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	10/11/2024

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

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: October 7, 8, 9, 10 and 11, 2024. Facility number: 000127 Provider number: 155222 AIM number: 100291430 Census Bed Type: SNF/NF: 59 Total: 59 Census Payor Type: Medicare: 2 Medicaid: 50 Other: 7 Total: 59 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review was completed on October 16, 2024.	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.	
F 0584 SS=D Bldg. 00	483.10(i)(1)-(7) Safe/Clean/Comfortable/Homelike Environment Based on observation, interview and record review, the facility failed to ensure the concrete in the outside patio was free of uneven areas for 3 of 3 residents and 1 of 1 family member who voiced concerns for the environment. (Resident 37, 44, 15 and 262) Finding includes:	F 0584	**Corrective actions accomplished for those residents founds to be affected by the alleged practice:** All residents who cross over the concrete have the potential to be affected by the alleged practice. Anti-rollbacks were added to the wheelchair on 8/19/24 for Resident	11/06/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Sydnie Reed	Executive Director	10/27/2024

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	1. During a resident council interview, on 10/10/24 at 2:08 p.m., Resident 37 indicated the patio area was a safety concern due to uneven concrete. Resident 37 and Resident 44 indicated other residents had tripped over the uneven concrete and Resident 15 tipped his wheelchair backwards and hit his head while trying to go over the uneven concrete. During an observation, on 10/10/24, the outdoor patio area had multiple areas of uneven concrete. 2. The clinical record for Resident 15 was reviewed on 10/11/24 at 12:06 p.m. The diagnoses included, but were not limited to, acquired absence of the right and left legs below the knee, nicotine dependence, chronic obstructive pulmonary disease, weakness, and anxiety disorder. A post fall evaluation, dated 8/19/24 at 12:37 a.m., indicated Resident 15 was outside smoking. As the resident was finished and going back inside, he tried to pop a wheelie over the small bump and fell backwards hitting his head on the concrete. An annual Minimum Data Set (MDS) assessment, dated 9/5/24, indicated Resident 15 used a manual wheelchair for mobility and required substantial/maximal assistance (helper did more than half the effort). 3. During an interview, on 10/11/24 at 12:06 p.m., Resident 262's daughter indicated her father's legs would sometimes drop off his foot pedals when his wheelchair went over the uneven concrete. The resident's wife indicated other residents had issues getting over the uneven concrete when they were propelling themselves in their wheelchairs.		15 to prevent further occurrences of falls. **Identification of other residents having the potential to be affected by the same alleged practice and corrective action taken:** All residents who cross over the concrete have the potential to be affected. There were no other residents harmed by the alleged practice. Facility installed runner ramps to ensure the concrete was free of uneven surfaces. **Measures put in place and systemic changes made to ensure the alleged deficit practice does not recur:** Facility completed education with management team, nursing staff, and activities staff on assisting residents as needed when there are uneven areas in concrete. **How the corrective measures will be monitored to ensure the alleged deficit practice does not recur:** The Maintenance Director/designee will conduct weekly audits of the outside patio for 8 weeks, then monthly for 4 months to ensure all concrete stays even. Any discrepancies will be corrected immediately. The results of the audit observations will be reported, reviewed, and trended for compliance through the facility Quality Assurance	

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	During an interview, on 10/11/24 at 12:12 p.m., a staff member indicated the residents would occasionally have trouble getting over the uneven concrete. During a facility tour, on 10/11/24 at 2:26 p.m., the Executive Director (ED) indicated the concrete was uneven in the patio area. At exit conference, the facility did not provide an environmental policy and indicated they followed the state regulations. 3.1-19(f)(5)		Committee for a minimum of six months and then randomly thereafter for further recommendation.	
F 0684 SS=D Bldg. 00	483.25 Quality of Care Based on observation, interview and record review, the facility failed to ensure the physician was notified before medications were given when a resident was suspected of being intoxicated from alcohol intake for 1 of 1 resident reviewed for quality of care. (Resident 53) Findings include: During an observation, on 10/7/24 at 3:01 p.m., a bruise was noted on the right side of Resident 53's face. During an interview, on 10/07/24 at 4:12 p.m., the resident indicated she fell and did not remember falling. The clinical record for Resident 53 was reviewed on 10/08/24 at 2:52 pm. The diagnoses included, but were not limited to, moderate protein calorie malnutrition, anemia, major depressive disorder, opioid abuse, alcohol abuse, and anxiety.	F 0684	**Corrective actions accomplished for those residents founds to be affected by the alleged practice:** One resident was potentially affected by the alleged practice. The provider was notified of the administration of the medication prior to the fall and facility requested a medication review. A new order was placed for staff to perform further monitoring upon return from leave of absence for Resident 53 to ensure there are no signs or symptoms of impairment and to obtain vital signs and begin neurological checks, notify MD, and review medication regimen to identify medications that may interact with substances and obtain hold orders if a resident is deemed to be impaired.	11/06/2024

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	A physician's order, dated 9/20/24, indicated to give temazepam (a medication used for insomnia) 30 mg (milligrams) at bedtime. A physician's order, dated 9/20/24, indicated to monitor for sedative and hypnotic side effects. The monitoring included, but were not limited to, sedation, drowsiness, increased falls, dizziness, weakness and hangover effect every shift related to hypnotic medication use. A medication administration record, dated 10/1/24 to 10/31/24, indicated the temazepam was administered at 9:36 p.m., on 10/6/24. A telehealth progress note, dated 10/6/24 at 10:38 p.m., indicated the resident had a fall. She was found on the floor with right cheek and eye edema. The resident appeared to be intoxicated. She was out on a leave of absence and when she returned to the facility, she was showing signs of intoxication. She struck her head when she fell. She refused to participate with neurologic checks. A progress note, dated 10/6/24 at 11:01 p.m., indicated the resident was found on the floor at approximately 10:00 p.m. She was alert and oriented. She had a bruise and edema on the left cheek and eye. The resident was not cooperative and refused neurological checks (tests to evaluate the nervous system). An order was obtained to send the resident to the emergency department for evaluation. An interdisciplinary team follow-up progress note, dated 10/7/24 at 1:15 p.m., indicated the resident had an unwitnessed fall upon her return to the facility from a leave of absence. The resident reported to the staff she fell out of bed. She was		**Identification of other residents having the potential to be affected by the same alleged practice and corrective action taken:** All residents who have a history of alcohol/substance abuse have the potential to be affected. There were no other residents harmed by the alleged practice. Facility completed a whole house audit of residents with history of alcohol/substance abuse and placed orders for increased monitoring upon return from leave of absences. **Measures put in place and systemic changes made to ensure the alleged deficit practice does not recur:** Facility completed education with nursing staff that administers medications on the substance abuse policy, provider notification policy, and the medication administration policy with emphasis on notifying a provider if a resident is showing any signs or symptoms of impairment prior to medication administration. **How the corrective measures will be monitored to ensure the alleged deficit practice does not recur:** The DON/designee will conduct audits of 5 residents per week for 4 weeks, then 3 residents per week for 4 weeks, and then 4 residents per month for	

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	found by staff on the floor next to her bed. The root cause of the incident indicated when the resident returned from her leave of absence at approximately 9:30 p.m., the staff reported the resident smelled of alcohol and appeared intoxicated. The resident was uncooperative and was not allowing the staff to perform neurological checks after hitting her head during the fall. There was no documentation the physician was notified of the resident's suspected intoxication prior to administering the temazepam. During an interview, on 10/11/24 at 3:00 p.m., Director of Nursing indicated if a resident was intoxicated the medication should have been held. A current publication, titled "Mobile PDR," indicated "... increased central nervous system (CNS) and respiratory depressant effects may be seen when temazepam is used with alcohol...ethanol ingestion should be avoided during temazepam use...ethanol intoxication may increase the risk of serious CNS or respiratory depressant effects...." A current policy, titled "Medication Administration," not dated and received from the Director of Nursing on 10/11/24 at 3:00 p.m., indicated "...a resident centered, individualized approach to medication administration will be used for administering medications as possible...safety and avoiding adverse effects are considered a high priority for medication administration and may preclude some preferences ...." A current policy, titled "Resident Substance Abuse in Facility," not dated and received from the Director of Nursing on 10/11/24 at 3:00 p.m.,		4 months to ensure all residents with substance abuse history who leave the facility on leave of absence are appropriately assessed according to the orders. Any discrepancies will be corrected immediately and education will be provided. The results of the audit observations will be reported, reviewed, and trended for compliance through the facility Quality Assurance Committee for a minimum of six months and then randomly thereafter for further recommendation.	

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	indicated "...being under the influence of illicit drugs or alcohol places the resident at risk for overdose, falls, and respiratory depression and places other residents at risk for injury by a resident under the influence of illicit or illegal drugs or alcohol...the facility will safeguard the resident under the influence of illicit or illegal drugs to the extent possible, as well as provide a safe environment for other residents, staff and visitors...." 3.1-37(a)			