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	03/15/2023

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

(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 a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00402753, IN00403911, IN00403763 and IN00403910. Complaint IN00402753 - Federal/State deficiencies related to the allegations are cited at F725 and F921. Complaint IN00403911 - Federal/State deficiencies related to the allegations are cited at F921. Complaint IN00403763 - No deficiencies related to the allegation are cited. Complaint IN00403910 - No deficiencies related to the allegation are cited. Survey dates: March 9, 10, 13, 14 and 15, 2023 Facility number: 000127 Provider number: 155222 AIM number: 100291430 Census Bed Type: SNF/NF: 71 Total: 71 Census Payor Type: Medicare: 5 Medicaid: 59 Other: 7 Total: 71 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.	F 0000	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
Sydnie Reed	Executive Director	04/18/2023

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.

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	03/15/2023

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

(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
	Quality review was completed on March 24, 2023.			
F 0550 SS=D Bldg. 00	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be			

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	03/15/2023

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

(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
	free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. Based on observation, interview and record review, the facility failed to ensure residents were dressed in regular clothing like other residents unless their preferences were identified for alternative clothing for 2 of 3 residents reviewed for dignity. (Resident E and D) Findings include: 1. During an observation, on 3/10/23 at 12:11 p.m., Resident E was lying in bed and had on a hospital gown. His roommate was also wearing a hospital gown. The other residents in the facility were observed wearing regular clothing. During an observation, on 3/13/23 at 4:13 p.m., the resident was lying in bed, in his room, and was wearing a hospital gown. The record for Resident E was reviewed on 3/13/23 at 11:38 a.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus, anxiety disorder, major depressive disorder, and peripheral vascular disease. A care plan, dated 3/26/21, indicated the resident had impaired cognitive function or impaired thought processes related to an altered mental status. The interventions included, but were not limited to, promote dignity. During an interview, on 3/15/23 at 3:09 p.m., the Clinical Support Nurse indicated there was no care plan or documentation to indicate the resident's preference was to wear a hospital gown.	F 0550	**What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice:** On 3/10/23 Residents E and Resident D were offered assistance to dress in regular clothes. Both residents initially declined then later Resident D stated he wanted to get dressed in regular clothing and facility staff assisted him with care. Both residents were offered assistance daily thereafter with occasional acceptance from Resident D. Resident E has consistently refused. The plan of care has been updated to reflect preference. No Residents were harmed by the alleged deficient practice. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:** All residents have the potential to be affected. The facility completed interviews with all residents or families of those that are not able to be interviewed to ensure resident preference for dressing is up to date in care plan and on Kardex.	04/21/2023

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	03/15/2023

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

(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
	2. During an observation, on 3/10/23 at 11:33 a.m., Resident D was lying in bed. He was wearing a hospital gown and indicated he had clothes in the closet. During an observation, on 3/13/23 at 11:47 a.m., the resident was lying in bed, the room was darkened, and he was wearing a hospital gown. The record for Resident D was reviewed on 3/13/23 at 3:02 p.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus, anxiety disorder, severe major depressive disorder without psychotic features, adult failure to thrive, and a history of TIA and cerebral infarction without residual deficits. A current care plan, not dated, indicated the resident was on a restorative program for dressing and/or grooming related to depression, weakness, diabetes mellitus, and pain. The goal was for the resident to be neatly groomed and dressed daily. The interventions included, but were not limited to, provide dressing and/or grooming program 6-7 times weekly. A current care plan, not dated, indicated the resident had an activities of daily living (ADL) performance deficit and required assistance with ADL care. The interventions included, but were not limited to, the resident required assistance of one staff for dressing. During an interview, on 3/15/23 at 3:09 p.m., the Clinical Support Nurse indicated the resident did not have documentation to show a preference for wearing hospital gowns. A current policy, titled "Resident Rights," not		**What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** Education was conducted with direct care staff using Resident Rights policy with emphasis on resident preference to ensure all residents preferences for dressing are established upon admission and preference is reflected on Kardex. **How the corrective action will be monitored to ensure the deficient practice will not recur:** The DON/Designee will complete observation of 5 residents per week for 4 weeks, then 3 residents per week for 8 weeks, then 1 resident per week for 12 weeks to ensure resident preference is up to date on Kardex and plan of care is being followed for dressing. Any discrepancies found will be immediately corrected and re-education will be provided. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for three months and then quarterly thereafter once full compliance has been achieved for a total of 6 months of monitoring. Frequency and duration of reviews will be increased as needed, if areas of noncompliance exist.	

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	03/15/2023

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

(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
	dated and received from the Administrator on 3/9/23 at 3:30 p.m., indicated "...It is the policy of this facility to provide resident centered care that meets the psychosocial, physical and emotional needs and concerns of the residents...The purpose of this policy is to guide employees in the general principals of dignity and respect of caring for residents...Care for residents will be provided in a safe and respectful manner...Residents have a choice and a voice in how they will be treated...Residents have a right to...To participate in the decisions that affects the resident's care...." 3.1-3(t)			
F 0554 SS=D Bldg. 00	483.10(c)(7) Resident Self-Admin Meds-Clinically Approp §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. Based on observation, interview and record review, the facility failed to ensure a resident had a self-medication assessment prior to leaving nasal spray at the bedside for the resident to self-administer for 1 of 1 resident observed for self-medication administration. (Resident 36) Finding includes: During an observation, on 3/13/23 at 9:36 a.m., Resident 36's Calcitonin (it helps maintain a healthy level of calcium in the blood) 200 unit/act (unit dose) nasal spray bottle was left on the bedside table. RN 6 picked up the bottle and administered 1 spray in both nostrils of Resident 36. The record for Resident 36 was reviewed on	F 0554	**What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice:** Resident 36 discharged on 3/13/23 shortly after the medication administration. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:** All residents whom which to self-administer medications have the potential to be affected. Any resident who wishes to self-administer will have a	04/21/2023

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	03/15/2023

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

(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
	3/13/23 at 2:15 p.m. Diagnoses included, but were not limited to, hypertension, congestive heart failure, chronic obstructive pulmonary disease, depression, myositis (a group of rare conditions, weak, painful, or aching muscles). A physician's order, dated 1/27/23, indicated to give Calcitonin 200 unit/act 1 spray in a nostril daily. During an interview, on 3/13/23 at 9:36 a.m., RN 6 did not know if the resident could keep his spray in his room. During an interview, on 3/13/23 at 9:38 a.m., Resident 36 indicated the medication had been on his bedside table for a long time and he took it when he wanted. During an interview, on 3/13/23 at 3:55 p.m., the Director of Nursing (DON) indicated the nurses should never leave medications in a resident's room. A self-medication assessment was not found during the record review. A self-medication assessment for the resident was requested, on 3/15/23 at 3:30 p.m., from the Clinical Support Nurse and was not provided by the facility upon exit. A current policy, titled "Bedside Medication Storage," revised 8/2020 and received by the Administrator on 3/15/23 at 8:30 p.m., indicated "...Bedside medication storage is permitted for residents who wish to self-administer medication, upon the written order of the prescriber and once self-administration skills have been assessed and deemed appropriate in the judgment of the		Self-Administration assessment completed and an MD order will be placed for self-administration. The care plan will be updated to reflect the preference of self-administration. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** Education has been provided to all licensed nurses and QMAs using the “Medication Self Administration” policy with emphasis on leaving medications at bedside. **How the corrective action will be monitored to ensure the deficient practice will not recur:** The DON/Designee will complete observations of medication administration to ensure any resident with medication at bedside has an order to self-administer and an assessment has been completed. The observations will be completed on 5 residents per week for 4 weeks then, 3 residents per week for 8 weeks then, 1 resident per week for 12 weeks. Any discrepancies will be immediately corrected and re-education will be provided to nurse or QMA. The results of these reviews will be discussed at the monthly facility Quality	

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	03/15/2023

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

(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
	facility's interdisciplinary resident assessment team (or equivalent). 1. A written order for the bedside storage of medication is present in the resident's medical record. 2. Bedside storage of medications is indicated on the resident Medication Administration Record (MAR) and in the care plan for the appropriate medications...." A current policy, titled "Resident Self-Administration of Medication," revised 9/25/22 and received by the Administrator on 3/15/23 at 3:30 p.m., indicated "...It is the policy of this facility to provide resident centered care that safeguards the resident's right for self-administration of their own medication that supports resident dignity and self-determination...The facility will not require or compel any resident to administer their own mediation if they do not desire to do so or cannot safety do so...The facility will periodically review the ability to self-administer mediation based upon change in status...Determine if the resident desires to self-administer their own medication. a. Resident may not self-administer medication until the assessment is completed by the IDT team and determined to be safe to do so...." 3.1-11(a)		Assurance Committee meeting monthly for three months and then quarterly thereafter once full compliance has been achieved for a total of 6 months of monitoring. Frequency and duration of reviews will be increased as needed, if areas of noncompliance exist.	
F 0561 SS=D Bldg. 00	483.10(f)(1)-(3)(8) Self-Determination §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to			

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	03/15/2023

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

(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
	choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. Based on observation, interview and record review, the facility failed to ensure dependent residents were offered and assisted out of bed and were offered the toileting method of their choice for 2 of 3 residents reviewed for choices. (Resident D and 15) Findings include: 1. During an observation, on 3/10/23 at 11:33 am., Resident D was lying in bed in his room. He indicated he wanted to go to therapy and eat in the dining room. Someone took his wheelchair and he had been getting out of bed before the wheelchair was removed. There was no wheelchair in the room or in the hallway for the resident. He indicated he only got out of bed once a week for therapy and it was not enough.	F 0561	**What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice:** No residents were harmed by the facility's alleged deficient practice. Resident D was offered to get up on 3/13/23 but initially refused. Later that day Resident D changed his mind and accepted assistance getting up to his wheelchair which was available in the corner of his room. His plan of care and Kardex have been updated to reflect this preference. Resident 15 will be assessed by therapy to establish safest mode of toileting for resident. Facility will	04/21/2023

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	03/15/2023

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

(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
	During an observation, on 3/13/23 at 11:47 a.m., the resident was lying in bed, in his room, the room was darkened, his eyes were open, and he waved. During an observation, on 3/13/23 at 12:45 p.m., the resident was still in bed, he had an empty lunch tray on his bedside table, and he was covered with a blanket up to his neck. The record for Resident D was reviewed on 3/13/23 at 3:02 p.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus with diabetic neuropathy, major depressive disorder, anxiety disorder, history of TIA and cerebral infarction without residual deficits, adult failure to thrive, and generalized muscle weakness. A current care plan, not dated, indicated the resident would make false allegations and would report staff would not get him up then refuse when offered to get up. The interventions included, but were not limited to, speak in a calm manner, encourage the resident to maintain as much independence and control/decision making as possible. A current care plan, not dated, indicated the resident had an activity of daily living (ADL) self-care performance deficit and required assistance with ADL care. The interventions included, but were not limited to, required extensive assistance of two staff with transfer and bed mobility. During an observation, on 3/13/23 at 4:16 p.m., the resident was lying in bed with his eyes closed, and the room was darkened. During an interview, on 3/13/23 at 4:31 p.m., QMA		update plan of care to reflect therapy recommendations when assessment is complete. Facility does have mechanical lift slings with commode opening. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:** Any resident who needs assistance with rising from bed or needs assistance with toileting have the potential to be affected. The facility will complete interviews with residents whom need assistance with rising from bed and toileting to ensure facility is providing care per resident's preference. Any new admission will be interviewed for preferences and plan of care and Kardex updated to reflect preferences. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** Education has been provided to direct care staff utilizing the "Resident's Right" policy with emphasis on preference. The facility will place any preference on the plan of care and Kardex to ensure all appropriate staff have knowledge of preferences. **How the corrective action will**	

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	03/15/2023

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

(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
	4 indicated the resident only got out of bed to get showers and it was his choice not to get out of bed. During an observation, on 3/14/23 at 11:15 a.m., the resident was lying in bed in his room. CNA 5 went to the resident's room and asked him if he wanted to get up after the surveyor had requested for CNA 5 to ask the resident. The resident was not able to see the surveyor who was in the hallway. The resident indicated he did want to get up. His wheelchair was in the corner of his room. CNA 5 assisted the resident to get dressed and then get up in the wheelchair using a mechanical lift. During an interview, on 3/15/23 at 3:09 p.m., the Clinical Support Nurse indicated the resident had gotten up out of bed today and went to an activity. During an interview, on 3/15/23 at 5:27 p.m., the Clinical Support Nurse indicated the resident stated he would like to get up out of bed more often. 2. During an interview, on 03/09/23 at 3:53 p.m., Resident 15 indicated he would get up at 8:00 a.m., and did not want to go to bed until 10:00 p.m. He did not get his brief changed in between. The staff get him up with the mechanical lift and if he asked to be changed then staff would not let him get back up in his electric chair, so he stayed in his wet or soiled briefs until time to go to bed. During an interview, on 03/09/23 at 4:09 p.m., the resident indicated if therapy would set things up and if the bathroom were larger, he could use a handicap toilet, and not have to use adult briefs. The record for Resident 15 was reviewed on 03/13/23 at 10:40 a.m. Diagnoses included, but		**be monitored to ensure the deficient practice will not recur:** The DON/Designee will complete observations of 5 residents per week for 4 weeks, then 3 residents per week for 8 weeks then, 1 resident per week for 12 weeks to ensure residents who need assistance getting into wheelchair or assistance with toileting are provided care per their preference and plan of care. Any discrepancies will be immediately corrected and re-education will be provided. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for three months and then quarterly thereafter once full compliance has been achieved for a total of 6 months of monitoring. Frequency and duration of reviews will be increased as needed, if areas of noncompliance exist.	

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	03/15/2023

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

(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
	were not limited to, multiple sclerosis, paraplegia, and muscle weakness. A care plan, dated 2/27/23, indicated the resident was incontinent of urine and he used a urinal related to impaired mobility, neurological conditions, disorder of the kidney and ureter, and neuromuscular dysfunction of the bladder. Interventions included, but were not limited to, check the resident for continence and wash, rinse, dry perineum and change clothing as needed after incontinence episodes. A care plan, dated 2/27/23, indicated the resident had an activities of daily living deficit (ADL's) and required assistance with ADL's related to weakness of the left side, multiple sclerosis, and paraplegia. Interventions included, but were not limited to, resident required extensive assist of one staff with toileting, and resident required the use of a mechanical lift with two persons support due to increased weakness. During an interview, on 03/13/23 at 2:03 p.m., the resident indicated he had not been toileted because they would not get him up after they used the mechanical lift to get him into the bed and change him. The bathroom in his room was not handicap accessible for him. His wheelchair or the mechanical lift will not fit through the bathroom door. During an interview, on 03/13/23 at 4:25 p.m., the resident indicated he had no handicap bathroom here and wanted to leave. He wanted to be able to enjoy his own space. During an interview, on 3/15/23 at 4:39 p.m., Qualified Medication Assistant 4 indicated if a resident had to use a mechanical lift, they could			

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	03/15/2023

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

(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
	not toilet them in the shower room, because they did not have mechanical lift slings with holes for toileting. The shower room had handicap accessible toileting. During an interview, on 03/15/23 at 5:06 p.m., the Clinical Support Nurse indicated she was not aware of any mechanical lift slings with the commode opening in the facility. A current policy, titled "Resident Rights," not dated and received from the Administrator on 3/19/23 at 3:30 p.m., indicated "...residents have a choice and a voice in how they will be treated...residents will be treated with dignity and respect including, but not limited to; choice of care options...." 3.1-3(u)(3)			
F 0567 SS=E Bldg. 00	483.10(f)(10(i)(ii) Protection/Management of Personal Funds §483.10(f)(10) The resident has a right to manage his or her financial affairs. This includes the right to know, in advance, what charges a facility may impose against a resident's personal funds. (i) The facility must not require residents to deposit their personal funds with the facility. If a resident chooses to deposit personal funds with the facility, upon written authorization of a resident, the facility must act as a fiduciary of the resident's funds and hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in this section. (ii) Deposit of Funds. (A) In general: Except as set out in paragraph (f)(l0)(ii)(B) of this section, the facility must deposit any residents' personal funds in			

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	03/15/2023

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

(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
	excess of $100 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $100 in a non-interest bearing account, interest-bearing account, or petty cash fund. (B) Residents whose care is funded by Medicaid: The facility must deposit the residents' personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain personal funds that do not exceed $50 in a noninterest bearing account, interest-bearing account, or petty cash fund.			
	Based on interview and record review, the facility failed to ensure there was enough money at the facility to provide residents their personal funds when requested. This deficient practice had the potential to affect 64 of 71 residents who resided in the facility and received Medicare and Medicaid. Finding includes: During an interview, on 3/9/23 at 3:54 p.m., Resident 15 indicated he had not been able to get his $50 yet this month. The staff would say they have to go to the bank before he could get his money. During an interview, on 3/9/23 at 4:35 p.m.,	F 0567	**What corrective actions have been accomplished for those residents found to have been affected by the deficient practice;** No Residents were harmed by the alleged deficient practice. Facility followed up with residents 15, F, D 42, and 31 to ensure they were able to withdraw their money when requested with no further concerns. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective**	04/21/2023

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	03/15/2023

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

(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
	Resident F indicated she could not get money when she wanted to get it. During an interview, on 3/10/23 at 11:37 a.m., Resident D indicated he had asked about getting his money from his account but did not have an answer yet. During an interview, on 3/13/23 at 4:06 p.m., Receptionist 7 indicated the residents would come to the front desk and ask if they could take money out of their account. Sometimes the facility would run out of money since they only kept $600 at a time. If the $600 was gone then she would have to ask for more money and would have to wait until the next day before the money would be available. There were times when there was no cash onsite and the residents would have to come back the next day. She indicated there were two residents she knew who were not able to get their money since there was no cash available. They were Resident 42 and Resident 31. During an interview, on 3/14/23 at 2:32 p.m., the Regional Business Office Manager indicated the facility had some staff turnover in the last few months. They only kept $600 at the facility at one time and the facility staff had not been replenishing the money box timely to keep the funds flowing. They did not have a system to keep track of the residents who requested money and were not able to get it when the facility was out of cash. They only kept track of which residents received their money. A current policy, titled "Resident Trust Fund," dated 6/1/2016 and received from the Regional Business Office Manager on 3/14/23 at 3:45 p.m., indicated "...Upon admission, or at any time upon the resident's request, the resident will be given		**actions will be taken;** 64 residents have the potential to be affected. The facility raised cash on hand to ensure resident requests would be able to be met on a daily basis. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** Education was completed with the Business office staff on the Resident Trust Fund and Resident Rights policies with an emphasis on ensuring residents are able to withdraw funds, if applicable, when requested. **How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place;** Facility will interview 5 residents per week for 4 weeks, then 3 residents per week for 8 weeks, then 1 resident per week for 12 weeks to ensure resident are able to withdraw money, if applicable, when requested. Any discrepancies found will be immediately corrected and re-education will be provided. Results of the audit will be brought to QAPI for six months or until 100% compliance is achieved. Any discrepancies will be correctly immediately	

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	03/15/2023

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

(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
	the opportunity to open a resident fund account with the facility...Withdrawals...All withdrawals require the resident's and/or their legal representative's signature. If the resident is unable to sign and their legal representative is not available, two witness signatures are required for the withdrawal...Disbursements in excess of $50.00 shall be made by check. However, for residents utilizing Medicare Part A benefits, disbursements in excess of $100.00 shall be made by check...Resident Trust Fund Petty Cash...The resident trust fund petty cash is maintained in a safe or other secure cabinet in a secure location. Resident Fund Petty Cash will be maintained daily in accordance with the RFMS [resident funds management system] ...and reimbursed on the 15th and last day of each month at a minimum, or more frequently as needed due to activity level...." A current policy, titled "Resident Rights," not dated and received from the Administrator on 3/9/23 at 3:30 p.m., indicated "...It is the policy of this facility to provide resident centered care that meets the psychosocial, physical and emotional needs and concerns of the residents...Residents have a right to...The right to manage their own money including but not limited to...Depositing their money with the nursing home or ask them to hold or account for their money by signing a written statement requesting this...The facility must allow residents access to resident bank accounts, cash, and other financial records...." 3.1-6(f)(1)			
F 0600 SS=E Bldg. 00	483.12(a)(1) Free from Abuse and Neglect §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from			

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	03/15/2023

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

(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
	abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; Based on interview and record review, the facility failed to ensure residents were free of perceived verbal and physical abuse during personal care and misappropriation of property for 4 of 4 residents reviewed for abuse. (Resident E, D, B and C) Findings include: 1. During an interview, on 3/10/23 at 12:11 p.m., Resident E indicated a female staff came to his room in the middle of the night and was "playing with him". He had told another staff who said they would keep the female staff out of his room. He indicated the female staff should not be in his room and she "should not do that". He indicated CNA 2 had taken money from his lock box which was observed on the resident's bedside table. The record for Resident E was reviewed on 3/13/23 at 11:38 a.m. Diagnoses included, but were not limited to, immobility, type 2 diabetes mellitus with diabetic neuropathy, anxiety disorder, major depressive disorder, and peripheral vascular disease. A Minimum Data Set (MDS) assessment, dated	F 0600	**What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice: On 3/10/23 a skin and pain assessment were completed for Residents E, D, B and C without findings. Resident E could not recall a total amount of money he thought was missing. SSD interviews completed with each resident and no psychosocial harm noted and all residents stated they felt safe in the facility.** **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: The facility initiated an investigation and placed the employee on administrative leave. Head to toe skin assessments were completed**	04/21/2023

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	03/15/2023

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

(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
	2/6/23, indicated the resident had a Brief Interview for Mental Status (BIMS) score of 13 which indicated the resident was cognitively intact. During an interview, on 3/10/23 at 12:15 p.m., the Administrator indicated the SSD (Social Services Director) was just notified this morning of Resident E stating a female staff had "played with him" and an investigation had been started. The administrator was made aware of the allegation of the money being taken and she had not been notified of the money previously. 2. During an interview, on 3/10/23 at 11:55 a.m., Resident D indicated a night shift CNA with long dark hair "throws me around like a rag doll". The resident told the CNA she did not need to be so rough and the CNA "stuck her nose up in the air". He indicated "it kind of hurts when she is so rough". The record for Resident D was reviewed on 3/13/23 at 3:02 p.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus with diabetic neuropathy, major depressive disorder, anxiety disorder, history of TIA and cerebral infarction without residual deficits, adult failure to thrive, and generalized muscle weakness. A MDS assessment, dated 12/30/22, indicated the resident had a BIMS score of 12 which indicated the resident was moderately cognitively impaired. During an interview, on 3/13/23 at 3:45 p.m., the Administrator indicated CNA 2's last shift to work was 3/9/23 on the night shift and she left the building on 3/10/23 in the a.m. The facility had started an investigation. CNA 2 told the Administrator the only time she touched Resident E's lockbox was to get money for items from the		**by nursing staff on all residents with a BIMS score of 9 or less without findings. SSD conducted interviews with all residents with a BIMS score of 10 or higher without findings.** **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Education has been provided to all staff utilizing the Indiana Abuse Policy with emphasis on the definition of abuse, when to report, and who to report to.** **How the corrective action will be monitored to ensure the deficient practice will not recur: The ED/Designee will conduct interviews with 5 residents per week for 4 weeks then, 3 residents per week for 8 weeks then, 1 resident per week for 12 weeks to ensure no incidents have occurred. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for three months and then quarterly thereafter once full compliance has been achieved for a total of 6 months of monitoring. Frequency and duration of reviews will be increased as needed, if areas of noncompliance exist.**	

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	03/15/2023

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

(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
	vending machine for the resident. CNA 2 indicated she would "spread the folds" when providing incontinence care. Resident E told the Social Services Director (SSD) about CNA 2 "playing with him" although she had not documented in the electronic health record since she did not have access to document yet. During an interview, on 3/13/23 at 4:31 p.m., QMA 4 indicated she heard from other CNAs about CNA 2 being rough especially when doing peri care. During an interview, on 3/15/23 at 10:02 a.m., the Administrator indicated CNA 2 was interviewed. CNA 2 indicated she cleaned thoroughly when providing incontinence care to the residents. The administrator indicated the CNA would not be back to work until the investigation was completed. She indicated if a resident thought staff was being too rough with them and causing pain then this could be considered a resident's perception of abuse. 3. During an interview, on 3/9/23 at 3:51 p.m., Resident B indicated CNA 2 was being rough during resident care and made him feel like a sack of potatoes when she turned him in bed. CNA 2 was not very gentle when she provided care. The record for Resident B was reviewed on 3/13/23 at 2:15 p.m. Diagnoses included, but were not limited to, Parkinson's disease, atrial fibrillation, depression, alcohol abuse, hypertension, cardiomegaly, and lymphedema. A care plan, dated 7/26/22 and revised on 8/3/22, indicated the resident had an ADL (Activities of Daily Living) Self Care Performance Deficit. The interventions included, but were not limited to, the resident required assistance with 1 staff for			

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	03/15/2023

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

(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
	dressing, hygiene, toileting, and bathing. A MDS assessment, dated 1/25/23, indicated the resident had a BIMS score of 14 which indicated the resident was cognitively intact. 4. During an interview, on 3/10/23 at 12:37 p.m., Resident C indicated CNA 2 took a washcloth and started wiping the resident's peri area. The resident told CNA 2 to stop, and she continued causing the resident pain. CNA 2 finished the resident's peri care and was exiting the room. The resident stopped CNA 2 and asked her to change her wet gown and pad. The record for Resident C was reviewed on 3/13/23 at 11:46 a.m. Diagnoses included, but were not limited to, chronic pain syndrome, restless legs syndrome, hypertension, type 2 DM, and depressive disorder. A care plan, revised on 3/6/23, indicated the resident had an ADL Self Care Performance Deficit. The interventions included, but were not limited to, the resident required assistance with 2 staff with toilet use, transfer, and bed mobility. A MDS assessment, dated 1/30/23, indicated the resident had a BIMS score of 15 which indicated the resident was cognitively intact. During an interview, on 3/10/23 at 12:37 p.m., the Administrator spoke with CNA 2. She told the Administrator she was just doing a thorough job while providing peri care to Resident C. The Administrator stated she believed this was CNA 2 culture. During a Resident Council meeting, on 3/13/23 at 2:00 p.m., Resident G indicated the night shift			

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	03/15/2023

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

(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
	CNA 2 was very loud. CNA 2 would come in her room around 3:00 a.m., turn on the overhead light and would ask in a loud voice if she had a bowel movement today. During an interview, on 3/15/23 at 12:21 p.m., the Clinical Support Nurse indicated Resident D (Resident E's roommate) did validate Resident E's concern. Resident E made the accusation CNA 2 was playing with him, although she was cleaning the resident during peri care. CNA 2 indicated Resident C still had stool in the vagina and the resident agreed to the continued cleaning. Resident B indicated CNA 2 rushed during care, woke him up in the middle of the night, and when he said he did not want to be awakened because he couldn't get back to sleep, CNA 2 told him to "try harder". Upon exit, the facility had not completed their investigation for the allegations of abuse and misappropriation. A current policy, titled "Abuse & Neglect & Misappropriation of Property," not dated and received at the entrance conference from the Administrator indicated "...Indiana defines abuse/battery as a person who knowingly or intentionally touches another person in a rude, insolent or angry manner or in a rude, insolent or angry manner places any bodily fluid or waste on another person. It is the policy of this facility to provide resident centered care that meets the psychosocial, physical, and emotional needs and concerns of the residents. It is the intent of this facility to prevent the abuse, mistreatment, or neglect of residents or the misappropriation of their property. Furthermore, it is the intent of this facility to employ only properly screened persons as a part of the resident care team by the			

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	03/15/2023

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

(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
	applicable requirements. Employees will receive abuse prevention training as required as part of their orientation, as needed/indicated and annually thereafter. In the event an allegation is made, the facility will take measures to protect residents from harm during an investigation. Accurate and timely reporting of incidents, both alleged and substantiated, will be sent to officials in accordance with the state law. If the alleged violation is verified, appropriate corrective action will be taken by the facility...." 3.1-27(a)(1) 3.1-27(b)			
F 0641 SS=D Bldg. 00	483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. Based on interview and record review, the facility failed to ensure the Minimum Data Set (MDS) assessment was coded correctly for a resident with a diagnosed mood disorder for 1 of 1 resident reviewed for MDS accuracy. (Resident 11) Finding includes: The record for Resident 11 was reviewed on 3/14/23 at 3:28 p.m. Diagnoses included, but were not limited to, multiple sclerosis, functional quadriplegia, mood disorder due to known physiological condition, major depressive disorder, generalized anxiety disorder, and generalized muscle weakness. An admission MDS assessment, dated 5/17/22, indicated the resident had manic depression [bipolar disorder].	F 0641	**What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice:** Resident 61's MDS has been resubmitted to reflect the change to mood disorder. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:** Any resident with a mood diagnosis disorder have the potential to be affected. The MDS nurse will review the most recent MDS for any resident with a diagnosis of mood disorder and ensure Bipolar	04/21/2023

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	03/15/2023

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

(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
	A quarterly MDS assessment, dated 8/17/22, indicated the resident had manic depression [bipolar disorder]. A quarterly MDS assessment, dated 12/8/22, indicated the resident had manic depression [bipolar disorder]. A PASARR (pre-admission screening and resident review), dated 7/11/23, indicated the resident's mental health diagnoses included major depression and suspected anxiety. There was no evidence of a serious behavioral health condition. If changes occurred or new information refuted the findings, a new screen must be submitted. A new PASARR screen was not completed to include a new mental health diagnosis of bipolar. A psychiatry Nurse Practitioner (NP) note, dated 3/2/23, indicated the resident had a history of major depressive disorder and mood disorder. The assessment and plan indicated major depressive disorder and anxiety and to continue diazepam (an antianxiety medication). The diagnoses codes were F06.32 for a mood disorder due to a known physiological condition with major depressive like episode and F41.1 for generalized anxiety disorder. The diagnoses codes did not include bipolar disorder. During an interview, on 3/15/23 at 6:23 p.m., the Clinical Support Nurse indicated a diagnosis of mood disorder would transfer to a bipolar diagnosis in the MDS. The resident had a mood disorder. Upon exit, the facility did not provide a policy for MDS assessments.		disorder is not coded on the MDS. If any discrepancies are noted a new MDS will be submitted to correct the coding. Any new admissions with a diagnosis of mood disorder will be coded under mood disorder on MDS. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** Education was provided to the MDS nurse using RAI manual with emphasis on coding mood disorders accurately. **How the corrective action will be monitored to ensure the deficient practice will not recur:** The R2C2/Designee will complete an audit 5 MDS's per week for 4 weeks then, 3 MDS's per week for 8 weeks then, 1 MDS per week for 12 weeks to ensure resident with a mood disorder diagnosis are coded accurately. Any discrepancies will be immediately corrected and re-education will be provided. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for three months and then quarterly thereafter once full compliance has been achieved for a total of 6 months of monitoring. Frequency and duration of reviews will be	

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	03/15/2023

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

(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
	3.1-31(d)(3)		increased as needed, if areas of noncompliance exist.	
F 0644 SS=D Bldg. 00	483.20(e)(1)(2) Coordination of PASARR and Assessments §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. Based on record review and interview, the facility failed to ensure a Preadmission Screening and Resident Review (PASARR) level two was completed for 1 of 2 residents reviewed for PASARR. (Resident 61) Finding includes: The record for Resident 61 was reviewed on 03/13/23 at 10:42 a.m. Diagnoses included, but were not limited to, bipolar disorder, insomnia, depression, and anxiety. A diagnosis list indicated bipolar disorder was added to the diagnosis list on 6/1/20.	F 0644	**What corrective actions have been accomplished for those residents found to have been affected by the deficient practice;** No Residents were harmed by the alleged deficient practice. The status change assessment was completed for resident 61 to trigger the Level 2. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective**	04/21/2023

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	03/15/2023

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

(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
	A PASARR level 1, dated 8/5/20, indicated the resident had a diagnosis of bipolar disorder. A level 2 was to be completed. There was no level 2 in the electronic medical record. During an interview, on 3/15/23 at 5:00 p.m., the Administrator indicated she did not find the level 2 in the electronic medical record but would look on the website for the level 2. During an interview, on 3/15/23 at 8:30 p.m., the Administrator indicated she could not locate the level 2. A current policy, titled "Indiana PASSR," indicated "...the preadmission screening and resident review process...to ensure residents with serious mental illness...are identified and placed appropriately...ensures the individuals are provided with the disability services they need, including rehab and specialized services...." 3.1-16(d)(1)(A) 3.1-16(d)(1)(B)		**actions will be taken;** All residents have the potential to be affected. The facility will complete an audit for all residents to ensure all status change assessments have been completed. Any new admission with a related condition will be included in the preadmission screening. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** Education on Indiana PASARR with an emphasis on status change assessments was completed with the Social Services Director. **How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place;** Facility will complete an audit of 5 residents with related conditions per week for 4 weeks then, 3 residents with related conditions per week for 8 weeks then, 1 resident with related conditions per week for 12 weeks to ensure status change assessments are being completed. Any discrepancies will be immediately corrected and re-education will be provided. Results of the audit will be brought to QAPI for six months	

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	03/15/2023

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

(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
			or until 100% compliance is achieved. Any discrepancies will be correctly immediately	
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on observation, interview and record review, the facility failed to assess a resident who had dental implants utilized for dentures (appliances), to assess if the dentures were available, and to assess if the resident wanted replacement dentures for 1 of 1 resident reviewed for dental. (Resident D) Finding includes: During an observation, on 3/10/23 at 11:40 a.m., Resident D had metal dental implants sticking out of his gums. The implants were not flush with the gums. The resident did not have any teeth for the implants and indicated the teeth were lost. It was difficult at first to eat with the implants sticking up and not having teeth on them, although he was used to it now. The record for Resident D was reviewed on 3/13/23 at 3:02 p.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus with diabetic neuropathy, anxiety disorder, major depressive disorder, esophagitis, and adult failure	F 0684	**What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice:** No residents were harmed by the facility's alleged deficient practice. Resident D has a Dental appointment scheduled to evaluate potential denture fitting. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:** All resident with dental implants have the potential to be affected. The facility conducted an interview with all resident whom have dental implants and no other concerns were noted. **What measures will be put into**	04/21/2023

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	03/15/2023

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

(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
	to thrive. A care plan, dated 4/22/22, indicated the resident had oral/dental problems and was edentulous (had no teeth). The interventions included, but were not limited to, observe for signs and symptoms of infection, abscess, swelling, fever, pain, and redness. The care plan did not include the implants, the missing dentures, or how to clean the implants. A facility dental note, dated 10/11/22, indicated the resident did not wear the upper and lower dentures over the implants. There were 8 dental implants. The dental staff swabbed the oral tissues with chlorhexidine to help decrease the bacterial load in the mouth. The record for Resident D did not contain any documentation to indicate the facility reviewed the dental notes and were aware the resident had dental implant located in his gums. During an interview, on 3/14/23 at 11:47 a.m., QMA 4 indicated she asked the resident if he had dentures/appliances here for the implants and the resident was not sure. She was not aware the resident had the dental implants until the surveyor asked about them. During an interview, on 3/14/23 at 2:18 p.m., QMA 4 indicated she talked to the Social Services Director (SSD) about the resident's dentures/appliances and the SSD was looking into locating the dentures. During an interview, on 3/15/23 at 5:27 p.m., the Clinical Support Nurse indicated she talked to the resident, and he would like to get replacement		**place or what systemic changes will be made to ensure that the deficient practice does not recur:** Education was provided to direct care staff utilizing “Dental Care” policy with emphasis on assessing dental status for residents with implants, ensuring residents with dentures have them available for use and residents are referred to dentist for all dental concerns. **How the corrective action will be monitored to ensure the deficient practice will not recur:** DON/Designee will conduct an audit of 5 residents per week for 4 weeks then, 3 residents per week for 8 weeks then, 1 resident per week for 12 weeks to ensure residents with dental implants have dentures available for use and are routinely seen by the dentist. Any discrepancies will be immediately corrected and re-education will be provided. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for three months and then quarterly thereafter once full compliance has been achieved for a total of 6 months of monitoring. Frequency and duration of reviews will be increased as needed, if areas of noncompliance exist.	

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	03/15/2023

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

(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
	appliances/dentures to fit on the implants. The facility would refer him to the dentist for the replacements. A current policy, titled "Resident Rights," not dated and received from the Administrator on 3/9/23 at 3:50 p.m., indicated "...It is the policy of this facility to provide resident centered care that meets the psychosocial, physical and emotional needs and concerns of the residents...Care for residents will be provided in a safe and respectful manner...Residents have a right to...Receive proper medical care including but not limited to...To participate in the decisions that affects the resident's care...." 3.1-37(a)			
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 observation, interview and record review, the facility failed to ensure oxygen tubing was dated and oxygen was set at the physician prescribed levels for 3 of 3 residents reviewed for oxygen (Resident 28, 30 and 44). Findings include: 1. During an observation, on 3/10/23 at 3:25 p.m.,	F 0695	**What corrective actions have been accomplished for those residents found to have been affected by the deficient practice;** No Residents were harmed by the alleged deficient practice. Oxygen tubing was immediately removed, replaced, and dated for resident	04/21/2023

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	03/15/2023

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

(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
	Resident 28 was lying in bed in her room. She had oxygen by nasal cannula set at 4 LPM (liters per minute). During an observation, on 3/13/23 at 11:51 a.m., the resident was sitting up in her wheelchair. The oxygen concentrator next to her bedside was set at 3.5 LPM, was still turned on with the oxygen tubing including the nasal cannula lying on the floor. The record for Resident 28 was reviewed on 3/14/23 at 3:40 p.m. Diagnoses included, but were not limited to, right wrist fracture, chronic obstructive pulmonary disease, congestive heart failure, and acute respiratory failure with hypoxia. A physician's order, dated 1/18/23, indicated oxygen at 2 LPM per nasal cannula. During an interview, on 3/13/23 at 11:52 a.m., QMA 4 indicated the resident's oxygen concentrator should be set at 2 LPM and it was at 3.5 LPM. She picked up the tubing from the floor and indicated it would need to be disposed of and new tubing obtained. 2. During an observation, on 3/9/23 at 4:10 p.m., Resident 30 was lying in bed and was receiving 2 liters (L) of oxygen. She was wearing a nasal cannula (NC) and the oxygen tubing was not dated. The record for Resident 30 was reviewed on 3/13/23 at 10:14 p.m. Diagnoses included, but were not limited to, cerebral infarction, atrial fibrillation, dementia, and hypertension. A physician's order, dated 2/28/23, indicated to provide supplemental oxygen at 2 L per NC. A physician's order, dated 3/5/23, indicated to		28, 30, and 44. Orders were also validated with the NP and oxygen was set according to orders for residents 28, 30, and 44. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken;** Any residents with oxygen orders have the potential to be affected. The facility will complete an audit of all residents with new oxygen orders to ensure the oxygen is set at the physician prescribed levels and oxygen tubing is dated. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** Education on following physician orders and the supplemental oxygen using nasal cannula policies will be provided to nursing staff. **How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place;** The Director of Nursing/Designee will audit 5 residents with oxygen orders per week for 4 weeks then, 3 residents with oxygen orders per week for 8 weeks then, 1 resident with oxygen orders per week for	

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	03/15/2023

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

(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
	change the oxygen tubing and to initial and date the tubing every Sunday. A care plan, dated 10/7/22 and last revised on 3/6/23, indicated the resident had oxygen therapy. The interventions included, but were not limited to, monitor for signs and symptoms of respiratory distress. During an interview, on 3/9/23 at 4:12 p.m., LPN 3 indicated the oxygen tubing did not have a date and she was not aware of the facility policy. During an interview, on 3/10/23 at 10:20 a.m., the Director of Nursing (DON) indicated the oxygen tubing should be dated and changed once a week. 3. During an observation, on 3/13/23 at 10:13 p.m., Resident 44 was lying in bed and was receiving 1 liter of oxygen. She was wearing a nasal cannula and the oxygen tubing was not dated. The record for Resident 44 was reviewed on 3/13/23 at 10:13 a.m. Diagnoses included, but were not limited to, encephalopathy, atrial fibrillation, congestive heart failure, cognitive communication deficit, endocarditis valve, dementia, and anxiety. A care plan, dated 2/22/23 and last revised on 3/14/23, indicated the resident was at risk for impaired oxygen exchange related to the requirement of oxygen use. The interventions included, but were not limited to, monitor for signs and symptoms of respiratory distress, oxygen settings at 2 L per NC continuously and humidified. A physician's order, dated 2/22/23, indicated to provide supplemental oxygen at 2 L per NC to keep O2 saturation greater than 94%.		12 weeks to ensure tubing is being dated weekly and that the oxygen settings match the physician orders Results of the audit will be brought to QAPI for six months or until 100% compliance is achieved. Any discrepancies will be correctly immediately	

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	03/15/2023

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

(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
	A physician's order, dated 2/26/23, indicated to change the oxygen tubing and to initial and date the tubing every Sunday. During an interview, on 3/9/23 at 4:02 p.m., LPN 3 indicated the resident's oxygen tubing was not dated. The resident's oxygen concentrator was on 1 liter and the humidity bottle was empty. She was not sure of any policies. A current policy, titled "Supplemental Oxygen using Nasal Cannula," not dated and received from the Administrator on 3/10/23 at 3:00 p.m., indicated "...It is the policy of this facility to provide resident centered care that meets the psychosocial, physical and emotional needs and concerns of the residents. Safety is a primary concern for our residents, staff, and visitors...A nasal cannula will be used when the physician orders supplemental oxygen to be administered by this route and at a specified rate of flow. Generally, oxygen can be delivered via a nasal cannula in low to moderate oxygen concentrations intra-nasally (1 LPM to 6 LPM) ...The nurse of RT will obtain the required tubing and oxygen tank or concentrator...Label the tubing when opened. The nurse or RT will obtain a pronged nasal cannula and attach it to the tubing unless otherwise attached...Maintenance a. Nasal cannula and tubing will be labeled and dated when opened. b. Nasal cannulas and tubing are changed weekly or when soiled and labeled with date opened...." 3.1-47(a)(6)			
F 0725 SS=F Bldg. 00	483.35(a)(1)(2) Sufficient Nursing Staff §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff			

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	03/15/2023

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

(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
	with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. Based on observation, interview and record review, the facility failed to ensure there was enough staff to complete documentation on the medication administration record, to re-order medications when needed, to assist a dependent resident to get out of bed by their preference, and to have resident funds available. This deficient practice had the potential to affect 71 of 71 residents who resided in the facility. 1. During an interview, on 3/13/23 at 11:50 a.m., Resident 9 indicated she was supposed to get ointment in her eye four times a day and sometimes would only have it administered once a	F 0725	**What corrective actions have been accomplished for those residents found to have been affected by the deficient practice;** No residents were harmed by the facility's alleged deficient practice. MD was notified that medications may not have been given. Resident 9 and G were offered medication per MD order. Resident D was offered to get up on 3/13/23 but initially refused. Later that day Resident D	04/21/2023

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	03/15/2023

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

(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
	day. She would ask for the eye medication during the evening, and the staff would not administer it. The record for Resident 9 was reviewed on 3/14/23 at 12:09 p.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus with diabetic neuropathy, major depressive disorder, peripheral vascular disease, and heart failure. A Medication Administration Record (MAR), dated January 2023, indicated the following: a. moxifloxacin (an antibiotic) ophthalmic solution to instill 2 drops in the right eye every 4 hours was not documented if it was administered on 1/28/23 for the 12:00 p.m., dose. b. ofloxacin (an antibiotic) ophthalmic solution 0.3% to instill one drop in the right eye four times a day was not documented if it was administered on 1/28/23 at 1:00 p.m., and 1/29/23 at 9:00 p.m. c. There were 14 other doses of medications not documented as being administered for the month. A MAR, dated February 2023, was missing documentation for 9 different medication administration times to indicate if the medications were administered. A MAR, dated March 1 through March 8, 2023, indicated the following: a. prednisolone sodium phosphate ophthalmic solution 1% to instill one drop in the right eye four times a day was not documented if it was administered on 3/10/23 at 9:00 p.m. b. There were 8 other medications which were not documented as being administered for the month. 2. During an observation, on 3/10/23 at 11:33 am., Resident D was lying in bed in his room. He indicated he wanted to go to therapy and eat in the dining room. Someone took his wheelchair and		changed his mind and accepted assistance getting up to his wheelchair which was available in the corner of his room. His plan of care and Kardex have been updated to reflect this preference. Facility increased money on hand daily to meet the needs of residents requesting to withdraw. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken;** All residents have the potential to be affected. The facility will complete interviews with residents whom need assistance with rising from bed to ensure facility is providing care per resident's preference. Any new admission will be interviewed for preferences and plan of care and Kardex updated to reflect preferences. Facility The facility raised cash on hand to ensure resident requests would be able to be met on a daily basis. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** Education on the Medication Administration and Resident Rights was completed with nursing staff with an emphasis on administering, documenting, and reordering medications. Education was completed with the Business	

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	03/15/2023

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

(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
	he had been getting out of bed before the wheelchair was removed. There was no wheelchair in the room or in the hallway for the resident. He indicated he only got out of bed once a week for therapy and it was not enough. The record for Resident D was reviewed on 3/13/23 at 3:02 p.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus with diabetic neuropathy, major depressive disorder, anxiety disorder, history of TIA and cerebral infarction without residual deficits, adult failure to thrive, and generalized muscle weakness. A current care plan, not dated, indicated the resident had an activity of daily living (ADL) self-care performance deficit and required assistance with ADL care. The interventions included, but were not limited to, required extensive assistance of two staff with transfer and bed mobility. During an interview, on 3/13/23 at 4:31 p.m., QMA 4 indicated the resident only got out of bed to get showers, and it was his choice not to get out of bed. During an observation, on 3/14/23 at 11:15 a.m., the resident was lying in bed in his room. CNA 5 went to the resident's room and asked him if he wanted to get up after the surveyor had requested for CNA 5 to ask the resident. The resident was not able to see the surveyor who was in the hallway. The resident indicated he did want to get up. His wheelchair was in the corner of his room. CNA 5 assisted the resident to get dressed and then get up in the wheelchair using a mechanical lift. During an interview, on 3/15/23 at 3:09 p.m., the		office staff on the Resident Trust Fund and Resident Rights policies with an emphasis on ensuring residents are able to withdraw funds, if applicable, when requested. **How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place;** The DON/Designee will complete observation of 5 residents per week for 4 weeks, then 3 residents per week for 8 weeks, then 1 resident per week for 12 weeks to ensure resident preference is up to date on Kardex and plan of care is being followed for dressing. The DON/Designee will complete audits of the MAR for 5 residents per week for 4 weeks, then 3 residents per week for 8 weeks, then 1 resident per week for 12 weeks to ensure documentation is being completed, medications are being administered, and medications are being reordered. Facility will interview 5 residents per week for 4 weeks, then 3 residents per week for 8 weeks, then 1 resident per week for 12 weeks to ensure resident are able to withdraw money, if applicable, when requested. Any discrepancies found will be immediately corrected and re-education will be provided. Results of the audit will be brought	

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	03/15/2023

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

(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
	Clinical Support Nurse indicated the resident had got up out of bed today and went to an activity. During an interview, on 3/15/23 at 5:27 p.m., the Clinical Support Nurse indicated the resident stated he would like to get up out of bed more often. 3. During an interview, on 3/13/23 at 4:06 p.m., Receptionist 7 indicated the residents would come to the front desk and ask if they could take money out of their account. There were times when there was no cash onsite and the residents would have to come back the next day. During an interview, on 3/14/23 at 2:32 p.m., the Regional Business Office Manager indicated the facility had some staff turnover in the last few months. The facility staff had not been replenishing the money box timely to keep the funds flowing. 4. The record for Resident G was reviewed on 3/13/23 at 10:41 a.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus, seizures, hypertension, tobacco use, depressive disorder, and anxiety disorder. A MAR, dated January 2023, indicated the following: a. blood sugar check three times a day was not documented if was administered on 1/1/23 for the 5:00 p.m. check, 1/12/23 for the 5:00 p.m. check, and 1/13/23 for the 12:00 p.m. check. b. buspirone (to treat anxiety) HCI 10 mg tablet to give 2 tablets by mouth was not documented if it was administered on 1/13/23 at 2:00 p.m. c. gabapentin (to treat nerve pain) 600 mg tablet was not documented if was administered on 1/12/23 at 4:00 p.m., or 1/13/23 at 4:00 p.m. d. Insulin Lispro injection solution 100 Unit/ml inject as per sliding scale was not documented if		to QAPI for six months or until 100% compliance is achieved. Any discrepancies will be correctly immediately	

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	03/15/2023

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

(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
	was administered on 1/12/23 at 5:00 p.m., or 1/13/23 at 11:00 a.m. A MAR, dated March 2023, indicated the following: a. blood sugar check three times a day was not documented if was administered on 3/13/23 at 5:00 p.m. b. Insulin Glargine 100 unit/ml inject 50 units subcutaneously two times a day was not documented if was administered on 3/12/23 at 9:00 p.m., or 3/13/23 at 9:00 p.m. c. furosemide (to treat edema) 40 mg tablet was not documented if was administered on 3/12/23 at 5:00 p.m., or 3/13/23 at 5:00 p.m. d. metformin (to treat diabetes) HCI 1000 mg tablet was not documented if administered on 3/12/23 at 5:00 p.m., or 3/13/23 at 5:00 p.m. e. carvedilol (to treat high blood pressure) 3.125 mg tablet was not documented if administered on 3/13/23 at 6:00 p.m. f. Insulin Lispro injection solution 100 Unit/ml inject as per sliding scale was not documented if was administered on 3/13/23 at 5:00 p.m. A care plan, dated 7/25/22, indicated the resident had diabetes mellitus. The interventions included, but were not limited to, administer insulin injections per orders, rotate injection sites, and offer bedtime snacks. A pharmacy packing slip indicated the resident received Lispro 100u/ml Kwik pen on 3/13/23 at 12:51 a.m. and signed by LPN 10. A pharmacy packing slip indicated the resident received Glargine 100u/ml insulin pens on 3/14/23 not timed and signed by LPN 3. During an interview, on 3/13/23 at 2:00 p.m., the			

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	03/15/2023

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

(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
	resident complained the facility did not have her insulin over the weekend on 3/11/23 to 3/12/22 and was always running out of her medication. She did not receive her insulin until Sunday night. During an interview, on 3/15/23 at 11:20 a.m., RN 9 indicated if the resident had blank boxes on the MAR the medication was not given. 5. The record for Resident 44 was reviewed on 3/13/23 at 10:13 a.m. Diagnoses included, but were not limited to, encephalopathy, atrial fibrillation, congestive heart failure, cognitive communication deficit, endocarditis valve, dementia, and anxiety. A MAR, dated January 2023, indicated the following: a. hydrocodone-acetaminophen (pain medication) 5-325 mg tablet was not documented if was administered on 1/13/23 at 5:00 p.m., or 1/23/23 at 5:00 a.m. A MAR, dated March 2023, indicated the following: a. digoxin (to treat heart failure or heart rhythm problems) 125 mcg (microgram) tablet was not documented if was administered on 3/7/23 at 8:00 a.m. During an interview, on 3/13/23 at 9:36 a.m., RN 6 indicated if there were blank boxes on the MAR the medication was not given. During a Resident Council meeting, on 3/13/23 at 2:00 p.m., Resident G indicated the facility was always running out of her medications. She went 2 days over the weekend without insulin. Resident G received a long-lasting insulin two times a day and she missed 2 doses. Resident H indicated she also was missing medication and the residents			

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	03/15/2023

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

(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
	had to chase down a nurse just to get their medications. A current policy, titled "Medication Administration," not dated and received from the Clinical Support Nurse on 3/13/23 at 3:00 p.m., indicated "...It is the policy of this facility to provide resident centered care that meets the psychosocial, physical and emotional needs and concerns of the residents...y. Do not share or "borrow" medication from others. aa. For medications that expire, label the date opened on the label (insulin, irrigation solutions etc.) dd. Medication will be charted when given...a. Documentation of mediation will be current for medication administration. b. Documentation of medications will follow accepted standards of nursing practice...." A current policy, titled "Resident Rights," not dated and received from the Administrator on 3/9/23 at 3:30 p.m., indicated "...It is the policy of this facility to provide resident centered care that meets the psychosocial, physical and emotional needs and concerns of the residents...The purpose of this policy is to guide employees in the general principals of dignity and respect of caring for residents...Care for residents will be provided in a safe and respectful manner...Residents have a choice and a voice in how they will be treated...Residents have a right to...To participate in the decisions that affects the resident's care...." This Federal Tag relates to Complaint IN00402753. 3.1-17(a) 3.1-17(b)(1)			

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	03/15/2023

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

(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 0755 SS=D Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Based on observation and interview, the facility failed to dispose of loose pills for 3 or 4 medication carts and record temperatures for a refrigerator/freezer for 1 or 2 medication storage	F 0755	**What corrective action will be accomplished for those residents found to have been affected by the alleged**	04/21/2023

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	03/15/2023

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

(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
	rooms reviewed for medication storage. (100, 200 and 300 medication carts and Hall 400 medication storage room) Findings include: 1. During an observation, on 3/15/23 beginning at 11:20 p.m., the 100, 200 and 300 hall medication carts had the following: a. The 100-hall cart had two unidentified pink pills and two unidentified white pills in the bottom of the second drawer. b. The 200-hall cart had three unidentified yellow pills and two unidentified white pills in the bottom of the second drawer. c. The 300-hall cart had one unidentified white pill in the bottom of the second drawer. During an interview, on 3/15/23 at 12:15 p.m., Qualified Medication Assistant (QMA) 11 indicated there was one white pill in the bottom of the second drawer and it should not be there. During an interview, on 3/15/23 at 11:20 a.m., Licensed Practical Nurse (LPN) 9 indicated the pills should not be in the bottom of the drawers and she would get rid of them. During an interview, on 3/15/23 at 12:05 p.m., QMA 11 indicated she thought the loose pill found in the bottom of the second drawer was a Gabapentin (used to treat seizures and pain) capsule. QMA 11 took the pill and placed it in the sharp container. 2. During a medication storage observation, on 3/13/23 at 4:40 p.m., the 400-hall refrigerator in the medication storage room had a temperature log which was dated November of 2022. QMA 2		**deficient practice:** No residents were found to be harmed by the facility's deficient practice. The loose pills were immediately cleaned out of the cart and the refrigerator temps were checked to ensure they were at proper temperature. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:** All resident have the potential to be affected. No residents were found to be affected by the alleged deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** Education has been completed with licensed nurses and QMAs using the "Medication Storage" policy with emphasis on removing loose pills from medication carts and maintaining refrigerator temp logs. **How the corrective action will be monitored to ensure the deficient practice will not recur:** DON/Designee will conduct audits of 5 medication carts per week for 4 weeks then 3 medication carts for 8 weeks then 1 medication cart per week for 12	

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	03/15/2023

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

(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
	indicated she did not know where the current temperature log was located. The refrigerator contained cartons of Ozempic (an injectable medication to lower blood sugar) and a vial of TB solution. During an interview, on 3/14/23 at 10:10 a.m., the Director of Nursing indicated the refrigerator logs had been up to date. She did not know how a temperature log, dated November 2022, had been posted on the front of the refrigerator in the 400-hall medication room. A current policy, titled "Medication Administration," no date and received from the Clinical Support Nurse on 3/13/23 at 3:02 p.m., indicated "...It is the policy of this facility to provide resident centered care that meets the psychosocial, physical and emotional needs and concerns of the residents. Safety of residents, visitors, and employees is a top priority of care...The purpose of this policy is to provide guidance for general medication administration to be provided by personnel recognized as legally able to administer...a. Administer medication only as prescribed by the provider...r. Medication carts will be clean and organized. s. Do not touch the medication, either when opening a liquid or dose pack...1. Dropped medications will be discarded...." 3.1-25(m) 3.1-25(o)		weeks for loose pills. The DON/Designee will conduct audits of 4 refrigerator temp logs per week for 24 weeks to ensure medications are stored within acceptable temperature range. Any discrepancies will be immediately corrected and re-education will be provided. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for three months and then quarterly thereafter once full compliance has been achieved for a total of 6 months of monitoring. Frequency and duration of reviews will be increased as needed, if areas of noncompliance exist.	
F 0759 SS=D Bldg. 00	483.45(f)(1) Free of Medication Error Rts 5 Prcnt or More §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5			

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	03/15/2023

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

(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
	percent or greater; Based on observation, interview and record review, the facility failed to ensure nasal spray and insulin were administered correctly resulting in an 8% medication error rate for 2 of 12 residents observed for medication administration (Residents 36 and 61). Findings include: 1. During an observation, on 3/13/23 at 9:36 a.m., RN 6 entered Resident 36's room to give the morning medication. A bottle of nasal spray was on the bedside table. The nurse identified the nasal spray as Calcitonin (it helps maintain a healthy level of calcium in the blood) 200 unit/act (unit dose) spray. RN 6 gave 1 spray of the Calcitonin in each nostril then returned the nasal spray bottle to the medication cart. The record for Resident 36 was reviewed on 3/13/23 at 2:15 p.m. Diagnoses included, but were not limited to, hypertension, congestive heart failure, chronic obstructive pulmonary disease, depression, and myositis (a group of rare conditions, weak, painful, or aching muscles). A physicians' order, dated 1/27/23, indicated to give Calcitonin 200 unit/act in a nostril one time a day. During an interview, on 3/13/23 at 9:36 a.m., RN 6 was unaware the nasal spray was for one nostril only. During an interview, on 3/13/23 at 3:55 a.m., the Director of Nursing (DON) indicated the nurse should have look at the order. The manufacturer's instruction for using	F 0759	**What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice:** No resident was harmed by the facility's alleged deficient practice. Resident 36 discharged to home on 3/13/23. The nurse was given immediate education and the facility NP was notified. Resident 61's blood glucose was rechecked on 3/13/23 at 12:07pm and was within normal limits. Facility NP was notified of medication error and QMA was immediately educated. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:** Residents whom are prescribed medications delivered nasally via nasal sprays and subcutaneous injection via kwik pens have the potential to be affected. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** The DON/Designee completed education with all licensed nurses and QMAs utilizing the "Medication Administration" policy and manufacturers guidelines for Kwik pen administration with emphasis on right dose and	04/21/2023

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	03/15/2023

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

(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
	Calcitonin was retrieved on 3/16/23 from the Nursing Drug Book 2023. The instructions indicated spray into one nostril while the patient holds the other nostril closed. Spray into one nostril daily.2. During a medication administration observation, on 3/13/23 at 12:17 p.m., LPN 8 was administering 16 units of Humulin (short acting) insulin to Resident E with a Kwik Pen. She set the Kwik Pen at 16 units and did not prime (test dose) the Kwik Pen prior to administering the insulin. During an interview, on 3/13/23 at 12:18 p.m., LPN 7 indicated she did not prime the Kwik Pen prior to administering the medication. The record for Resident 61 was reviewed on 03/13/23 at 10:42 a.m. Diagnoses included, but were not limited to, acute respiratory failure with hypoxia, asthma, type 2 diabetes mellitus, chronic obstructive pulmonary disease, morbid obesity, and paraplegia. A physician's order, dated 8/19/21, indicated to give Humalog solution 100/units inject 16 units subcutaneously with meals. A manufacturer insert, not dated, for Humalog Kwik Pen, indicated "...prepare to inject...For each injection...Select a dose of 2 units...Take off the outer needle cap...and inner needle cap...With the pen pointing up, tap the insulin to move the air bubbles to the top...Press the button all the way in and make sure insulin comes out of the needle...Repeat up to two more times with the same needle if needed...If insulin does not come out after three times, change the needle and try again...Check that the dose counter shows '0' after the safety test...Turn the dose counter to the number of Humalog Kwik Pen unit that equal your dose...."		priming Kwik pens. **How the corrective action will be monitored to ensure the deficient practice will not recur:** The DON/Designee will observe medication administration of subcutaneous injections via Kwik pen for 5 residents per week for 4 weeks then, 3 residents per week for 8 weeks then, 1 resident per week for 12 weeks to ensure Kwik pen is primed before medication is delivered subcutaneously. The DON/Designee will observe medication administration for 5 random residents per week for 4 weeks then, 3 residents per week for 8 weeks then, 1 resident per week for 12 weeks to ensure medications are delivered via the right dose. Any discrepancies will be immediately corrected and re-education will be provided. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for three months and then quarterly thereafter once full compliance has been achieved for a total of 6 months of monitoring. Frequency and duration of reviews will be increased as needed, if areas of noncompliance exist.	

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	03/15/2023

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

(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
	A current policy, titled "Medication Administration," no date and received by the Clinical Support Nurse on 3/13/23 at 3:02 p.m., indicated "...It is the policy of this facility to provide resident centered care that meets the psychosocial, physical and emotional needs and concerns of the residents. Safety of residents, visitors and employees is a top priority of care...The purpose of this policy is to provide guidance for general medication administration to be provided by personnel recognized as legally able to administer...a. Administer medication only as prescribed by the provider...Do not touch the medication, either when opening a liquid or dose pack...1. Dropped medication will be discarded...." 3.1-25(b)(9) 3.1-48(c)(1)			
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable			

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	03/15/2023

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

(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
	diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP			

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	03/15/2023

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

(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
	and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. Based on observation, interview and record review, the facility failed to ensure staff wore gloves when touching a resident's medication for 1 of 12 residents observed for medication administration. (Resident 35) Finding includes: 1. During an observation, on 3/13/23 at 9:55 a.m., RN 6 was preparing Resident 35's medication. She popped the Divalproex Sodium DR (for seizures) 500 mg (milligram) tablet from the medication card into her bare hand and then place the pill in a medication cup. The record for Resident 35 was reviewed on 3/13/23 at 9:55 a.m. Diagnoses included, but were not limited to, seizures, hypertension, and cognitive communication deficit. A physician's order, dated 8/25/22, indicated to give Divalproex Sodium DR 500 mg tablet twice a day. During an interview, on 3/13/23 at 9:55 a.m., RN 6 indicated she should have not touched the pill with her bare hands.	F 0880	1.The facility will ensure personal protective equipment is donned and doffed correctly and hand hygiene is consistently implemented to potentially prevent the spread of infections. Resident #35 was being administered by mouth medications as per physician order, during the administration staff # 6 failed to following correct hand hygiene with don/doffing gloves. Resident #35 was assessed by the DON on 3/13/23 and did not have a negative outcome as a result of the deficient practice. Staff # 6 had 16 additional residents on the unit requiring medication administration. The residents are screened daily for s/s of infection. There were no adverse findings. Employee #6 was given verbal education immediately on by the	04/21/2023

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	03/15/2023

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

(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
	During an interview, on 3/13/23 at 11:45 a.m., the Director of Nursing indicated RN 6 should have not touched a medication with her bare hands. A current policy, titled "Medication Administration," undated, indicated "...It is the policy of this facility to provide resident centered care that meets the psychosocial, physical and emotional needs and concerns of the residents...Do not touch the medication, either when opening a liquid or dose pack. i. Dropped medication will be discarded...Preparation c. Obtain appropriate supplies including but not limited to i. Gloves ii. Cups...f. Perform appropriate hand hygiene before beginning medication administration...h. Perform hand hygiene before and after each resident's medication is administered. 3.1-18(b)		DON following the observation of the deficient practice, was sent home, and will not return to facility. As a result of the deficient practice the facility will: · The DON/IP nurse will provide education to all licensed nursing staff on standard precautions with medication administration. utilizing the facility policies, “Medication administration, Standard Precautions and General Hand Hygiene” The facility will also utilize the CDC guide for donning and doffing. · Following the education, a return demonstration will be completed by all licensed staff which administer medications as per physician orders. The DON/IP nurse will provide documented additional education. · The facility will conduct a root cause analysis with the assistance of the IP nurse, QAPI committee, and the Governing Body To assure continued compliance the facility will: · The DON/IP nurse will conduct rounds daily throughout the facility to ensure staff is donning appropriate PPE, doffing PPE upon exit, and performing hand hygiene while administering medications appropriately for six weeks.	

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	03/15/2023

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

(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
			· Results of the audits will be reviewed by the QAPI committee monthly for six months to determine of current interventions are adequate or if additional action is needed to ensure infection prevention and control procedure are implemented appropriately.	
F 0921 SS=E Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview, the facility failed to ensure cabinets were free from marks, tiles were free from cracks and the walls were free from cracks, scratches, gouges, and paint chips, free from bent blinds, free from dirty clothes off the floor, and failed to ensure toilet bolts were covered for 13 of 13 rooms observed for environment. (Rooms 101, 105, 112, 205, 216, 304, 305, 310, 314, 407, 412, 422, and 424) Finding includes: During a tour, on 3/15/23 beginning at 3:00 p.m., with the Administrator and Director of Plant Operations, the following were observed: 1. Room 101 had bent blinds. There were 4 bottom slots bent on the bottom of the blind and the pull downs did not work. 2. Room 105 had 1 inch by 1.5-inch gouges on the left side of the wall and a 2ft (foot) by 4 ft section of the same wall with several black scratches all. 3. Room 112 had an area on the wall by the head	F 0921	**What corrective actions have been accomplished for those residents found to have been affected by the deficient practice;** No residents were harmed by the facility's alleged deficient practice. Paint touch up and repairs requests have been submitted for rooms 101, 105, 112, 205, 216, 304, 305, 310, 314, 407, 412, & 422. Clothes in room 422 and gloves in room 424 were removed immediately. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken;** All residents have the potential to be affected. The facility will complete a whole house audit to identify any additional repairs needing to be made. Facility will utilize Room Readiness audit tool	04/21/2023

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	03/15/2023

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

(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
	of the bed with 2 ft by 2 ft black marks. The wall behind the headboard also had black scuff marks. 4. Room 205's wheelchair brakes would not lock and moved back in forth. 5. Room 216 had a large bubble on the wallpaper on the left wall. 6. Room 304 had scrapes on the wall. 7. Room 305 had large gouges in the bathroom door and scuff marks on the room door. 8. Room 310 had scratches on the wall behind the chair. 9. Room 314 had scratches on the wall next to the window. 10. Room 407's cabinets by the sink had white marks on the tiles. The tiles appeared dirty with cracked areas and dark lines between the cracks. The wall behind the bed by the window was missing paint in several large areas which were bigger than a soft ball. 11. Room 412 had tiles under the sink which were dirty, was missing part of the baseboard, had gouging on the wall behind the bed, a white plaster area was on the wall by the window. There were no bolt covers on either side of toilet, bolts were sticking up about two inches. The wall to the bathroom had gouged and missing paint. 12. Room 422, dirty clothes were left on the floor of the bathroom and were observed there for days before they were picked up. 13. Room 424, the bolt on the left side of the toilet		for any new admissions to ensure repairs are made before admissions enter. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** Education on Resident Rights and Room Readiness will be completed with the Maintenance staff and housekeeping with an emphasis on ensuring environment is safe/functional/sanitary/comfortable. **How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place;** Facility will audit 5 rooms per week for 4 weeks then, 3 rooms per week for 8 weeks then, 1 room per week for 12 weeks to ensure environment is safe/functional/sanitary/comfortable. Any discrepancies will be immediately corrected and re-education will be provided. Results of the audit will be brought to QAPI for six months or until 100% compliance is achieved. Any discrepancies will be correctly immediately	

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	03/15/2023

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

(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
	was missing a cap with the bolt sticking up about one inch. There were used gloves folded inside each other on the floor next to the trash can, the wall next to the bathroom had black marks all over it, there were purple marks on the tile under the sink, the tile between the window wall and bed had big missing chunks. During an interview, on 3/10/23 at 2:43 p.m., the Administrator indicated she told Maintenance about the wheelchair brakes for Room 205. During an interview, on 3/15/23 at 3:00 p.m., the Maintenance Director indicated he fixed the brakes on the wheelchair and covered the toilet bolts. The bubbled wallpaper was caused by painting over the wallpaper, the scratches, gouges, and chipped paint on the walls were caused by wheelchairs. A current policy, titled "Resident Rights," not dated and received from the Administrator on 3/9/23 at 3:30 p.m., indicated "...It is the policy of this facility to provide resident centered care that meets the psychosocial, physical and emotional needs and concerns of the resident. Safety of residents, visitors, and employees is a top priority of care...b. Privacy concerning their Privacy, Property, and Living Arrangements including but not limited to: 1. Keep and use personal belongings and property as long as they don't interfere with the rights health, or safety of others...." The facility did not have an Environmental policy. This Federal Tag relates to Complaints IN00403911 and IN00402753. 3.1-19(f)(5)			

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	03/15/2023

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

(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