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	07/21/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00357114, IN00357265 and IN00357791. Complaint IN00357114-Unsubstantiated due to lack of evidence. Complaint IN00357265-Substantiated. Federal/State deficiency related to the allegations is cited at F698. Complaint IN00357791-Substantiated. Federal/State deficiency related to the allegations is cited at F732. Survey dates: July 19 and 21, 2021 Facility number: 000127 Provider number: 155222 AIM number: 100291430 Census bed type: SNF/NF: 70 Total: 70 Census payor type: Medicare: 6 Medicaid: 52 Other: 12 Total: 70 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1. Quality review was completed on July 23, 2021.	F 0000		
F 0698 SS=D	483.25(l) Dialysis			

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

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Bldg. 00	§483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.			
	Based on interview and record review, the facility failed to ensure transportation was followed through with for the scheduled and verified appointments to transport 1 of 3 residents to dialysis (Resident B). Finding includes: A Confidential interview was conducted during the course of the survey. The Confidential Interviewee indicated the Resident B was discharged from the hospital on 6/8/21. He admitted to the facility on 6/8/21 as a short term resident. The facility agreed to transport him back and forth to his dialysis appointments in Anderson, Indiana three days a week (approximately 98 miles round trip from the facility) prior to accepting him as a resident since he was only going to be at the facility short term. The resident did not show up at the dialysis center in Anderson, Indiana from 6/9/21 to 6/15/21, so he had gone 8 days without dialysis treatment. The dialysis treatment center in Anderson, Indiana assumed he was going to dialysis in Muncie, Indiana, which was where the hospital was located. The facility indicated they did not have transportation to take him to the Anderson, Indiana dialysis center. He was scheduled for the Kokomo, Indiana dialysis center because it was closer to the facility he was staying at. Transportation was set up for the resident to be picked up by a transportation company on 6/18/21 and a Senior bus service in	F 0698	Resident B was sent to hospital twice for evaluation and dialysis due to missed dialysis, however the hospital did not feel the resident required dialysis either time and he returned with no new orders. Family has since agreed to transport resident and resident is regularly attending dialysis and has had no adverse outcomes. 2) All residents who receive dialysis have the potential to be affected. An audit was completed for residents receiving dialysis for the last 30 days related to transportation and attending dialysis with no other deficiencies noted. 3) IDT team and licensed nursing staff will be educated on policy "Transportation" with emphasis on notification to ED/DON to ensure back-up transportation is arranged per plan of correction. 4) Facility will identify a back up plan for all residents who receive dialysis in the incidence that their regularly scheduled	08/04/2021

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town was scheduled as a second pick up transportation option in case the first option failed. Resident B was a no show for his dialysis treatment on 6/18/21. The dialysis doctor phoned the resident's doctor at the facility on 6/16/21 or 6/17/21, to talk to him about getting the facility to get the resident to his dialysis treatments, due to all the missed dialysis appointments and because when the resident was sent to the Emergency Room (ER) to get dialyzed, the Emergency Room Physician sent him back to the facility without giving him dialysis due to his labs were "okay." The Confidential Interviewee indicated when Resident B lived in Independent Living, the facility sent someone with him to his treatments. One Friday, the present facility sent the resident to dialysis in a CNA's (Certified Nursing Assistant's) personal vehicle because they were not able to secure transportation. Resident B missed his dialysis treatments from 6/8/21 to 6/23/21 (15 days). His dialysis port was sluggish when he had his first dialysis treatment. Five out of those 15 days missed were at the Kokomo dialysis center and the other 10 days were at the Anderson dialysis center.

During the confidential interview, this was what the interviewee indicated occurred on the resident's dialysis days:

On 6/21/21, the resident was scheduled to go to dialysis in Kokomo, but he was a no show and the facility indicated he refused to go.

On 6/23/21, the resident was scheduled to go to dialysis and he was brought to the appointment by family.

On 6/28/21, the resident was scheduled for

transportation is not available. Back up plans may include alternative ambulance/transport company, Uber/Lyft if medically/physically able with staff accompanying, handicap cab with a staff accompanying resident, and/or family transporting. DON/designee will audit dialysis residents to confirm there were no missed dialysis appointments related to transportation 5 days a week x 30 days, then 3 times a week x 30 days, then weekly x 4 months. All findings will be reported to the QAPI committee to determine when compliance is achieved or if ongoing monitoring is required.
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dialysis and he was a no show at the dialysis center due to no transportation.

On 6/30/21, he went to dialysis, then he was to be transported to another facility. The family told the dialysis center he was going back to his present dialysis center for two more weeks and family was transporting him to and from dialysis.

On 7/12/21, the resident was scheduled for dialysis, but did not have transportation because his family member forgot to pick him up.

On 7/16/21, the resident did not come to his scheduled dialysis appointment related to his Foley catheter.

On 7/21/21, the resident did not come to his scheduled dialysis appointment because his brother forgot to pick him up.

Resident B's record was reviewed on 7/20/21 at 12:30 p.m. Diagnoses included, but were not limited to, altered mental status, dependence on renal dialysis, impulse disorder, mild intellectual disabilities and epilepsy.

A Care Plan, dated 6/9/21, addressed the problem Resident B was on dialysis therapy. The interventions included, but were not limited to, the following: Day/time, Transportation: Type/location of dialysis access site, Dialysis center: 6/9/21-(Name of Dialysis Center), Phone Number.

The progress notes were reviewed which included, but were not limited to, the following notes:

On 6/8/21 at 1:40 p.m., the resident was admitted

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	to the facility. He goes to dialysis in Anderson, Indiana on Monday, Wednesday and Friday via (Name of Transport Company). The admitting nurse was to call the Kokomo Dialysis Center to ask if the resident could transfer to there for his dialysis treatments. On 6/9/21 at 12:21 p.m., the admitting nurse spoke with a dialysis nurse at the Anderson dialysis center who indicated she was sending an email to the Kokomo dialysis center in regards to the resident transferring to the Kokomo center and she would follow up with the nurse as soon as she received confirmation. On 6/9/21 at 2:41 p.m., the admitting nurse spoke with the Kokomo dialysis center who indicated they were not sure Resident B could transfer to their location at this time, information faxed to the Kokomo location. The Anderson center was contacted and the nurse there indicated the resident was able to continue there until a transfer was complete or if he could not transfer. Transportation was set up for 6/11/21 for a 9:30 a.m. pickup time with an 11:30 a.m. chair time. On 6/11/21 at 8:51 a.m., the facility received a call from the transportation company who indicated they were unable to get transportation for the resident for his dialysis treatment this day. The resident was sent to ER to be dialyzed. On 6/11/21 at 10:00, the facility called the transportation company and advised them the resident needed scheduled for dialysis transportation on Mondays, Wednesdays and Fridays in Anderson, Indiana and received confirmation numbers for all three days. The nurse voiced to the dispatcher these days were		required. <="" p="">	

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	ongoing and cannot be canceled because the resident cannot miss these appointments. On 6/11/21 at 12:03 p.m., the Nephrologist at the ER at the hospital indicated the resident's labs looked good and were reviewed by the Nephrologist (a Physician who only provided treatment to patients with kidney disease) who did not feel the resident needed dialyzed this day. On 6/11/21 at 1:16 p.m., the resident was to resume his dialysis schedule. The resident's transportation was being set up by the facility transportation company. On 6/14/21 at 9:04 a.m., the ambulance company called and notified the facility they did not have anyway to get the resident to his dialysis appointment this day. They indicated they notified the Unit Manager about this issue on Saturday 6/11/21. On 6/14/21 at 10:41 a.m., the nurse called the transportation company to ensure they had transportation scheduled for Resident B's dialysis appointments. The transportation company indicated to the nurse the resident was on the schedule, but this did not guarantee transportation. On 6/16/21 at 2:29 p.m., the Handicapped cab arrived this morning to pick up the resident to transport him for his dialysis treatment to Anderson, Indiana. The cab driver indicated he wanted the facility staff to call the dialysis center to ensure they would get the resident out of the cab because he was not allowed to assist a resident into or out of the cab. The nurse called the Anderson dialysis center and was informed the dialysis center could not assist with			

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transferring the resident into or out of the cab either. The resident was not able to go for his dialysis treatment this day.

On 6/16/21 at 2:50 p.m., after the Physician was updated on the resident missing his dialysis appointment this day. He gave an order to send the resident to the ER to be dialyzed.

On 6/16/21 at 7:56 p.m., Resident B returned from the ER without being dialyzed due to the Physicians indicated his labs and chest X-ray were fine and he had no fluid.

On 6/17/21 at 9:10 a.m., the family requested the SSD (Social Service Director) sent out four referrals for the resident to be transferred to facilities in Huntington, Indiana where his next of kin resides. The SSD sent the referrals out four facilities.

On 6/17/21 at 2:25 p.m., the SSD received call from the Kokomo dialysis center who indicated they would accept the resident now, but needed to secure transportation. The Director of Nursing (DON) came into the conversation at this time and explained to the dialysis nurse the transportation company the facility used had been inconsistent and not reliable. The dialysis nurse indicated she would look into a few things and call facility back.

On 6/17/21 at 3:46 p.m., the SSD called an ambulance company to transport Resident B for dialysis at the Kokomo dialysis center for tomorrow. The pick up time was approximately at 12:30 p.m., for arrival at 12:45 p.m.

On 6/24/21 at 2:37 p.m., a nurse called the transportation company and set up transport for

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	the resident to the Kokomo dialysis center. He had a standing order in place for routine pick up by the transportation company. She communicated to the charge nurse the resident would be picked up at 11:45 am on Monday, Wednesday, and Friday. On 6/28/21 at 10:28 a.m., the facility received a call from the transportation company indicating they were unable to obtain transportation for the resident. On 6/28/21 at 10:40 a.m., the SSD received a return call from a facility in Anderson, Indiana, who accepted Resident B as a resident in their facility. The plan was to have him picked up from dialysis on Wednesday 6/30/21 and taken to the new facility for admission. On 6/28/21 at 1:11 p.m., the resident missed his appointment for dialysis this shift. On 6/28/21 at 1:14 p.m., the SSD and DON spoke with the resident's family member and she agreed to transfer the resident to his dialysis appointments. The SSD was working on getting his dialysis treatments transferred back to the Anderson dialysis center. On 6/29/21 at 9:54 a.m., Late Entry: the resident's family member called and indicated she was not sure if she wanted him to go to the new facility in Anderson tomorrow 6/30/21. The family member indicated their parents would not be able to visit in Anderson due to it being too far away. The SSD explained the transportation company the facility was using was not reliable as seen by multiple routine cancellation. The resident's family would need to be responsible for transportation to and from his dialysis			

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	appointments if he were to stay in Kokomo. The family member indicated they were not able to help. The SSD informed her, the SSD would reach out to the ED and call her back. The SSD went and spoke with the resident and he indicated his family was here and asked the SSD to speak with them in regards to staying at facility. The SSD went to speak with the ED and the resident's family members were all in ED's office. They too were wanting the resident to stay at the facility and not to transfer. The SSD explained the family members would need to provide the transportation to and from dialysis due to their transportation company was not being reliable because either they did not show up to transport the resident or they called to cancel. The ED and SSD explained the importance of dialysis for the resident to the family and they agreed indicating they would talk and see if they could figure out a schedule they would all be able to assist with so the resident could stay at the facility until he discharged to a group home. The SSD attempted to call the family member back with no answer, so a voicemail with a request of a return call was left. On 6/30/21 at 8:28 a.m., the SSD received call from the family member, indicating family was going to take the resident to and from his dialysis appointments until he moved to the group home in a few weeks. The SSD called and ensured appointments were scheduled through the Kokomo dialysis center and called and canceled the transfer to other facility. The family and the resident was pleased at this time. On 6/29/21 at 11:00, the ED left the family member a voicemail regarding transportation to the facility in Anderson.			

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	On 7/12/21 at 1:00 a.m., Late Entry: Note Text: the family was contacted three times regarding the resident's dialysis appointments. The family had not yet returned the calls. The resident's record was reviewed for refusal of dialysis treatments and there was no documentation found to indicate the resident missed his dialysis treatments due to he refused them. During an interview, on 7/21/21 at 11:00 a.m., the ED (Executive Director) and the Interim DON (Director of Nursing) were in attendance. The ED indicated when asked about Resident B's transportation to dialysis, she knew he had refused to go to dialysis at times. She knew there were transportation set up with the transportation company the facility had to use, then they would call to cancel and would not show up at the last minute. She did not know he had been sent out to the ER for evaluation and treatment due to not being dialyzed twice. The family and the facility had a care plan meeting after he had missed several dialysis treatment days to discuss with the family about them being responsible for providing transportation for the resident to and from dialysis, if he was going to stay at the facility until a group home could be found and the legistics be worked out. The family and the resident agreed to providing the transportation from then on. The ED indicated she would look into this more and provide more information if she had it because she was newly hired when this resident came into the facility. A current policy, titled "Policies and Standard Procedures," dated as reviewed on 5/29/2019 and provided by the ED on 7/19/21 at 11:00 a.m., indicated "...Policy...The facility will assist the			

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	resident in making transportation arrangements to and from the source of any needed service, such as dental visits, or physician visits in the event the resident requires such assistance. Procedure: 1. Social Services or their designee will: A. Contact the resident or responsible party to inquire of need of transportation assistance. B. Social Services will collaborate with nursing for a needs assessment for transportation...D. Coordinate with clinical services...1. Provide an escort with a cell phone, as needed to contact the facility in the event of an emergency...E. Make the arrangement for pick up, drop off and any needed medical records or devices that should accompany the resident on the visit...." This Federal tag relates to Complaint IN00357265. 3.1-37 (a) 3.1-37 (b)			
F 0732 SS=C Bldg. 00	483.35(g)(1)-(4) Posted Nurse Staffing Information §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census.			

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	§483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.			
	Based on observation and interview, the facility failed to ensure timely posting of the daily nursing staff information for 1 of 3 days observed during the survey. This deficient practice had the potential to impact 70 of 70 residents and visitors. Finding includes: Upon entering the facility on 7/19/21 at 4:30 a.m., the nurse staffing information posted on the bulletin board in the hallway leading to the Main and West hallways was dated 7/12/21 and 7/13/21. The plastic sleeve lacked a current nursing staffing posting dated 7/19/21. LPN 1 provided a copy of those nursing staffing sheets and indicated as far as she knew those were the only ones posted at that time. She was the	F 0732	#1: N/A #2: No residents were found to be affected. #3: Education was provided to the facility Scheduler, Administrative Team using the using the nursing staff hours policy on 7/23/21 The scheduler/designee will update staff posting Monday thru Friday. On Weekends and after hours the designee will update posting. #4: Daily audits will be conducted the ED/designee Monday-Friday for 2 weeks, then 3 times per	07/23/2021

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KOKOMO HEALTHCARE CENTER	429 W LINCOLN RD KOKOMO, IN 46902

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	manager on call for the weekend and she was responsible for placing the new sheets up and there were no new sheets available for the weekend for her to post. This Federal tag relates to Complaint IN00357791. 3.1-17(b)		week for 2 weeks, then weekly for 1 month, then Bi-monthly for 1 month, then monthly for 3 months. All findings will be reported to the QAPI committee to determine when compliance is achieved or if ongoing monitoring is required.	