2 LPM to keep 02 sats above 92%. A progress note, dated 8/12/21 at 10:33 a.m., indicated the residents 02 sats were 86% on room air. The resident was placed on 02 at 3 LPM per NC. The progress notes did not include a notification to the physician of the resident's condition which required the 02 to be increased to 3 LPM. A progress note, dated 8/16/21 at 11:39 a.m., indicated the residents 02 sats were 92% on 4 LPM per NC. The progress notes did not include a notification to the physician or family for the increase in the oxygen to 4 LPM. During an interview, on 8/16/2021 at 12:03 p.m., the Director of Nursing (DON) confirmed the physician orders for residents C, D and E were as written and no new orders had been obtained for the increased oxygen liters. She indicated as a nursing measure which she learned in nursing school, the oxygen liters could be bumped up to 10 LPM and within 24 hours the physician would need notified. However the documentation did not include the notification to the physician. 4. The record for Resident B was reviewed on 8/12/21 at 1:30 p.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease, heart failure, lymphedema, diabetes			

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	mellitus, cardiomegaly, osteoarthritis, major depressive disorder and generalized muscle weakness. A physician's order, dated 11/08/2018, indicated Cardizem (a heart medication) CD capsule extended release to give 120 mg (milligram) related to hypertension and to hold if the systolic blood pressure was less than 100 or the pulse was less than 60. A Medication Administration Record (MAR) dated 6/1/21 through 6/30/21, indicated on 6/2/2021, the resident's pulse was 59 and the Cardizem CD 120 mg was still administered. During an interview, on 8/16/2021 at 2:18 p.m., the DON indicated the MAR did indicate the dose of Cardizem had been administered with a pulse of 59 and it was only one away from the parameters set by the physician to not give the medication. A current policy, titled, "Notification of Changes", dated 2020 and received from the DON on 8/12/2021 at 4:38 p.m., indicated, "...The purpose of this policy is to ensure the facility promptly informs the resident, consults the resident's physician; and notifies, consistent with his or her authority, resident's representative when there is a change requiring notification...Circumstances requiring notification include...Accidents...Significant change in the resident's physical, mental or psychosocial condition such as deterioration in health, mental or psychosocial status...Circumstances that require a need to alter treatment...This may include...New treatment...Discontinuation of current treatment due to...Adverse consequences...Acute condition...Exacerbation of a chronic condition...Competent individuals...The			

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	facility must still contact the resident's physician and notify resident's representative if known...When a resident is mentally competent, such a designated family member should be notified of significant changes in the resident's health status because the resident may not be able to notify them personally, especially in the case of sudden illness or accident...." This Federal Tag relates to Complaint IN00358778 and IN00360083. 3.1-5(a)(3)			
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on interview and record review, the facility failed to follow the physician's orders for the use of oxygen and to notify the physician the oxygen treatment had been changed for 3 of 3 residents reviewed for supplemental oxygen use (Resident C, D and E). Findings include: 1. The record for Resident C was reviewed on 8/12/2021 at 2:45 p.m. Diagnoses included, but were not limited to, dementia with behavioral disturbance, obstructive hydrocephalus, major	F 0695	· Resident CDE either no longer resides at the facility or were unable to be identified. · Progress notes reviewed for the past 30 days of all residents with O2 orders to ensure O2 was administered within the Physician ordered parameters. Ensuring MD notification is occurring of those residents who received O2 outside of Physician ordered parameters. · Education provided to all licensed staff regarding ensuring	09/10/2021

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	depressive disorder, hypertensive heart disease, osteoarthritis, Covid 19 and dysphagia. A physician's order, dated 4/20/2020, indicated oxygen (02) at 2 LPM (liters per minute) to keep the saturation (sats) above 90% as needed. A progress note, dated 12/2/2020 at 7:31 a.m., indicate the resident's 02 sats were 88% on room air. The resident was placed on 02 at 2 LPM per nasal cannula (NC). The resident's sats were in the 80's so the oxygen was increased to 3 LPM with no improvement in the resident's 02 sats. The oxygen was then increased to 5 LPM per NC and the 02 sats were 94%. A progress note, dated 12/2/2020 at 9:40 a.m., indicated the resident's oxygen saturation (02 sats) were 90% on 5 LPM of 02. The progress note, on 12/2/2020 at 7:31 a.m., did not included notification to the physician of the increased oxygen to 5 LPM nasal cannula. 2. The record for Resident D was reviewed on 8/12/21 at 1:57 p.m. Diagnoses included, but were not limited to, Alzheimer's disease, peripheral vascular disease, depressive disorder, macular degeneration and Covid 19. A physician's order, dated 11/21/2020, indicated 02 at 2-4 LPM per NC to keep 02 sats greater than 95%. A progress note, dated 12/3/2020 at 8:41 a.m., indicated the resident's 02 sat was 91% on 5 LPM per NC. A progress note, dated 12/6/2020 at 8:31 p.m., indicated the resident remained on continuous		O2 is being administered within the Physician ordered parameters and notifying MD when administered outside of parameters. · During Clinical start up, DON/ designee will review progress notes to ensure O2 is administered within the Physician ordered parameters and the MD is notified when administered outside of the ordered parameters to obtain new O2 parameter orders. This review will be completed 5 times weekly x 30 days, the 3 times weekly x 60 days, then 2 x weekly x 60 days then weekly x 30 days. · Any issues or concerns will be monitored through QAPI process on an ongoing basis for a minimum of 6 months to track trends. If any trends are identified, then audits are to be completed on QAPI recommendations. If no trends are identified, then reviews will be completed on a PRN basis	

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	oxygen at 10 LPM. The progress notes did not include a notification to the physician for the increases in the oxygen to 5 LPM and 10 LPM. During an interview, on 8/16/2021 at 12:03 p.m., the Director of Nursing (DON) confirmed the physician orders for residents C and D were as written and no new orders had been obtained for the increased oxygen liters. She indicated as a nursing measure which she learned in nursing school, the oxygen liters could be bumped up to 10 LPM and within 24 hours the physician would need notified. 3. The record for Resident E was reviewed on 8/13/21 at 2:00 p.m. Diagnoses included, but were not limited to dementia with Lewy bodies, chronic obstructive pulmonary disease, type 2 diabetes, schizophrenia, psychotic disorder with hallucinations, Parkinson's disease and visual hallucinations. A physician's order, dated 7/27/21, indicated 02 at 1-2 LPM to keep 02 sats above 92%. A progress note, dated 8/12/21 at 10:33 a.m., indicated the residents 02 sats were 86% on room air. The resident was placed on 02 at 3 LPM per NC. A progress note, dated 8/16/21 at 11:39 a.m., indicated the residents 02 sats were 92% on 4 LPM per NC. The progress notes did not include a notification to the physician or family for the increase in the oxygen to 3 LPM and 4 LPM. A current policy, titled "Notification of Changes," dated 2020 and received from the DON on			

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	8/12/2021 at 4:38 p.m., indicated "...The purpose of this policy is to ensure the facility promptly informs the resident, consults the resident's physician; and notifies, consistent with his or her authority, resident's representative when there is a change requiring notification...Circumstances requiring notification include...Accidents...Significant change in the resident's physical, mental or psychosocial condition such as deterioration in health, mental or psychosocial status...Circumstances that require a need to alter treatment...This may include...New treatment...Discontinuation of current treatment due to...Adverse consequences...Acute condition...Exacerbation of a chronic condition...Competent individuals...The facility must still contact the resident's physician and notify resident's representative if known...When a resident is mentally competent, such a designated family member should be notified of significant changes in the resident's health status because the resident may not be able to notify them personally, especially in the case of sudden illness or accident...." A current policy, titled "Oxygen Administration," dated 2021 and received from the DON on 8/16/21 at 12:24 p.m., indicated "...Oxygen is administered to residents who need it, consistent with professional standards of practice, the comprehensive person centered care plans, and the resident's goals and preferences...Oxygen is administered under the orders of a physician, except in the case of an emergency. In such case, oxygen is administered and orders for oxygen are obtained as soon as practicable when the situation is under control...Staff shall document the initial and ongoing assessment of the resident's condition warranting oxygen and the response to oxygen therapy...Staff shall notify the			

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	physician of any changes in the resident's condition, including changes in vital signs, oxygen concentrations, or evidence of complications associated with the use of oxygen..." This Federal Tag relates to Complaint IN00358778. 3.1-47(a)(6)			
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 follow physician ordered vital sign parameters for medication administration and to recognize potential adverse effects of a	F 0757	· Resident B no longer resides at the facility. · The vital signs exception report reviewed for the past 30	09/10/2021

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	medication for 1 of 3 residents reviewed for closed records. (Resident B). Finding includes: The record for Resident B was reviewed on 8/12/21 at 1:30 p.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease, heart failure, lymphedema, diabetes mellitus and cardiomegaly. A physician's order, dated 11/08/2018, indicated Cardizem (a heart medication) CD capsule extended release to give 120 mg (milligram) related to hypertension and to hold if the systolic blood pressure was less than 100 or the pulse was less than 60. A Medication Administration Record (MAR), dated 6/1/21 through 6/30/21, indicated on 6/2/2021, the resident's pulse was 59 and the Cardizem CD 120 mg was still administered. The Nursing Drug Handbook, updated 2021, indicated the adverse reactions to Cardizem included, but were not limited to, arrhythmia's (irregular heart beat), bradycardia (low pulse rate) abnormal EKG (a test to evaluate the heart) and abdominal discomfort. The nursing considerations included, but were not limited to, if the systolic blood pressure was below 90 or the heart rate was below 60 beats per minute, to withhold the dose and to notify the prescriber. A progress note, dated 6/4/21 at 8:01 p.m., indicated the resident turned on his call light and stated he needed to go to the hospital. The resident pointed to his stomach and indicated he had stomach discomfort. The resident's blood pressure was 102/40 and his pulse ranged from		days of all residents with medication orders with hold parameters to identify any abnormal Vital signs and then verified with the MAR to ensure medications were not administered outside the Physicians ordered parameters. The MD was notified of any resident who received medications outside of hold parameters. · Education provided to all licensed staff regarding ensuring Medications are held per MD parameters and notifying MD when administered outside of parameters. · During Clinical start up, DON/ designee will review the vital signs exception report to identify any abnormal Vital signs and then verify with the MAR to ensure medications are not administered outside the Physicians ordered parameters. This review will be completed 5 times weekly x 30 days, the 3 times weekly x 60 days, then 2 x weekly x 60 days then weekly x 30 days. · Any issues or concerns will be monitored through QAPI process on an ongoing basis for a minimum of 6 months to track trends. If any trends are identified, then audits are to be completed on QAPI recommendations. If no trends are identified, then reviews will be completed on a PRN basis	

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(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
	38-53. The resident was educated on drinking fluids and consuming his meals as he had refused dinner. A progress note, dated 6/7/2021 at 4:30 p.m., indicated the resident's sister and brother in law were at the facility and were concerned the resident was not acting right. His pulse rate was 32, his blood pressure was 85/55, he was slow to respond and his eyes were glassy in appearance. The resident was sent to the ER for evaluation and treatment. A [name of hospital] ICU (intensive care unit) note, dated 6/7/21, indicated the assessment and recommendations included, but were not limited to, hypotension with a clinical scenario most consistent with sepsis, bradycardia likely secondary to medications and hyperkalemia (elevated potassium) and there was no evidence of an acute myocardial event (heart attack). A Discharge Death Summary, from [name of hospital] dated 6/9/2021, indicated the resident was admitted on 7/7/21 at 8:06 p.m. The patient had been sick about a week, his heart rate was 30, his blood pressure was 60/40 and he was sent to the emergency department. He had multiple abnormal heart rhythms. His problems included, but were not limited to, bradycardia (slow heart rate) and hypotension (low blood pressure). During an interview, on 8/12/2021 at 4:14 p.m., RN 2 indicated she did not complete a follow up assessment or document on the resident's low pulse of 38-53 on 6/4/2021 after the 8:01 p.m. note and she should have. During an interview, on 8/16/2021 at 2:18 p.m., the DON indicated the MAR did indicate the dose of			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155367	A. BUILDING 00 B. WING	08/16/2021

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	Cardizem had been administered with a pulse of 59 and it was only one away from the parameters set by the physician to not give the medication. A current policy, titled, " Medication Administration", dated 2021 and received from the DON on 8/16/2021 at 2:04 p.m., indicated, "...Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection...Obtain and record vital signs, when applicable or per physician orders. When applicable, hold medication for those vital signs outside the physician's prescribed parameters...." This Federal Tag relates to Complaint IN00360083. 3.1-48(a)(5)			