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	09/21/2022

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 the Investigation of Complaint IN00389653. This visit resulted in an Extended Survey-Substandard Quality of Care-Immediate Jeopardy. Complaint IN00389653-Substantiated. Federal/State deficiency related to the allegation is cited at F684. Survey dates: September 19, 20 and 21, 2022 Facility number: 000127 Provider number: 155222 AIM number: 100291430 Census Bed Type: SNF/NF: 76 Total: 76 Census Payor Type: Medicare: 11 Medicaid: 57 Other: 8 Total: 76 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review was completed on September 27, 2022.	F 0000	**Preparation and execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The plan of correction is prepared and executed solely because it is required by the provisions of federal and state law.**	
F 0684 SS=J Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that			

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 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.

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	applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on interview and record review, the facility failed to ensure staff assessed and notified the physician of a resident who experienced a change in condition timely and failed to initiate cardiopulmonary resuscitation (CPR) when a resident went unresponsive for 1 of 3 residents reviewed for death. (Resident B) The immediate jeopardy began on September 6, 2022, when Resident B had a change of condition which was not assessed by the licensed nurse on duty. Resident B was later found unresponsive, and the licensed nurse failed to start CPR and notify the physician of the death. The Executive Director (ED) and Regional Nurse Consultant (RNC) were notified of the immediate jeopardy on 9/19/22 at 2:20 p.m. The immediate jeopardy was removed on 9/21/22, but noncompliance remained at the lower scope and severity level of isolated, no actual harm with potential for more than minimal harm that is not immediate jeopardy. Finding includes: An Indiana State Department of Health incident report, dated 9/6/22 at 6:39 p.m., indicated staff notified the Registered Nurse (RN) of a resident, who was a full code, of the resident's change in condition. The RN determined respirations had ceased and notified the family, the resident was deceased.	F 0684	***The facility recognizes that it must persuade your office that appropriate systems are in place to assure ongoing compliance with the federal regulations for participation in the Medicare and Medicaid programs. Please accept the following as our process to ensure that the necessary steps will be taken to provide the best care possible to the residents at Kokomo Healthcare Center.*** **1) Resident B was found nonresponsive, without a pulse, and not breathing around 4:30am by staff on 9/6/22. Staff provided post mortem care, notified family, and released body to mortuary. 2) An audit was conducted on 9/6/22 for all current residents for change in condition and code status. No other concerns identified at this time.3) All licensed nurses, C.N.A.'s, and Q.M.A.'s were educated on the facilities policy identified as, General Code Status, MD Notification, chain of command/escalation process, and Change in**	09/22/2022

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	The record for Resident B was reviewed on 9/19/22 at 11:32 a.m. Diagnoses included, but were not limited to, acute and chronic respiratory failure with hypoxia, hypothyroidism, type 2 diabetes, Morbid (severe) obesity, chronic kidney disease and chronic obstructive pulmonary disease. Resident B's physician's orders, with a start date of 2/21/22, indicated the resident was a full code and to initiate CPR. A Quarterly Minimum Data Set (MDS) assessment, dated 7/8/22, indicated the resident's cognition was moderately impaired. A progress note, dated 9/6/22 at 7:45 a.m., indicated Resident B had expired. His family member wanted to see the resident before the funeral home came to pick him up. A progress note, dated 9/6/22 at 8:25 a.m., indicated the funeral home arrived to pick up the resident. The last progress note, prior to 9/6/22, was on 8/29/22. There were no other progress notes to address the resident's change of condition, his code status, the nurse's assessment of the resident, or pertaining to initiated CPR. A care plan, dated 02/18/2022, indicated Resident B had a CPR code status. The goals indicated the resident would be cared for with respect and dignity and will be comfortable during the end-of-life process and the resident's code status would be honored. The resident requested to be full code. (CPR to be performed if required) A facility "Investigation Planning Tool," dated 9/6/22 at 7:08 a.m., indicated staff notified RN 1 a		**Condition with emphasis on initiating CPR as soon as a code status is identified as a "Full Code", "CPR", "Attempt Resuscitation".4) The DON/Designee will conduct code status and change in condition audits daily for any new admission or change of condition utilizing the 24-hour report during clinical AM meeting, any concerns will be reported to NP/MD this is an on-going practice. Facility will continue to conduct code blue drills x1 per shift weekly for 4 weeks, then 1x weekly for 8 weeks, then 1x monthly for 3 months to ensure the policy and protocols were followed per facility guidelines. The DON/Designee will complete interviews of random nursing staff 5 times per week for 4 weeks, then 3 times per week for 8 weeks, then 1 per week for 3 months to ensure staff are escalating if nurse is not responsive. The DON will report to the QAPI Committee monthly findings from the audits. This process will be monitored by the Director of Nursing Services, Administrator, and Medical Director. The QAPI committee will determine when 100% compliance is achieved and if further monitoring is required5) date certain 9/6/2022**	

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	resident, who was a full code, had a change in condition. RN 1 determined respirations had ceased and notified the family the resident was deceased. On 9/6/22, at 7:08 a.m., the Activities Director reported, to the Executive Director, Resident B had passed away and CPR had not been initiated. A "Witness Statement" from RN 1, dated 9/6/22, indicated QMA (Qualified Medication Aide) 3 came to his unit at 2:00 a.m., and asked him to come check on Resident B because he was throwing up. RN 1 could not leave his unit at that time. RN 1 indicated around 5:00 a.m., QMA 2 came to his unit and told him Resident B had passed away. He checked the chart, saw the resident was a full code so he notified the family he did not do compressions. A "Witness Statement" from QMA 2, dated 9/6/22, indicated around midnight to 1:00 a.m., it was reported to her Resident B was throwing up. She sent QMA 3 to go get RN 1, but he did not come. QMA 2 called down the unit RN 1 was on but there was no answer. She texted CNA (Certified Nurse Aide) 4 and CNA 5 and requested them to send RN 1 to her unit. Around 5:00 a.m., QMA 3 and CNA 6 reported to her Resident B was not responding or moving. She went to get RN 1, who returned to the unit with her, and he indicated there was no point in attempting CPR as the resident was already dead. A "Witness Statement" from QMA 3, dated 9/6/22, indicated Resident B started calling out around 2:00 a.m., she went to his room, and he was vomiting up dark emesis. She notified QMA 2 and then went to locate RN 1. She seen RN 1 in the hallway and attempted to wave him down. He continued to walk away from her, so she walked			

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	all the way to his unit. She asked RN 1 to come to her unit to check Resident B. RN 1 indicated this was normal for Resident B and he would come when he had time. He never came. QMA 2 tried to call RN 1's unit, and no one answered. She watched QMA 2 text the CNAs on RN 1's unit and they replied they were not near RN 1 at that time. QMA 3 indicated around 4:00 a.m., her and CNA 6 completed bed checks and found Resident B not moving or answering his name. His skin was colorless, and he had no pulse when she checked his wrist. He was not warm. She told QMA 2, who went and got RN 1. When RN 1 arrived, he indicated the resident had already passed and there was nothing he could do. A "Witness Statement" from CNA 4, dated 9/6/22, indicated she saw a text message from QMA 2 requesting to send RN 1 to her unit, but she did not see the message until QMA 2 came to her unit maybe 15 to 30 minutes later to inform RN 1 the resident had passed away. A "Witness Statement" from CNA 6, dated 9/6/22, indicated during her rounds, Resident B had vomited on himself, and she cleaned him up. Around 2:00 a.m., the resident was calling out from his room saying he was going to get sick. QMA 3 went to the resident's room and took him a basin. She went on break and when she returned QMA 3 was attempting to get RN 1 to come to their unit. When he did not come, QMA 2 attempted to call his unit, but no one answered. She went into Resident B's room at 3:45 a.m., and he was calm in his bed. She went back to his room around 4:30 a.m., with QMA 3, to complete bed checks and the resident was not responding and was not warm. She told QMA 2, who went to get RN 1. Ten to fifteen minutes later, RN 1 arrived at the unit, went to the resident's doorway. He did			

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	not attempt to get vitals and indicated the resident was already gone and there was nothing he could do. During an interview, on 9/19/22 at 10:10 a.m., the Regional Nurse Consultant (RNC) indicated RN 1 was terminated for failure to provide CPR and failure to notify a physician prior to the resident's death about a change in condition and his death. Resident B passed away, sometime between 4:30 a.m. and 5:00 a.m., but she was not sure of the exact time. There was one licensed nurse in the building at the time. He was working on another unit and a QMA 2 was working the unit Resident B was located on. The resident had a change of condition around 2:00 a.m., which included diarrhea, abdominal pain, and emesis. QMA 2 notified RN 1 of the resident's condition and asked him to assess the resident. There were two CNAs working with RN 1 on his unit. RN 1 indicated both CNAs were on break, and he could not leave his unit at the time. RN 1 indicated he forgot to go assess the resident when the CNAs returned. The RNC indicated QMA 2 indicated to her, she had notified RN 1 numerous times about the resident's condition and during one of the last times RN 1 responded with "not my patient, not my problem." The other CNAs and QMAs in the building did not notify the Director of Nursing (DON) or call 911 to get help for the resident. The resident was a full code. QMA 2 indicated to the RNC, after she notified RN 1, Resident B was not breathing, RN 1 stood at the resident's door and indicated the resident "looked dead." He did not go into the resident's room or check for a heartbeat. An attempt was made to call RN 1, on 9/19/22 at 1:05 p.m. and 8:58 p.m., with no answer. A voicemail message was left to return the call. No			

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	call was returned. During an interview, on 9/19/22 at 2:05 p.m., QMA 7 indicated when she arrived at the facility for her shift, on 9/6/22, QMA 2 told her Resident B had passed away. QMA 2 told her, Resident B had been vomiting since about 2:00 a.m. to 2:30 a.m. QMA 2 indicated the resident had asked to go to the hospital. When she asked QMA 2, why she did not send him to the hospital, QMA 2 indicated she did not know why she did not send him. QMA 7 arrived to work at 5:55 a.m., and RN 1 brought her the burial paperwork for the funeral home. During a phone interview, on 9/19/22 at 9:04 p.m., QMA 3 indicated, on the night of 9/5/22 into the morning of 9/6/22, Resident B was not assigned to her, but she and CNA 6 worked together to complete their two-person bed checks. Somewhere between 2:00 a.m. and 2:45 a.m., she heard the resident calling out in a confused manner. CNA 6 had told her the resident had just vomited and RN 1 (who had been the only licensed nurse in the facility since 6:00 p.m.) had been told earlier he was throwing up. When she went into the resident's room to check on him, she observed he had been vomiting what looked like dark red blood. She went to get CNA 6 to assist her with cleaning him up. She also notified QMA 2, and she came into the room to look at him, but she did not take a set of vital signs. QMA 2 observed the vomit. At that time, Resident B indicated he wanted to go to the hospital "to get some help." QMA 2 asked her to go tell RN 1 to come look at Resident B, as she had tried to call his unit to inform him of the resident's condition and no one was answering the phone. Sometime between 2:45 a.m. and 3:10 a.m., she went and informed RN 1,			

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	Resident B was throwing up what looked like dark blood, and he was requesting to go to the hospital to get some help. RN 1 indicated he would be down there. She called QMA 2 to let her know RN 1 would be down to check the resident, then she was going on break. When she came back from break, she started completing her bed checks. She told CNA 6 they needed to do Resident B's bed check, since he was the last resident to do a bed check on. To her knowledge, no staff member had gone back into the resident's room to check on him after she and CNA 6 cleaned him up earlier between 2:00 a.m. to 2:45 a.m. At approximately 4:30 a.m., she and CNA 6 went into the resident's room to do his bed check and they observed the resident had passed away. He was not breathing and when she felt for a pulse on his wrist, there was none. She did not remember his skin being cool or cold when she touched his wrist. He had his basin with a medium amount of dark blood in it and in his mouth had pure blood with blood clots with blood coming out the side of his mouth. During a phone interview, on 9/19/22 at 11:29 p.m., CNA 6 indicated on 9/6/22 she was the CNA assigned to care for Resident B. Earlier in the shift, approximately between 7:00 p.m. to 8:00 p.m., the resident was throwing up dark colored emesis with undigested food particles and she cleaned him up. She notified QMA 9 the resident vomited at that time. QMA 9 told her she had informed RN 1 about the resident vomiting. Sometime between 1:30 a.m. and 2:00 a.m., the resident was calling out he was going to get sick, so QMA 3 went into his room and gave him a basin. CNA 6 went to break and when she returned QMA 3 was talking to RN 1 about the resident's change in condition and asked him to come check on the resident. Around 4:30 a.m., she and QMA 3 went to Resident B's room to do his bed check and they observed he			

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	had passed away. He was not breathing. He did not respond to his name. He was not warm to the touch when she touched him. He had what looked like blood coming out the side of his mouth with a medium amount of blood inside his mouth with blood clots. They notified QMA 2, the resident had passed away and she went and got RN 1. When he came to the room, he stood at the door and did not say one word. During a phone interview, on 9/19/22 at 11:55 p.m., QMA 2 indicated she worked on Resident B's Hall on 9/5/22 at 10:00 p.m. to 9/6/22 at 6:00 a.m. CNA 6 mentioned to her Resident B had vomited on the second shift and QMA 9 had told RN 1 about him vomiting. The resident vomited dark colored emesis, between 12:00 a.m. to 1:00 a.m., and he did not look good at that time. He was responsive, able to talk and did not complain of any pain. He asked to go to the hospital at that time. Between 2:00 a.m. and 2:45 a.m., CNA 6 and QMA 3 did a bed check on him and he had thrown up the dark colored emesis again. He requested to go to the hospital "to get some help." She attempted to call RN 1, but no one answered the phone. She asked QMA 3 to go tell RN 1 about the change in condition with the resident and he needed to come to check the resident. She called RN 1's unit a few times and even texted both the aides on his unit to ask them to tell RN 1 to come see Resident B, but no one responded to her texts, or answered the phone. At approximately 4:30 a.m., they found Resident B had passed away. She went and got RN 1 and told him the resident had passed away. RN 1 only looked into Resident B's room; he did not enter the room. She told RN 1 the resident was a full code and he mumbled something she could not understand. He then called the family to notify them he was deceased.			

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	During an interview, on 9/20/22 at 2:55 p.m., the ED (Executive Director) indicated she was not made aware of Resident B's death until the Activities Director called her on 9/6/22 at 7:08 a.m. The facility staff on duty during the night shift, on 9/6/22, did not notify her or the DON (Director of Nursing) of Resident B's change of condition; RN 1's lack of providing the care to the resident; 911 not being called for the resident to be sent out to the hospital, when he asked to go to the hospital; or of the resident's death. During an interview, on 9/20/22 at 4:22 p.m., QMA 9 indicated the resident had not had any problems with emesis or complaints of abdominal pain on her shift until 9:30 p.m. At that time, the resident's wound to his backside was bleeding and his dressing needed changed. He had a small amount of clear colored emesis and he complained of his stomach hurting. He had a bowel movement which was loose. She informed RN 1 of the situation with the vomiting, bowel movement and the complaints of abdominal pain. She had asked him to come down to the resident's room to look at him and to change his dressing for her. Since she was a QMA, she was not allowed to change those types of dressings. He told her "No, he did not have time to change the dressing." She asked him again to come change the resident's dressing due to the amount of bleeding and the resident was not feeling good and he told her "No." She placed an extra-large brief under the residents bottom due to the dressing was bloody and needed to be changed. She passed the information regarding the dressing, the emesis, and the complaints of his stomach hurting onto the next QMA. During an interview, on 9/20/22 at 5:17 p.m., the Activities Director indicated she was informed by two of the day shift CNAs, of the resident's			

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	passing after she entered the facility on 9/6/22 at 7:00 a.m. She wanted to make sure the ED had been notified so she called her and informed her of the resident's passing. The ED had not been called and informed of the resident's death until the Activities Director called her. A current facility policy, titled "Initiate CPR," dated effective 5/19/2016 and received from the Regional Nursing Consultant on 9/19/22 at 11:28 a.m., indicated "...Code Status: the recorded, expressed wishes of the resident/patient indicating procedures to be performed or not performed in the event of cardiac or respiratory activities cease. Every resident has a code status-if not indicated otherwise, a full code will be performed in the event of respiratory/cardiac cessation. CPR: Cardio-Pulmonary Resuscitation includes external heart massage using chest compressions and clearing of the airway including oxygen delivery in an effort to restore or maintain cardiopulmonary function until a higher level of care is accessed...It is the policy of this facility to promote resident centered care by respecting resident's right to formulate an advanced directive including to initiate CPR by trained staff if requested and indicated following The American Heart Association Guidelines (AHA)...2) The facility will maintain and train staff on a communication method that will quickly alert staff as to the code status of a resident in the event heart or respirations cease. 3) Residents found unresponsive, not breathing or without a pulse, will have staff immediately locate the Code Status and communicate this to the team. 4) If CPR is indicated, staff will begin CPR and call 9-1-1...." A current facility policy, titled "Death Pronouncement," dated as revised on 5/23/2018 and received from the Regional Nursing			

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	Consultant on 9/19/22 at 11:28 a.m., indicated "...Nurses within the facility may report signs and symptoms to the physician but it is not within the scope of practice for a nurse to pronounce death or sign documents that note death has occurred. The nurse will report absence of vital signs and provide other clinical findings...A Nurse may accept telephone pronouncement of death from a qualified physician after reporting assessment of absence of blood pressure, absence of breathing, and absence of heartbeat as evidenced by absence of an apical pulse...Documentation Requirements: a. The cessation of respiration and heartbeat must be assessed by the nurse and fully documented in the medical record. b. Documentation will reflect that physician/other pronounced the resident deceased. c. After the physician makes pronouncement of death, obtain an order to release the body. d. Make notifications to family, resident representative and coroner, as applicable. i. A licensed nurse may accept telephone order from the physician to release the body to the funeral home...." A current facility policy, titled "Physician-Order-for-Scope-of-Treatment," dated effective 05/01/2018 and received from the Regional Nursing Consultant on 9/19/22 at 11:28 a.m., indicated "...A full-code status alerts the staff that in the event that respirations cease and/or the resident does not have a pulse (pulselessness), the staff will initiate CPR including calling 9-1-1, begin chest compressions, provide oral suctioning as appropriate, implement the use of a bag-valve mask for supplying oxygen, and employ the use of an AED if available to provide a cardiac shock as indicated by the AED. Upon arrival, the emergency transport staff may provide additional interventions and facility will hand off to the emergency care team...."			

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	09/21/2022

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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	The Immediate Jeopardy that began on 9/6/22 was removed on 9/21/22 when the facility completed the following: The Regional Nursing Consultant and Director of Nursing completed education for all licensed nurses, CNAs and QMAs on general code status, MD notification, chain of command/escalation process and change of conditions, with emphasis on initiating CPR as soon as the code status would be identified as full code, CPR or attempt resuscitation. The facility completed Code Blue Drill assessments. The facility conducted audits of all resident's code status and licensed staff response to change of conditions. This Federal tag relates to Complaint IN00389653. 3.1-37(a)			