| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155064 | A. BUILDING 00<br>B. WING | 12/03/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| APERION CARE KOKOMO | 3518 S LAFOUNTAIN ST<br>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<br><br>Bldg. 00 | This visit was for the Investigation of Complaint IN00447825<br><br>Complaint IN00447825-Federal/State deficiencies related to the allegations are cited at F557.<br><br>Unrelated deficiencies are cited.<br><br>Survey dates: December 2 and 3, 2024<br><br>Facility number: 000025<br>Provider number: 155064<br>AIM number: 100274850<br><br>Census bed type:<br>SNF/NF: 55<br>Total: 55<br><br>Census payor type:<br>Medicare: 4<br>Medicaid: 36<br>Other: 15<br>Total: 55<br><br>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.<br><br>Quality review was completed on December 10, 2024. | F 0000 | | |
| F 0557<br>SS=D<br>Bldg. 00 | 483.10(e)(2)<br>Respect, Dignity/Right to have Prsnl Property<br><br>Based on interview and record review, the facility failed to ensure a resident's specialized wheelchair was treated with respect when the wheelchair was unable to be located after his discharge from the | F 0557 | **F557**<br><br>This facility requests a desk review for the allegation. | 12/10/2024 |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Sherry Morgan | RN | 12/18/2024 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155064 | A. BUILDING 00<br>B. WING | 12/03/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| APERION CARE KOKOMO | 3518 S LAFOUNTAIN ST<br>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 for 1 of 3 residents reviewed for personal property. (Resident B)<br><br>Finding includes:<br><br>A document, titled "Intake Information," dated 11/22/24, indicated an anonymous person notified the Indiana Department of Health Resident B was loaned a Quickie QRI blue wheelchair from a specialized wheelchair company, when he was discharged from the rehabilitation hospital on 7/12/24. After he was admitted to the facility, he was placed in bed, and he never saw the loaner wheelchair again. He was transferred to the hospital on 7/30/24, and never returned to the facility. The facility was unable to find the loaner specialty wheelchair the resident was admitted to the facility in and his insurance company was being charged for the loaner chair.<br><br>During an interview, on 12/2/24 at 12:05 p.m., the Executive Director (ED) indicated Resident B was transported to the facility from the hospital on 7/12/24, on a stretcher by ambulance to his room. She knew how he was transported because she was in her office when he was wheeled by on the stretcher. There was no specialty wheelchair in his room. She was notified sometime in October 2024, by his mother that he had been transported to the facility on the day of admission by a van in his wheelchair and she wanted the wheelchair back. The ED indicated she looked for a specialty wheelchair and could not find one anywhere in the facility. She told the resident's mother to give her a description of the wheelchair, so she knew exactly what she was looking for and the mother never gave her a description. She thought they were looking for a high-back wheelchair and they never found one of those in the facility. | | *This Plan of Correction is the center's credible allegation of compliance.*<br><br>*Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*<br><br>**1) Immediate actions taken for those residents identified: Resident B no longer resides in the facility.**<br><br>**2) How the facility identified other residents: All new admissions have the potential to be affected.**<br><br>**3) Measures put into place/ System changes: All nursing, SSD, housekeeping and activity staff have been re-educated on including but not limited to, the Inventory process. All licensed nursing staff has been re-educated on properly completing the** | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155064 | A. BUILDING 00<br>B. WING | 12/03/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| APERION CARE KOKOMO | 3518 S LAFOUNTAIN ST<br>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 a phone interview, on 12/2/24 at 12:31 p.m., a confidential interviewee indicated an ambulance company van brought Resident B in a specialty loaner wheelchair to the facility to use until he came home, then he would get a wheelchair custom made for him when he got home. He had to return the loaner prior to getting the custom build wheelchair. The confidential interviewee provided a description of the wheelchair with the serial number.<br><br>The clinical record for Resident B was reviewed on 12/2/24 at 1:19 p.m. The diagnoses included, but were not limited to, flaccid neuropathic bladder, complete paraplegia, and muscle wasting and atrophy.<br><br>A facility document, titled "Admission-Admission Observation," dated 7/12/24 at 2:08 p.m., indicated the admission details for Resident B included, but were not limited to, arrival via ambulatory, stretcher or wheelchair (neither one of these options were selected as a way the resident arrived at the facility). The vitals area indicated at 2:40 p.m., the resident weighed 168 pounds using a wheelchair to weigh him.<br><br>During an interview, on 12/2/24 at 4:45 p.m., Resident B indicated he was transported to the admitting facility on 7/12/24, via a van in the loaner wheelchair he was given at the hospital prior to discharge. When he arrived at the facility, he was taken out of his wheelchair, placed in bed, and his wheelchair was removed from his room. He never saw the loaner wheelchair again.<br><br>During an interview, on 12/3/24 at 9:34 a.m., the Executive Director (ED) indicated if a resident was admitted with a wheelchair, the wheelchair should stay with the resident their entire stay at the | | **admission assessment to include personal belongings upon admission.**<br><br>**4) How the corrective actions will be monitored: The SSD, or designee, will ensure all new admissions have a completed inventory form within 24hr after admission. This audit will continue daily X 8 weeks, then M-F thereafter.**<br><br>**The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.**<br><br>**5) Date of compliance: 12/10/2024** | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155064 | A. BUILDING 00<br>B. WING | 12/03/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| APERION CARE KOKOMO | 3518 S LAFOUNTAIN ST<br>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.<br><br>During an interview, on 12/3/24 at 10:35 a.m., the Assistant Director of Nursing (ADON) indicated the day Resident B was admitted, he turned his call light on shortly after he was admitted, and she answered the call light. He wanted to get up out of bed, so she got a wheelchair from therapy, but it was not comfortable for him, so she had physical therapy complete a wheelchair evaluation on him.<br><br>During a phone interview, on 12/3/24 at 10:48 a.m., National Seating and Mobility in Indianapolis was called and Staff member 7 indicated a loaner Quickie QRI wheelchair was delivered to the Rehabilitation Hospital of Indiana (RHI) on 7/8/24, to Resident B, who was being discharged to Aperion Care Kokomo on 7/11/24.<br><br>During a phone interview, on 12/3/24 at 11:50 a.m., Team Lead staff member for Health Information Management 8 called back from RHI indicating an ambulance company transported Resident B in an ambulance van via his loaner wheelchair to the facility. An outside entity company came to their facility to measure the resident, then provided the resident with a loaner wheelchair until his was built.<br><br>During an interview, on 12/3/24 at 12:10 p.m., the Regional Vice President of Operations and LPN 12 was in attendance. LPN 12 indicated she was the nurse who admitted Resident B to the facility on 7/12/24. He was pushed into his room in a wheelchair. He sat up in the wheelchair for a while after being admitted, then he was placed in bed to finish his admission assessment. She had no idea what happened to the wheelchair he was transported to the facility in after he was placed in bed. | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155064 | A. BUILDING 00<br>B. WING | 12/03/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| APERION CARE KOKOMO | 3518 S LAFOUNTAIN ST<br>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 facility policy, titled "Resident Rights," dated 1/4/19 and provided by the Executive Director on 12/2/24 at 1:19 p.m., indicated "...These rights include the resident's right to...Retain and use personal possessions to the maximum extent that space and safety permit...."<br><br>This citation relates to Complaint IN00447825.<br><br>3.1-9(a)<br>3.1-9(b)<br>3.1-9(c) | | | |
| F 0686 SS=D Bldg. 00 | 483.25(b)(1)(i)(ii)<br>Treatment/Svcs to Prevent/Heal Pressure Ulcer<br>Based on interview and record review, the facility failed to ensure staff completed an accurate admission assessment of a resident's pressure ulcer by a licensed nurse qualified to assess pressure wounds according to their policy and procedure for 1 of 1 new admission reviewed for a pressure ulcer. (Resident B)<br><br>Finding includes:<br><br>During a phone interview, on 12/2/24 at 12:31 p.m., a confidential interviewee indicated Resident B had a pressure ulcer which was almost healed when he arrived at this facility, on 7/12/24, but when he left the facility to be hospitalized on 7/30/24, the pressure ulcer on his coccyx was a Stage 4.<br><br>The clinical record for Resident B was reviewed on 12/2/24 at 1:19 p.m. The diagnoses included, but were not limited to, flaccid neuropathic bladder, complete paraplegia, and muscle wasting and atrophy. | F 0686 | **F686**<br>**This facility requests a desk review for the allegation.**<br><br>*This Plan of Correction is the center's credible allegation of compliance.*<br><br>*Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*<br><br>**1) Immediate actions taken for those residents identified:**<br>**Resident B no longer resides in** | 12/10/2024 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155064 | A. BUILDING 00<br>B. WING | 12/03/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| APERION CARE KOKOMO | 3518 S LAFOUNTAIN ST<br>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 rehabilitation hospital document, titled "Wound Care Note," dated 6/21/24, from Resident B's admission prior to his admission to the facility indicated on admission to the hospital he presented with a sacral (coccyx) Deep Tissue Injury (DTI) (intact skin with localized area of persistent non-blanchable deep red, maroon, and purple discoloration due to damage of underlying soft tissue) which evolved to an unstageable pressure wound.<br><br>The physical exam of the coccyx wound, dated 7/8/24 at 9:00 p.m., indicated Resident B's pressure injury wound measurements were 9 cm (centimeters) wide, 5.5 cm long and 0.2 cm deep and the wound tissue had 20% slough attached to it (non-viable yellow, tan, gray, green or brown tissue; usually moist, could be soft, stringy and mucinous in texture) and/or eschar (dead or devitalized tissue that was hard or soft in texture; usually black, brown, or tan in color, and might appear scab-like). The stage was unstageable (full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because the wound bed is obscured by slough or eschar).<br><br>A facility document for Resident B's admission, titled "Admission/Re-Admission Observation" dated 7/12/24 at 11:00 a.m., indicated Resident B had a sacrum pressure area, which measured approximately 2.5 cm in diameter with a yellowish and white wound bed with a pink center.<br><br>The documentation of the pressure ulcer did not include the stage of the pressure ulcer and if there was any drainage observed.<br><br>A facility document, titled "Weekly Skin | | **the facility.**<br><br>**2) How the facility identified other residents: All new admissions have the potential to be affected.**<br><br>**3) Measures put into place/ System changes: All licensed nursing staff has been re-educated on a head-to-toe skin assessment upon admission, including but not limited to, staging pressure ulcers. A wound nurse is available M-F to assess skin integrity on all new admissions. A leadership wound assessment will be completed within 24hrs (M-F) following an admission. A facility wide skin audit was completed 12/6/2024 with no new findings.**<br><br>**4) How the corrective actions will be monitored: All new admission audits and leadership wound assessment will be completed within 24hrs (M-F) of an admission. The wound nurse, or designee, will assess all new admits ensuring appropriate staging, orders and** | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155064 | A. BUILDING 00<br>B. WING | 12/03/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| APERION CARE KOKOMO | 3518 S LAFOUNTAIN ST<br>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 |
|---|---|---|---|---|
| | Observation," dated 7/16/24 at 8:30 a.m., indicated Resident B had a pressure wound to his coccyx area and his right buttock. The comment section area indicated no new areas were noted. The dressing and treatment were completed following his shower.<br><br>The coccyx and right buttock pressure wounds lacked documentation of size (length x width x depth), stage of pressure ulcer, odor, drainage and description.<br><br>A facility document, titled "Initial Wound Evaluation & Management Summary," dated 7/23/24, indicated Resident B had an unstageable pressure wound to his coccyx. The wound measured 5 cm x 4.2 cm x 1.0 cm. There was a moderate amount of serosanguineous drainage. There was 100% necrotic tissue (necrotic tissue and eschar were usually firmly adherent to the base of the wound and often the sides/ edges of the wound).<br><br>A hospital document, titled "Inpatient Consult to Wound Care," dated 7/30/24, indicated Resident B had a pressure wound to his sacrum (coccyx). The wound was a deep, foul smelling open wound. The wound was open. The wound was present on admission. The stage 4 wound measured 5 cm x 4 cm x 3.5 cm, there was 90% slough and 10% bone was seen. The wound bed was black. The exposure was bone exposed with necrosis. There was scant amount of drainage from the wound with an odor coming from wound.<br><br>During an interview, on 12/3/24 at 3:45 p.m., the Director of Nursing (DON) indicated the previous Assistant Director of Nursing (ADON) quit her position in July 2024 around the time the resident was admitted. The previous ADON was | | **interventions are in place. This audit will continue M-F X 8 weeks, then M-F thereafter.**<br><br>**The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.**<br><br>**5) Date of compliance: 12/10/2024** | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155064 | A. BUILDING 00<br>B. WING | 12/03/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| APERION CARE KOKOMO | 3518 S LAFOUNTAIN ST<br>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 |
|---|---|---|---|---|
| | responsible for assessing and managing the wounds in the facility.<br><br>A current policy, titled "Pressure Injury and Skin Condition Assessment," dated 1/17/18 and provided by the Executive Director on 12/3/24 at 11:30 a.m., indicated "...Pressure and other ulcers (diabetic, arterial, venous) will be assessed and measured at least every seven (7) days by licensed nurse, and documented in the resident's clinical record...A wound assessment will be initiated and documented in the resident chart when pressure and/or other ulcers are identified by licensed nurse...Pressure injuries and other ulcers...will be measured at least weekly and recorded in centimeters in the resident's clinical record. 11. A wound assessment for each identified open area will be completed and will include: a. Site location b. Size (length x width x depth) c. Stage of Pressure ulcer d. Odor e. Drainage f. Description g. Date and initials of individual performing the assessment...."<br><br>3.1-40(a)(2) | | | |
| F 0690 SS=D Bldg. 00 | 483.25(e)(1)-(3)<br>Bowel/Bladder Incontinence, Catheter, UTI<br><br>Based on interview and record review, the facility failed to ensure staff anchored an indwelling catheter with proper placement into a resident's bladder for 1 of 1 resident reviewed for an indwelling catheter. (Resident B)<br><br>Finding includes:<br><br>During a phone interview, on 12/2/24 at 12:31 p.m., a confidential interviewee indicated prior to Resident B being admitted to the hospital on 7/30/24, two nurses placed indwelling catheters in | F 0690 | **F690**<br>**This facility requests a desk review for the allegation**<br><br>*This Plan of Correction is the center's credible allegation of compliance.*<br><br>*Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the* | 12/10/2024 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155064 | A. BUILDING 00<br>B. WING | 12/03/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| APERION CARE KOKOMO | 3518 S LAFOUNTAIN ST<br>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 wrong place and caused trauma to his urinary tube. The first nurse put too large of a tube in, and it had to be removed because of the blood in the catheter, then the second nurse put too large of a catheter in as well and it was inserted in the wrong place.<br><br>The clinical record for Resident B was reviewed on 12/2/24 at 1:19 p.m. The diagnoses included, but were not limited to, flaccid neuropathic bladder, complete paraplegia, and muscle wasting and atrophy.<br><br>A nursing progress note, dated 7/29/24 at 10:50 a.m., indicated an indwelling catheter size 16 French/10 cubic centimeter (cc) balloon was inserted into Resident B's bladder without difficulty for a diagnosis of neurogenic bladder.<br><br>This progress note did not indicate if there was a urine return, or the color of the urine return when the indwelling catheter was anchored.<br><br>A nursing progress note, dated 7/29/24 at 11:12 a.m., indicated the nurse who anchored the indwelling catheter on Resident B was called to his room by a CNA due to complaints of blood in his catheter. Upon entering the resident's room, there was a dark red fluid in the resident's catheter. The catheter was removed without difficulty. The nurse covered the urethral meatus and applied pressure after removing the catheter. After the resident was cleaned up, there was no bleeding noted to the opening of the urethra. A PRN (as needed) pain medication was given to the resident as requested.<br><br>A nursing progress note, dated as a late entry on 7/29/24 at 3:20 p.m., indicated a 12 French indwelling urethral catheter with a six-cc balloon | | *facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*<br><br>**1) Immediate actions taken for those residents identified: Resident B no longer resides in the facility.**<br><br>**2) How the facility identified other residents: All residents who has a foley catheter or receives a new order for a foley catheter have the potential to be affected.**<br><br>**3) Measures put into place/ System changes: All licensed nursing staff has been re-educated on, including but not limited to, properly inserting a foley catheter. All licensed nurse reviewed the policy and procedure and showed return demonstration on how to properly insert a foley catheter and document necessary information.**<br><br>**4) How the corrective actions** | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155064 | A. BUILDING 00<br>B. WING | 12/03/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| APERION CARE KOKOMO | 3518 S LAFOUNTAIN ST<br>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 anchored without difficulty. A large amount of bloody urine with blood clots drained into the catheter drainage bag and from around the catheter at the meatus.<br><br>A hospital document, titled "ED [Emergency Department] Progress Notes," dated 7/30/24 at 4:48 a.m., indicated the resident had an indwelling catheter, which was reportedly placed by the facility staff last night and it resulted in penile bleeding and hematuria (blood in the urine.) The abdomen and pelvis IV (intravenous) contrast CAT Scan completed on 7/30/24 at 6:43 a.m., indicated the indwelling catheter was malpositioned (not correctly placed) with the balloon blown up within the penile urethra. Urology was consulted for the malposition indwelling catheter.<br><br>During an interview, on 12/3/24 at 11:11 a.m., the Regional Vice President of Operations indicated he did not have any further information to provide for the catheter anchored on 7/29/24, at the facility prior to the resident's hospitalization on 7/30/24. The nurse should have documented if she got a urine return or not.<br><br>A current policy, titled "FOLEY CATHERIZATION AND REMOVAL," undated and provided by the Executive Director on 12/3/24 at 10:17 a.m., indicated "...INSERTION PROCEDURE: Follow approved sterile technique for catheter insertion. (Same as straight catheter technique for male or female) Inflate balloon to the capacity with sterile water to test for balloon patency. Deflate for insertion, then re-inflate. 6. Pull catheter gently to be sure it is secured in the bladder...Document pertinent observations on nursing record...." | | **will be monitored: The DON or designee, will ensure all new residents with a foley catheter has proper placement and documentation within 24hrs of placement of catheter. This audit will continue M-F X 8 weeks, then M-F thereafter.**<br><br>**The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.**<br><br>**5) Date of compliance: 12/10/2024** | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155064 | A. BUILDING 00<br>B. WING | 12/03/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| APERION CARE KOKOMO | 3518 S LAFOUNTAIN ST<br>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 |
|---|---|---|---|---|
| | 3.1-41(a)(2) | | | |