	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155367	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		(X3) DATE SURVEY COMPLETED 08/16/2021		
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP COD 2905 W SYCAMORE ST			
GOLDE	N LIVING CENTER	-SYCAMORE VILLAGE		KOKOI	MO, IN 46901		
(X4) ID PREFIX TAG	(EACH DEFICIE)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD ) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE	(X5) COMPLETION DATE
0000							
Bldg. 00	regulatory or LSC IDENTIFYING INFORMATION           00		F 00	00	Preparation, submission an implementation of this plan correction does not constitu admission of or an agreement the facts and conclusion se on the survey report. Our of correction is prepared and executed as a means to continuously improve the que care and to comply with all applicable State and Federa regulatory requirements. Taking into the consideration low severity nature of the ci- We hereby request Desk re- paper compliance for our Pre- Sincerely, Kaushik Patel	of ite an ent with t forth f plan of uality of al in the tations. view /	

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

TITLE

(X6) DATE

PRINTED: 09/03/2021

Any defiencystatement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

	PLAN OF CORRECTION IDENTIFICATION NUMBER A. BU		(X2) MULTIPLE CO A. BUILDING B. WING	DNSTRUCTION 00	(X3) DATE SURVEY COMPLETED 08/16/2021	
	PROVIDER OR SUPPLIE N LIVING CENTER	R -SYCAMORE VILLAGE	2905 W	ADDRESS, CITY, STATE, ZIP COD / SYCAMORE ST MO, IN 46901	,	
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPI DEFICIENCY)	ILD BE COMPLETION	
F 0580	483.10(g)(14)(i)-					
SS=D Bldg. 00	§483.10(g)(14) N (i) A facility must resident; consult physician; and ne her authority, the when there is- (A) An accident i results in injury a requiring physicia (B) A significant of physical, mental, (that is, a deterio psychosocial stat conditions or clin (C) A need to alth (that is, a deterio psychosocial stat conditions or clin (C) A need to alth (that is, a need to form of treatmen consequences, co of treatment); or (D) A decision to resident from the §483.15(c)(1)(ii). (ii) When making (g)(14)(i) of this s ensure that all pe in §483.15(c)(2) upon request to f (iii) The facility m resident and the any, when there (A) A change in r assignment as sp (B) A change in r or State law or re paragraph (e)(10 (iv) The facility m	change in the resident's or psychosocial status ration in health, mental, or tus in either life-threatening ical complications); er treatment significantly of discontinue an existing t due to adverse or to commence a new form transfer or discharge the effacility as specified in notification under paragraph section, the facility must ertinent information specified is available and provided the physician. nust also promptly notify the resident representative, if is- room or roommate pecified in §483.10(e)(6); or resident rights under Federal egulations as specified in				

PRINTED: 09/03/2021

# DEPARTMENT OF HEALTH AND HUMAN SERVICES

AND PLAN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155367	B. WING 08/1		COMPI 08/16	LETED	
	PROVIDER OR SUPPLIE N LIVING CENTER	R SYCAMORE VILLAGE		2905 V	ADDRESS, CITY, STATE, ZIP COD V SYCAMORE ST MO, IN 46901		
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETIO DATE
	representative(s) §483.10(g)(15) Admission to a c facility that is a c defined in §483.4 admission agree configuration, ind that comprise the and must specify room changes be under §483.15(c Based on interview failed to notify the administration of d given outside of th for 4 of 4 resident: condition. (Reside Findings include: 1. The record for I 8/12/2021 at 2:45 were not limited to disturbance, hyper Covid 19. A physician's orde oxygen (02) at 2 I the oxygen saturat needed. A progress note, d indicate the resident air. The resident w nasal cannula (NC 80's so the oxygen no improvement in	<ul> <li>omposite distinct part. A omposite distinct part (as 5) must disclose in its ment its physical cluding the various locations e composite distinct part, of the policies that apply to etween its different locations (9).</li> <li>w and record review, the facility e physician when the physician ordered parameters is reviewed for a change in mts C, D, E, B).</li> <li>Resident C was reviewed on p.m. Diagnoses included, but b, dementia with behavioral tensive heart disease and</li> <li>er, dated 4/20/2020, indicated .PM (liters per minute) to keep ion (02 sats) above 90% as</li> <li>ated 12/2/2020 at 7:31 a.m., nt's 02 sats were 88% on room vas placed on 02 at 2 LPM per t). The resident's 02 sats. The ncreased to 5 LPM per NC and</li> </ul>	F 0:		<ul> <li>Resident CDEB either not longer resides at the facility or were unable to be identified.</li> <li>Progress notes reviewed the past 30 days of all resident with O2 orders to ensure O2 w administered within the Physic ordered parameters. MD was notified of those residents who received O2 outside of Physici ordered parameters. The vital signs exception report reviewed the past 30 days of all resident with medication orders with ho parameters to identify any abnormal Vital signs and then verified with the MAR to ensur medications are not administer outside the Physicians ordered parameters. The MD was notif of any resident who received medications outside of hold parameters.</li> <li>Education provided to all licensed staff regarding ensuri Medications are held per MD parameters and O2 is being administered within the Physici</li> </ul>	l for ts vas cian cian cd for ts ld e red d fied	09/10/202

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

X1) PROVIDER/SUPPLIER/CLIA

IDENTIFICATION NUMBER

STATEMENT OF DEFICIENCIES

AND PLAN OF CORRECTION

155367	B. WI	NG		08/16/	2021
SYCAMORE VILLAGE		2905 W	ADDRESS, CITY, STATE, ZIP COD V SYCAMORE ST MO, IN 46901		
STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
CY MUST BE PRECEDED BY FULL	1	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLET
LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	-	DATE
ed 12/2/2020 at 9:40 a.m., nt's 02 sats were 90% on 5			ordered parameters and notifyi MD when administered outside parameters. · During Clinical start up, DON/ designee will review	0	
scribed 02 at 2 LPM and the			progress notes to ensure O2 is		
STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION ed 12/2/2020 at 9:40 a.m., ht's 02 sats were 90% on 5	<u> </u>	KOKON ID PREFIX	MO, IN 46901 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) ordered parameters and notifyi MD when administered outside parameters. During Clinical start up, DON/ designee will review	ng e of	

(X2) MULTIPLE CONSTRUCTION

00

A. BUILDING

(X3) DATE SURVEY

COMPLETED

(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) COMPLETIO DATE
	<ul> <li>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.</li> <li>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.</li> <li>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.</li> <li>A physician's order, dated 11/21/2020, indicated 02 at 2-4 LPM per NC to keep 02 sats greater than 95%.</li> <li>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.</li> <li>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.</li> <li>A progress note, dated 12/6/2020 at 8:31 p.m., indicated the resident remained on continuous oxygen at 10 LPM.</li> <li>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.</li> <li>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</li> </ul>		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	

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

	NT OF DEFICIENCIES OF CORRECTION	x1) provider/supplier/clia identification number 155367	(X2) MULTII A. BUILDI B. WING		NSTRUCTION 00	CC	ATE SURVEY DMPLETED 8/16/2021
	PROVIDER OR SUPPLIE	ER R-SYCAMORE VILLAGE	29	05 W	ddress, city, state, zif SYCAMORE ST O, IN 46901	? COD	
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION	ID PREI TA	IX	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE IE APPROPRIATE	(X5) COMPLETIC DATE
	schizophrenia, psy	nary disease, type 2 diabetes, ychotic disorder with rkinson's disease and visual					
		er, dated 7/27/21, indicated 02 at 02 sats above 92%.					
	indicated the resid	lated 8/12/21 at 10:33 a.m., lents 02 sats were 86% on room vas placed on 02 at 3 LPM per					
	to the physician of	s did not include a notification f the resident's condition which be increased to 3 LPM.					
		lated 8/16/21 at 11:39 a.m., lents 02 sats were 92% on 4					
		s did not include a notification r family for the increase in the					
	the Director of Nu physician orders f written and no new the increased oxyg nursing measure v school, the oxygen 10 LPM and within need notified. How	ew, on 8/16/2021 at 12:03 p.m., ursing (DON) confirmed the for residents C, D and E were as w orders had been obtained for gen liters. She indicated as a which she learned in nursing n liters could be bumped up to in 24 hours the physician would wever the documentation did not ration to the physician.					
	8/12/21 at 1:30 p.1 not limited to, chr	Resident B was reviewed on m. Diagnoses included, but were onic obstructive pulmonary ıre, lymphedema, diabetes					

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

	NT OF DEFICIENCIES OF CORRECTION	x1) provider/supplier/clia identification number 155367	(X2) MULTIPLE CC A. BUILDING B. WING	00	CON 08/	te survey 19leted 16/2021
	PROVIDER OR SUPPLI	ER R-SYCAMORE VILLAGE	2905 W	address, city, state, zip c ' SYCAMORE ST 10, IN 46901	COD	
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE , DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
		egaly, osteoarthritis, major er and generalized muscle				
	Cardizem (a heart extended release t to hypertension an	er, dated 11/08/2018, indicated medication) CD capsule o give 120 mg (milligram) related nd to hold if the systolic blood than 100 or the pulse was less				
	dated 6/1/21 throu 6/2/2021, the resid	ministration Record (MAR) ugh 6/30/21, indicated on dent's pulse was 59 and the mg was still administered.				
	DON indicated th Cardizem had bee and it was only or	ew, on 8/16/2021 at 2:18 p.m., the e MAR did indicate the dose of en administered with a pulse of 59 he away from the parameters set o not give the medication.				
	dated 2020 and re 8/12/2021 at 4:38 of this policy is to informs the reside physician; and no authority, residen change requiring requiring notificat includeAcciden resident's physicat condition such as or psychosocial st require a need to a includeNew treat current treatment consequencesA	tsSignificant change in the I, mental or psychosocial deterioration in health, mental atusCircumstances that alter treatmentThis may atmentDiscontinuation of				

	T OF HEALTH AND HU! R MEDICARE & MEDIC				PRINTED: 09/03 FORM APPROVE OMB NO. 0938-03
	NT OF DEFICIENCIES OF CORRECTION	x1) provider/supplier/clia identification number 155367	(X2) MULTIPLE ( A. BUILDING B. WING	construction 00	(X3) DATE SURVEY COMPLETED 08/16/2021
	PROVIDER OR SUPPLIEF	SYCAMORE VILLAGE	2905	i address, city, state, zip cod W SYCAMORE ST DMO, IN 46901	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF facility must still cc and notify resident's	-	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE (X5) COMPLETIO DATE
	such a designated fa notified of significa health status becaus able to notify them case of sudden illne	sident is mentally competent, amily member should be ant changes in the resident's see the resident may not be personally, especially in the ess or accident"			
- 0695 SS=D Bldg. 00	Suctioning § 483.25(i) Respir tracheostomy care The facility must en needs respiratory tracheostomy care is provided such of professional stand comprehensive per the residents' goa 483.65 of this sub Based on interview failed to follow the of oxygen and to not treatment had been reviewed for supple C, D and E). Findings include:	e and tracheal suctioning, care, consistent with dards of practice, the erson-centered care plan, ls and preferences, and	F 0695	<ul> <li>Resident CDE either no longer resides at the facility or were unable to be identified.</li> <li>Progress notes reviewed the past 30 days of all residen with O2 orders to ensure O2 v administered within the Physic ordered parameters. Ensuring notification is occurring of thos residents who received O2 ou</li> </ul>	d for tts vas cian J MD se

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

were not limited to, dementia with behavioral

disturbance, obstructive hydrocephalus, major

Event ID: 6

600J11 Facility

Facility ID: 000258

.

Education provided to all

licensed staff regarding ensuring

If continuation sheet Page 7

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# DEPARTMENT OF HEALTH AND HUMAN SERVICES

NTERS FOR MEDICARE ( STATEMENT OF DEFICIE AND PLAN OF CORRECTI	CIES X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING	OMB NO. 0938-039 [X3] DATE SURVEY COMPLETED 08/16/2021
NAME OF PROVIDER OR	UPPLIER NTER-SYCAMORE VILLAGE	STREET ADDRESS, CITY, STATE, ZI 2905 W SYCAMORE ST KOKOMO, IN 46901	PCOD
PREFIX(EACH)TAGREGULAdepressive osteoarthriA physicia oxygen (02 the saturatiA progress indicate the air. The res nasal canno 80's so the no improve oxygen wa the 02 satsA progress indicated th sats) were the The progress indicated th sats) were the The progress indicated the sats) were the the of the progress indicated the sats and the 02 satsA progress 	MARY STATEMENT OF DEFICIENCIE EFICIENCY MUST BE PRECEDED BY FULL <u>'ORY OR LSC IDENTIFYING INFORMATION</u> lisorder, hypertensive heart disease, s, Covid 19 and dysphagia. 's order, dated 4/20/2020, indicated at 2 LPM (liters per minute) to keep n (sats) above 90% as needed. note, dated 12/2/2020 at 7:31 a.m., resident's 02 sats were 88% on room dent was placed on 02 at 2 LPM per la (NC). The resident's sats were in the xygen was increased to 3 LPM with nent in the resident's 02 sats. The then increased to 5 LPM per NC and were 94%. note, dated 12/2/2020 at 9:40 a.m., e resident's oxygen saturation (02 0% on 5 LPM of 02. s note, on 12/2/2020 at 7:31 a.m., did l notification to the physician of the tygen to 5 LPM nasal cannula. d for Resident D was reviewed on :57 p.m. Diagnoses included, but were o, Alzheimer's disease, peripheral ease, depressive disorder, macular n and Covid 19. 's order, dated 11/21/2020, indicated 'M per NC to keep 02 sats greater than note, dated 12/3/2020 at 8:41 a.m., e resident's 02 sat was 91% on 5 LPM	ID PREFIX TAG       PROVIDERS PLANOF C CROSS-REFERENCED TO TH DEFICIENCY         TAG       02 is being administ the Physician ordere and notifying MD wh administered outside parameters.         •       During Clinical DON/ designee will r progress notes to en administered within t ordered parameters notified when admini of the ordered param obtain new O2 parar This review will be co times weekly x 30 da times weekly x 60 days the 30 days.         •       Any issues or of be monitored through process on an ongoi minimum of 6 month trends. If any trends then audits are to be on QAPI recommend trends are identified, will be completed on	ANSHOULD BE COMPLETION DATE DAT

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

Event ID: 600J11 Facility ID: 000258

PRINTED: 09/03/2021 FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES 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 COMPLETED 00 B. WING 08/16/2021 155367 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 2905 W SYCAMORE ST GOLDEN LIVING CENTER-SYCAMORE VILLAGE KOKOMO, IN 46901 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE 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

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

Event ID: 600J11

1 Facility ID: 000258

00258 If co

If continuation sheet Page

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09/03/2021

PRINTED:

	NT OF DEFICIENCIES OF CORRECTION			(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		(X3) DATE SURVEY COMPLETED 08/16/2021	
	PROVIDER OR SUPPLIE		2905 V	ADDRESS, CITY, STATE, ZIP V SYCAMORE ST	COD		
GOLDEN	N LIVING CENTER	-SYCAMORE VILLAGE	KOKOI	MO, IN 46901			
(X4) ID	SUMMARY	Y STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CO	DRRECTION	(X5)	
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	SHOULD BE APPROPRIATE	COMPLETIC	
TAG		OR LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE	
		p.m., indicated "The purpose of					
	this policy is to en	sure the facility promptly					
		nt, consults the resident's					
	physician; and not	ifies, consistent with his or her					
		's representative when there is a					
		notificationCircumstances					
	requiring notificat						
	includeAccident	sSignificant change in the					
	resident's physical	, mental or psychosocial					
	condition such as	deterioration in health, mental					
	or psychosocial sta	atusCircumstances that					
	require a need to a	lter treatmentThis may					
	includeNew trea	tmentDiscontinuation of					
	current treatment of	due toAdverse					
	consequencesAc	cute conditionExacerbation of					
	a chronic condition	nCompetent individualsThe					
	facility must still o	contact the resident's physician					
	and notify residen	t's representative if					
	knownWhen a re	esident is mentally competent,					
	such a designated	family member should be					
	notified of signific	cant changes in the resident's					
	health status becau	use the resident may not be					
	able to notify then	n personally, especially in the					
	case of sudden illr	ness or accident"					
		itled "Oxygen Administration,"					
	dated 2021 and red	ceived from the DON on 8/16/21					
	-	cated "Oxygen is administered					
		eed it, consistent with					
		ards of practice, the					
		rson centered care plans, and					
		s and preferencesOxygen is					
		or the orders of a physician,					
	-	of an emergency. In such case,					
	oxygen is adminis	tered and orders for oxygen are					
	obtained as soon a	s practicable when the					
	situation is under o	controlStaff shall document					
	the initial and ong	oing assessment of the					
	resident's conditio	n warranting oxygen and the					
	response to oxyge	n therapyStaff shall notify the					

PRINTED: 09/03/2021

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155367	(X2) MULTIPLE C A. BUILDING B. WING	005TRUCTION	(X3) DATE SURVEY COMPLETED 08/16/2021
	PROVIDER OR SUPPLIE	R -SYCAMORE VILLAGE	2905 V	ADDRESS, CITY, STATE, ZIP COD V SYCAMORE ST MO, IN 46901	
(X4) ID PREFIX TAG	(EACH DEFICIE	/ STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL PR 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
	condition, includir oxygen concentrat complications asso oxygen"	hanges in the resident's ng changes in vital signs, ions, or evidence of ociated with the use of			
	3.1-47(a)(6)	elates to Complaint IN00358778.			
= 0757 4 SS=D D Bldg. 00 D § E fr	Drugs §483.45(d) Unne Each resident's c	Free from Unnecessary cessary Drugs-General. drug regimen must be free y drugs. An unnecessary when used-			
	§483.45(d)(1) In duplicate drug th	excessive dose (including erapy); or			
	§483.45(d)(2) Fo	r excessive duration; or			
	§483.45(d)(3) Wi or	thout adequate monitoring;			
	§483.45(d)(4) Wi for its use; or	thout adequate indications			
	consequences w	the presence of adverse hich indicate the dose ed or discontinued; or			
	reasons stated ir (5) of this sectior	y combinations of the paragraphs (d)(1) through n. v and record review, the facility	F 0757	· Resident B no longer	09/10/202
	failed to follow ph parameters for me	ysician ordered vital sign dication administration and to l adverse effects of a	1 0/5/	resides at the facility. • The vital signs exception report reviewed for the past 30	

CENTERS FOR MEDICARE & MEDICAID SERVICES

OMB	NO.	0938-039

(X3) DATE SURVEY COMPLETED 08/16/2021	DNSTRUCTION 00	(X2) MULTIPLE C A. BUILDING B. WING	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155367	NT OF DEFICIENCIES OF CORRECTION	
ZIP COD	ADDRESS, CITY, STATE, ZIP / SYCAMORE ST /IO, IN 46901	2905 V	SYCAMORE VILLAGE	PROVIDER OR SUPPLIER	
F CORRECTION (X5) ION SHOULD BE COMPLET	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THI	ID PREFIX	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL		(X4) ID PREFIX
DATE	CROSS-REFERENCED TO THI DEFICIENCY)	TAG	LSC IDENTIFYING INFORMATION		TAG
s with	days of all residents		3 residents reviewed for closed	medication for 1 of	
	medication orders with		3).	records. (Resident E	
parameters to identify any abnormal Vital signs and then verified with the MAR to ensure medications were not administered outside the			,	× ×	
				Finding includes:	
			dent B was reviewed on	The record for Resid	
			Diagnoses included, but were	8/12/21 at 1:30 p.m.	
l parameters.	Physicians ordered p		nic obstructive pulmonary		
The MD was notified of any resident who received medications			e, lymphedema, diabetes	disease, heart failure	
			negaly.	mellitus and cardior	
ameters.	outside of hold paran				
ovided to all	<ul> <li>Education prov</li> </ul>		dated 11/08/2018, indicated	A physician's order,	
rding ensuring	licensed staff regardi		nedication) CD capsule	Cardizem (a heart m	
ld per MD	Medications are held		give 120 mg (milligram) related	extended release to	
tifying MD when	parameters and notif		to hold if the systolic blood	to hypertension and	
de of	administered outside		an 100 or the pulse was less	pressure was less th	
	parameters.			than 60.	
al start up,	During Clinical				
I review the vital	DON/ designee will re		nistration Record (MAR),	A Medication Admi	
port to identify	signs exception repo		h 6/30/21, indicated on	dated 6/1/21 through	
signs and then	any abnormal Vital si		nt's pulse was 59 and the		
to ensure	verify with the MAR to		ng was still administered.	Cardizem CD 120 n	
ot administered	medications are not a				
ans ordered	outside the Physiciar		Iandbook, updated 2021,	00	
	parameters. This revi		e reactions to Cardizem		
-	completed 5 times we		not limited to, arrhythmia's		
	days, the 3 times we		), bradycardia (low pulse rate)		
	days, then 2 x weekly		est to evaluate the heart) and		
•	then weekly x 30 day		ort. The nursing considerations		
	• Any issues or c		not limited to, if the systolic		
-	be monitored through		below 90 or the heart rate was	-	
-	process on an ongoir		ninute, to withhold the dose		
	minimum of 6 months		escriber.	and to notify the pre	
	trends. If any trends a		ad 6/4/21 at 9:01	A mmo ( 1 )	
	then audits are to be		ed 6/4/21 at 8:01 p.m.,		
	on QAPI recommend		nt turned on his call light and		
	trends are identified,		go to the hospital. The		
IT A FIKIN DASIS	will be completed on		his stomach and indicated he		
			fort. The resident's blood ) and his pulse ranged from		

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES 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 COMPLETED 00 B. WING 08/16/2021 155367 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 2905 W SYCAMORE ST GOLDEN LIVING CENTER-SYCAMORE VILLAGE KOKOMO, IN 46901 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) 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 600J11 Event ID: Facility ID: 000258 Page 13 of 14 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** 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 COMPLETED 00 155367 B. WING 08/16/2021 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 2905 W SYCAMORE ST GOLDEN LIVING CENTER-SYCAMORE VILLAGE KOKOMO, IN 46901 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE 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)

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