STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155678	A. BUILDING 00 B. WING	01/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERFORD PLACE HEALTH CAMPUS	800 ST JOSEPH DR KOKOMO, IN 46901

(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 a State Residential Licensure Survey. This visit also included the Investigation of Complaint IN00423969. Complaint IN00432969 - No deficiencies related to the allegations are cited. Survey dates: January 2, 3, 4, 5, 8 and 9, 2024. Facility number: 002667 Provider number: 155678 AIM number: 200300090 Census Bed Type: SNF/NF: 45 SNF: 26 Residential: 41 Total: 112 Census Payor Type: Medicare: 18 Medicaid: 37 Other: 16 Total: 71 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review was completed on January 16, 2024.	F 0000	**Waterford Place Health Campus** **POC due: 01/29/24 Date of Compliance: 01/31/24** **The submission of this plan of correction does not indicate and admission by Waterford Place Health Campus that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and the living environment provided to the residents of Waterford Place Health Campus. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests from the department a desk review for substantial compliance.**	
F 0582 SS=D	483.10(g)(17)(18)(i)-(v) Medicaid/Medicare Coverage/Liability Notice			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Rachel Bishir	Executive Director	01/29/2024

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
	155678	A. BUILDING 00 B. WING	01/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERFORD PLACE HEALTH CAMPUS	800 ST JOSEPH DR KOKOMO, IN 46901

(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
Bldg. 00	§483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155678	A. BUILDING 00 B. WING	01/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERFORD PLACE HEALTH CAMPUS	800 ST JOSEPH DR KOKOMO, IN 46901

(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, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. Based on record review and interview, the facility failed to ensure there was documentation to show the resident or resident's representative made the choice about the Skilled Nursing Facility Advanced Beneficiary Notice of Non-Coverage (SNF ABN) for 2 of 3 residents reviewed for beneficiary notification. (Resident 27 and 315) Findings include: 1. The Notice of Medicare Non-Coverage (NOMNC) for Resident 27 indicated rehabilitation services would end on 12/26/23. The SNF ABN form, for Resident 27, indicated the resident no longer required skilled services but wanted to continue to reside in the SNF. Medicare would not pay for the stay at the facility since the resident did not require daily skilled care. The resident had three options to choose and was to choose only one option. The options included the resident wanted the services to continue and to bill Medicare for an official decision on payment, the resident wanted to continue the services and do not bill Medicare, or the resident did not want the services. The facility could not choose the	F 0582	F582 – Medicare/Medicaid Coverage/Liability Notices MEDICARE / MEDICAID COVERAGE NOTICES 1 Residents #27 and #315 were affected by the alleged deficient practice. There were no adverse effects related to alleged deficient practice. An audit was completed immediately of all resident Advanced Beneficiary Notices (ABN). No additional deficiencies were found. 2 An audit was completed immediately of all resident ABN's. No additional deficiencies were found. Advanced Beneficiary Notices will be completed and reviewed with each corresponding resident and/or POA. The letter will be reviewed by the Business office Manager (BOM)/Administrator for complete documentation prior to issuing. 3 As a measure of on-going	01/31/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155678	A. BUILDING 00 B. WING	01/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERFORD PLACE HEALTH CAMPUS	800 ST JOSEPH DR KOKOMO, IN 46901

(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
	option for the resident. The resident/representative signed the form, on 12/21/23, and did not choose an option. The Electronic Health Record (EHR) did not have a note to include the facility talked to the resident or representative about which option was chosen. 2. The Notice of Medicare Non-Coverage (NOMNC) for Resident 315 indicated rehabilitation services would end on 12/22/23. The SNF ABN form, for Resident 315, indicated the resident no longer required skilled services but wanted to continue to reside in the SNF. Medicare would not pay for the stay at the facility since the resident did not require daily skilled care. The resident had three options to choose and was to choose only one option. The options included the resident wanted the services to continue and to bill to Medicare for an official decision on payment, the resident wanted to continue the services and do not bill Medicare, or the resident did not want the services. The facility could not choose the option for the resident. The resident/representative signed the form, on 12/20/23, and did not choose an option. The EHR did not have a note to include the facility talked to the resident or representative about which option was chosen. During the interview, on 1/8/24 at 1048 a.m., the Social Services Director indicated it was an oversight and she did not verify the resident chose an option on the SNFABN form. She did not document in the EHR which option the resident or representative wanted. During an interview, on 1/9/24 at 2:59 p.m., the Social Services Director indicated the facility did not have a policy on SNF ABN forms.		compliance, the BOM or designee will review all Notices issued weekly X 4 weeks, then monthly X 5 months and report to the facility QAPI committee. 4 The results of the audits will be reported to, reviewed by, and trended by the facility QAPI committee for a minimum of 6 months. On-going monitoring will continue beyond 6 months, if warranted until 100% compliance is achieved. 5 Completion Date: JANUARY 31, 2024	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155678	A. BUILDING 00 B. WING	01/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERFORD PLACE HEALTH CAMPUS	800 ST JOSEPH DR KOKOMO, IN 46901

(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
	3.1-4(f)(3)			
F 0679 SS=D Bldg. 00	483.24(c)(1) Activities Meet Interest/Needs Each Resident §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. Based on observation, interview and record review, the facility failed to ensure a cognitively impaired resident who resided on the memory care unit was provided with preferred activities while in isolation for Covid-19 for 1 of 4 residents reviewed for activities. (Resident 45) Finding includes: During an observation, on 1/3/24 at 10:37 a.m., Resident 45 was lying in bed, in her room, and her eyes were closed. There was no music playing and no reading material noted on the resident's bedside table. During an observation, on 1/4/24 at 10:21 a.m., Resident 45 was lying in bed and her eyes were closed. There was no music playing and the television was not on. During an interview, on 1/4/24 at 11:20 a.m., CRCA (Certified Resident Care Assistant) 3 indicated the television in the resident's room did not work. The	F 0679	F679 – Activities Meet Interest/Needs of Each Resident ACTIVIES FOR ISOLATED RESIDENTS 1 Resident #45 was affected by the alleged deficient practice. Resident did not have any adverse effects related to alleged deficient practice. The activity plan for resident #45 was immediately reviewed and staff in-serviced on compliance with the residents personalized activity plan. 2 An audit was completed immediately of all residents in isolation to ensure that activity care plans were in place addressing the current isolation circumstances and that activities were occurring per the resident's plan of care. 3 As a measure of on-going compliance, the Legacy	01/31/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155678	A. BUILDING 00 B. WING	01/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERFORD PLACE HEALTH CAMPUS	800 ST JOSEPH DR KOKOMO, IN 46901

(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 would watch television in the common area when she was not in isolation. During an observation, on 1/4/24 at 2:47 p.m., the resident was lying in bed, her eyes were opened. There was no music, the television was not on, and there were no books on the resident's side of the room. The record for Resident 45 was reviewed on 1/5/24 at 10:17 a.m. Diagnoses included, but were not limited to, dementia without behavioral disturbance, cognitive communication deficit, and anxiety disorder. An activity care plan, dated 1/2/24, indicated the resident had a history of enjoying Scripture, pet therapy, and exercise. The resident would positively respond to one-to-one activities of interest at least 6 times per week. The approaches included, but were not limited to, it was important to be around animals, and important to do things with groups of people. The group activities meaningful to the resident included pet therapy, religious, and exercise. A progress note, dated 12/26/23 at 5:06 a.m., indicated the resident was positive for Covid-19 and was placed into droplet isolation. A progress note, dated 12/28/23 at 4:11 a.m., indicated the resident continued in isolation. A progress note, dated 1/1/24 at 10:28 a.m., indicated the resident remained in isolation. A progress note, dated 1/5/24 at 8:43 a.m., indicated an order was obtained to discontinue the isolation.		Neighborhood Director and Life Enrichment Director or designee will review all residents in isolation for care plans addressing the current isolation circumstances and that activities are occurring per the resident's plan of care - weekly X 4 weeks, then monthly X 5 months and report to the facility QAPI committee. 4 The results of the audits will be reported to, reviewed by, and trended by the facility QAPI committee for a minimum of 6 months. On-going monitoring will continue beyond 6 months, if warranted, until 100% compliance is achieved. 5 Completion Date: JANUARY 31, 2024	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155678	A. BUILDING 00 B. WING	01/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERFORD PLACE HEALTH CAMPUS	800 ST JOSEPH DR KOKOMO, IN 46901

(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 and interview, on 1/8/24 at 11:07 a.m., the Legacy Unit Manager indicated she did not know where the remote was for the resident's television. The Unit Manager was able to turn on the television without using the remote control. During an interview, on 1/8/24 at 11:03 a.m., Life Enrichment Staff 4 indicated documentation showed the resident did not participate in activities on December 25, December 26, December 27, December 29, December 31, January 2, January 3, or January 4. During an interview, on 1/8/24 at 11:16 a.m., the Life Enrichment Clinical Support indicated the staff would go in the isolation room based on the resident's care plan and the family input. They would provide some type of independent activity if the resident was capable such as coloring pencils. The visits should have been charted in the electronic health record. The staff was not great at charting check-in visits with the residents in isolation. The Life Enrichment Team was new, and they still needed education. She could not show what activities Resident 45 participated in while in isolation since there was no documentation of the activities in the electronic health record. A Daily Rhythms Activity Protocol, not dated and received from the Life Enrichment Clinical Support on 1/8/24 at 11:39 a.m., indicated "...Through research and experience, we have learned that those living with the challenges of Alzheimer's disease and related forms of dementia benefit from a structured, predictable daily program of activities. Benefits of such a program include improved sleeping patterns, decreased depression, lower anxiety levels, fewer falls...."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155678	A. BUILDING 00 B. WING	01/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERFORD PLACE HEALTH CAMPUS	800 ST JOSEPH DR KOKOMO, IN 46901

(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 "Program Components/Standards," dated 6/3/2016 and received from the Life Enrichment Clinical Support on 1/8/24 at 11:48 a.m., indicated "...The Life Enrichment Department designs program which are meaningful, diverse, stimulating, and consistent with the needs, preferences, and abilities of each individual resident/patient...Programs are designed to provide opportunities for each resident/patient to meet their social, physical, cognitive, and emotional needs and recreation interests...The Life Enrichment Director will ensure that the life enrichment program contains the following programming standards/programming components... Intellectual/Cognitive Programs...Social Programs...encourage interaction with others...Dementia Programs...Programs that stimulate the 5 senses help to promote resident connection...." A current policy, titled "Resident Rights-Life Enrichment," dated 6/3/2016 and received from the Life Enrichment Clinical Support on 1/8/24 at 11:56 a.m., indicated "...Special care must be taken to assure the ongoing preservation of the rights of each resident in the provision of Life Enrichment services...All residents will be informed of opportunities, and provided assistance as needed, to participate in Campus and community opportunities of their choice...." 3.1-33(a)			
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			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155678	A. BUILDING 00 B. WING	01/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERFORD PLACE HEALTH CAMPUS	800 ST JOSEPH DR KOKOMO, IN 46901

(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 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 interview and record review, the facility failed to follow the physician's order to call the provider and complete a re-check for low blood sugars for 1 of 1 resident reviewed for quality of care related to insulin. (Resident 1) Finding includes: During an interview, on 1/2/24 at 3:05 p.m., Resident 1 indicated she had to go to the hospital for high blood sugars in the past. The record for Resident 1 was reviewed on 1/4/24 at 12:02 p.m. Diagnoses included, but were not limited to, type 2 diabetes with history of ketoacidosis (uncontrolled production of ketones) without coma, peripheral vascular disease, iron deficient anemia, and cognitive communication deficit. A physician's order, with a start date of 10/27/22 and an end date of 9/19/23, indicated the resident received insulin lispro (short acting insulin) per sliding scale 3 times per day. If the blood sugar was less than 70, call the MD. A current physician's order, dated 3/2/2020, indicated for blood sugars between 50-69, give a 15-gram carbohydrate oral feeding, wait 15 minutes, and recheck the blood sugar. If less than 70, than repeat the 15-gram carbohydrate 4 times a day as needed.	F 0684	F684 – Quality of Care PHYSICIAN NOTIFICATION 1 Resident #1 was affected by the alleged deficient practice. Audit completed immediately. Notifications to provider completed. No adverse reactions noted to the alleged deficient practice. 2 All residents diagnosed with diabetes requiring glucose monitoring have the potential to be affected. All nurses have been educated on following physicians orders related to call parameters for residents receiving blood glucose monitoring. All residents with orders to obtain blood glucose monitoring have been reviewed including but not limited to reviewing blood glucose levels, parameters on orders for MD notification, and completing audit to ensure all out of range glucose levels have individual trigger notifications. Audits along with notifications have been completed with no further concerns. 3 As a measure of on-going compliance, the Director of Health Services or designee will complete audits of 3 residents, as available, requiring blood glucose monitoring	01/31/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155678	A. BUILDING 00 B. WING	01/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERFORD PLACE HEALTH CAMPUS	800 ST JOSEPH DR KOKOMO, IN 46901

(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 blood sugar log indicated the following: a. On 5/24/23 at 9:35 a.m., the blood sugar was 69. There was no documentation there was a call to the provider or a 15-minute re-check was completed. b. On 5/31/23 at 10:04 a.m., the blood sugar was 53. There was no documentation there was a call to the provider or a 15-minute re-check was completed. c. On 7/5/23 at 10:00 a.m., the blood sugar was 63. There was no documentation there was a call to the provider or a 15-minute re-check was completed. d. On 7/29/23 at 8:14 a.m., the blood sugar was 54. There was no documentation there was a call to the provider or a 15-minute re-check was completed. e. On 8/6/23 at 8:06 a.m., the blood sugar was 59. There was no documentation there was a call to the provider completed. f. On 8/21/23 at 5:33 a.m., the blood sugar was 53. There was no documentation there was a call to the provider or a 15-minute re-check was completed. g. On 8/24/23 at 3:40 a.m., the blood sugar was 55. There was no documentation there was a call to the provider or a 15-minute re-check was completed. h. On 9/4/23 at 3:35 a.m., the blood sugar was 55. There was no documentation there was a call to the provider or a 15-minute re-check was completed. i. On 9/5/23 at 3:26 a.m., the blood sugar reading indicated "Low." There was no documentation a 15-minute re-check was completed. j. On 9/8/23 at 8:43 a.m., the blood sugar was 67. There was no documentation there was a call to the provider or a 15-minute re-check was completed.		with parameters in addition to appropriate notification 3 times weekly X 4 weeks, then 2 times weekly X 4 weeks, then weekly X 4 weeks, then monthly X 3 months. 4 The results of the audit observations will be reported to, reviewed by, and trended by the facility QAPI committee for a minimum of 6 months to ensure substantial compliance is maintained. On-going monitoring will continue beyond 6 months, if warranted, until 100% compliance is achieved. 5 Completion Date: JANUARY 31, 2024	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155678	A. BUILDING 00 B. WING	01/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERFORD PLACE HEALTH CAMPUS	800 ST JOSEPH DR KOKOMO, IN 46901

(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 1/4/24 at 4:11 p.m., the DHS (Director of Health Services) indicated they could not find any notification or re-checks for the low blood sugars and there should have been provider notification and re-checks completed. There was no policy for blood sugar monitoring provided by exit. 3.1-37(a)			
F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. Based on interview and record review, the facility failed to identify a weight loss, notify the physician, and implement interventions for 1 of 3 residents reviewed for nutrition. (Resident 12)	F 0692	F692 – Nutrition/Hydration Status Maintenance WEIGHT LOSS INTERVENTIONS / REPORTING 1 Resident #12 was affected	01/31/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155678	A. BUILDING 00 B. WING	01/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERFORD PLACE HEALTH CAMPUS	800 ST JOSEPH DR KOKOMO, IN 46901

(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
	Finding includes: The record for Resident 12 was reviewed on 1/5/24 at 12:18 p.m. Diagnoses included, but were not limited to, dementia without behavioral disturbance, type 2 diabetes mellitus, adult failure to thrive, anxiety, and major depressive disorder. A physician's note, dated 4/3/23 at 6:04 p.m., indicated the resident tested positive for Covid-19 on 3/30/23. If the resident had signs of dehydration an intravenous line should be considered for fluid resuscitation. The resident was to be monitored for falls, increased thirst, urination, weight loss, constipation, and diarrhea. The resident had the following weights: a. On 3/1/23, the weight was 114.4 pounds. b. On 4/7/23, the weight was 106.8 pounds which was a 6.64% weight loss in 37 days. The Electronic Health Record (EHR) did not include notification to the physician of the weight loss, a nutrition note, or interventions in place for the weight loss. During an interview, on 1/8/24 at 4:08 p.m., the Clinical Support Nurse indicated the facility should have notified the physician of the significant weight change and document the significant weight loss was noted. A current policy, titled Guidelines for Weight Tracking," dated as revised on 1/16/2021 and received from the Clinical Support Nurse on 1/8/24 at 4:45 p.m., indicated "...To ensure resident weight is monitored for weight gain and/or loss to prevent complications from arising from compromised nutrition/hydration...Unless otherwise indicated or ordered by the physician		by the alleged deficient practice. Resident did not have any adverse effects related to alleged deficient practice. 2 An audit was completed immediately of all residents weight changes to ensure appropriate notifications and interventions were in place. All licensed nursing staff were in-serviced on the policy for monitoring weight changes and notification to the attending physician. 3 As a measure of on-going compliance, the Director of Health Services or designee will review in Clinical Care Meeting on normal business days all residents with weight changes, as available, to ensure appropriate interventions and notifications are made. An audit will be done weekly X 4 weeks, then monthly X 5 months and report to the facility QAPI committee. 4 The results of the audits will be reported to, reviewed by, and trended by the facility QAPI committee for a minimum of 6 months. On-going monitoring will continue beyond 6 months, if warranted, until 100% compliance is achieved. 5 Completion Date: JANUARY 31, 2024	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155678	A. BUILDING 00 B. WING	01/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERFORD PLACE HEALTH CAMPUS	800 ST JOSEPH DR KOKOMO, IN 46901

(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 resident will have their weight taken and recorded monthly...The facility dietitian or representative will review the resident's nutritional status, usual body weight and current weight to implement a nutritional program when warranted...The physician, resident representative and dietitian shall be notified of a weight variance of 5% in 30 days, 7.5% in 90 days, and 10% in 180 days...." 3.1-46(a)(1)			
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey. This visit also included the Investigation of Nursing Home Complaint IN00423969. Complaint IN00432969 - No deficiencies related to the allegations are cited. Survey dates: January 2, 3, 4, 5, 8 and 9, 2024. Facility number: 002667 Residential Census: 41 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review was completed on January 16, 2024.	R 0000	**Waterford Place Health Campus** **POC due: 01/29/24 Date of Compliance: 01/31/24** **The submission of this plan of correction does not indicate and admission by Waterford Place Health Campus that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and the living environment provided to the residents of Waterford Place Health Campus. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with all state and federal requirements**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155678	A. BUILDING 00 B. WING	01/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERFORD PLACE HEALTH CAMPUS	800 ST JOSEPH DR KOKOMO, IN 46901

(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
			governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests from the department a desk review for substantial compliance.	
R 0298 Bldg. 00	410 IAC 16.2-5-6(c)(2) Pharmaceutical Services - Deficiency (2) A consultant pharmacist shall be employed, or under contract, and shall: (A) be responsible for the duties as specified in 856 IAC 1-7; (B) review the drug handling and storage practices in the facility; (C) provide consultation on methods and procedures of ordering, storing, administering, and disposing of drugs as well as medication record keeping; (D) report, in writing, to the administrator or his or her designee any irregularities in dispensing or administration of drugs; and (E) review the drug regimen of each resident receiving these services at least once every sixty (60) days. Based on observation, interview and record review, the facility failed to ensure narcotic medications were stored in a tamper free container and food was not stored in the refrigerator for 1 of 1 medication cart and 1 of 1 medication room reviewed for medication storage. Findings include: During a medication storage observation, on 1/4/24 at 12:00 p.m., the following were observed:	R 0298	R 298 – Pharmaceutical Services MEDICATION STORAGE 1 1. Residents #18 and #29 were affected by the alleged deficient practice. Residents did not have any adverse effects related to alleged deficient practice. The medications in question were immediately removed and destroyed per policy. The food items stored in the medication refrigerator were	01/31/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155678	A. BUILDING 00 B. WING	01/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERFORD PLACE HEALTH CAMPUS	800 ST JOSEPH DR KOKOMO, IN 46901

(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
	1. One (1) card of alprazolam (an antianxiety medication) 0.25 mg (milligrams) for Resident 18. The foil was torn on the back of the card over the dose number 26. The record for Resident 18 was reviewed. A physician's order, dated 11/6/23, indicated alprazolam 0.25 mg tablet, give 1 tablet every 4 hours. 2. One (1) card of hydrocodone/acetaminophen (a pain medication) 5/325 mg for Resident 29. The foil was torn on the back of the card over the dose number 6. The record for Resident 29 was reviewed. A physician's order, dated 6/16/23, indicated hydrocodone/acetaminophen 5/325 mg, give 1 tablet four times a day as needed for pain. 3. The medication refrigerator had two applesauce and one yogurt stored with medication. During an interview, on 1/4/24 at 12:02 p.m., the Director of Assisted Living indicated pills should not be left in the card and they should be destroyed. During an interview, on 1/4/24 at 12:05 p.m., the Director of Health Services indicated the policy stated the pills should not be left in the medication card and should have been destroyed with two nurses. During an interview, on 1/4/24 at 12:20 p.m., the Director of Assisted Living indicated she did not know the applesauce and yogurt were in the medication refrigerator. She was unaware of the facility policy for storing food with medications. A current policy, titled "Storage of Medications," dated as revised 11/18 and received from the Clinical Support Nurse on 1/4/24 at 2:13 p.m.,		immediately removed and discarded. An audit was completed immediately of all resident medication storage. No additional deficiencies were found. 2 An audit was completed immediately of all medication storage areas with no additional deficiencies found. Licensed nursing staff will be in-serviced by the Director of Health Services or designee on the medication storage policy. 3 As a measure of on-going compliance, the DHS/ADHS or designee will audit the medication storage areas 3 times weekly X 4 weeks, then 2 times weekly x 4 weeks, then weekly x 4 weeks, then monthly x 3 months and report to the facility QAPI committee. 4 The results of the audits will be reported to, reviewed by, and trended by the facility QAPI committee for a minimum of 6 months. On-going monitoring will continue beyond the 6 months, if warranted until 100% compliance is achieved. 5 Completion Date: JANUARY 31, 2024	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155678	A. BUILDING 00 B. WING	01/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERFORD PLACE HEALTH CAMPUS	800 ST JOSEPH DR KOKOMO, IN 46901

(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 "...Medication and biologicals are stored safely, securely, and properly. following manufacturer's or those of the supplier...Refrigerated medications are kept in closed and labeled containers, with internal and external medications separated and separate from fruit juices, applesauce, and other foods used in administering medications. Other foods such as employee lunches and activity department refreshments are not stored in this refrigerator. A current policy, titled "Guidelines for Disposal of Controlled Drugs," dated as revised 11/29/22 and received from the Clinical Support Nurse on 1/4/24 at 2:13 p.m., indicated "...To ensure controlled substances are destroyed in accordance with State Laws and Federal Regulations...When disposing of pharmaceutical controlled substances by transferring those substances into a collection receptacle...the nurse and DHS or DON, or other pharmacy-approved supervisory nurse - who removed the controlled substance medication from the medication cart shall transfer the medication to the MedSafe collection receptacle for disposal...."			