STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155819	A. BUILDING 00 B. WING	03/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WELLBROOKE OF KOKOMO	2200 SOUTH DIXON ROAD 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 Bldg. 00	This visit was for the Investigation of Complaint IN00402582. Complaint IN00402582 - Federal/state deficiencies related to the allegations are cited at F609 and F760. Survey dates: March 7 and 8, 2023 Facility number: 013153 Provider number: 155819 AIM number: 201254360 Census Bed Type: SNF/NF: 9 SNF: 37 Residential: 27 Total: 73 Census Payor Type: Medicare: 20 Medicaid: 9 Other: 17 Total: 46 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review was completed on March 21, 2023.	F 0000	The submission of this plan of correction does not indicate and admission by Wellbrooke of Kokomo 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 Wellbrooke of Kokomo. 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 0609 SS=D Bldg. 00	483.12(b)(5)(i)(A)(B)(c)(1)(4) Reporting of Alleged Violations §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Amorette Dunkle	Executive Director	03/30/2023

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	violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on interview and record review, the facility failed to ensure significant medication errors were reported to the Indiana Department of Health (IDOH) for 1 of 3 residents reviewed for reporting allegations. Finding includes: The record for Resident B was reviewed on 3/7/2023 at 2:46 p.m. Diagnoses included, but were not limited to, saddle embolus of pulmonary artery with acute cor pulmonale, acute respiratory failure with hypoxia, acute embolism, and thrombosis of unspecified deep veins of lower extremity,	F 0609	1. Resident B was affected. 2. All residents have the potential to be affected. Audit completed for all residents on anticoagulants to ensure all medication orders were accurate. Staff education completed related to significant medication errors. Education completed with the Executive Director (ED) and DHS on reportable guidelines. 3. As a measure of ongoing compliance, the ED or designee will audit charts to review	03/31/2023

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	bilateral, hypotension, and type 2 diabetes mellitus with hyperglycemia. The discharge instructions from the hospital, dated 12/22/2022, indicated the resident was to call and schedule an appointment with hematology in 2 weeks: a referral to discuss your blood clot and blood thinner. The discharge medication record from the hospital, dated 12/22/2022, indicated the resident was to receive Eliquis (a blood thinning medication used to prevent blood clots) 5 mg (milligrams) tablets, take 2 tablets (10 milligrams) twice daily for 3 days (12/22, 12/23, and 12/24/2022). The discharge medication record from the hospital, dated 12/22/2022, indicated the resident was to receive apixaban (also known as Eliquis) 5 mg tablet twice a day starting on 12/24/2022 for 30 days. The Medication Administration Record (MAR) indicated Resident B received Eliquis 5 mg on 12/22/2022 instead of 20 mg. The MAR indicated Resident B received Eliquis 5 mg on 12/23/2022 instead of 20 mg. The MAR indicated Resident B received Eliquis 10 mg on 12/24/2022 instead of 20 mg. The MAR indicated Resident B received Eliquis 10 mg on 12/25/2022, the correct dose. The MAR indicated Resident B did not receive Eliquis 10 mg on 12/26, 12/27, 12/28, 12/29, 12/30, 12/31/2022, 1/1/2023, 1/2, and 1/3.		for significant medication errors 5 times per week x4 weeks, then weekly x2 months, then monthly x3 months to ensure any findings have been reported according reporting guidelines. 4. As a quality measure, the ED or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted.	

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	Resident B was sent to the Emergency Room (ER) on 1/3/2023 with shortness of breath (SOB) and chest pain. Diagnoses from the ER indicated Acute Pulmonary Embolism (PE)/bilateral DVTs, and failed anticoagulation. The hospital note indicated the resident was admitted to the hospital PCU (progressive care unit) for close monitoring, it was unclear whether the resident had residual thromboembolism verse a new PE (pulmonary embolism). During an interview, on 3/8/2023 at 11:55 p.m., the Executive Director (ED) indicated the facility was not aware until 1/4/2023, the resident had not been receiving her Eliquis medication as per MD admission order. An investigation found the MD admission order had been transcribed incorrectly. The order transcribed discontinued the Eliquis medication on 12/25/2022. The medication error was not reported to the state because it had been a transcription error which caused the medication error. During an interview, on 3/8/2023 at 12:55 p.m., the DON indicated the facility was not aware until 1/4/2023, the resident had not been receiving her Eliquis medication as per MD admission order. An investigation found the MD admission order had been transcribed incorrectly. The order transcribed discontinued the Eliquis medication on 12/25/2022. The medication error was not reported to the state because it had been a transcription error which caused the medication error. The medications were not given on 12/23/2022 because of their unavailability. The facility pharmacy would not deliver during a snowstorm. No other pharmacies were contacted for the medications not given. This Federal tag relates to Complaint IN00402582.			

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	3.1-28(c)			
F 0760 SS=G Bldg. 00	483.45(f)(2) Residents are Free of Significant Med Errors The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. Based on interview and record review, the facility failed to ensure a resident received medications according to the hospital discharge instructions for 1 of 3 residents reviewed for significant medication error. (Resident B) Resident B was readmitted to the hospital. Findings include: The record for Resident B was reviewed on 3/7/2023 at 2:46 p.m. Diagnoses included, but were not limited to, saddle embolus of pulmonary artery with acute cor pulmonale, acute respiratory failure with hypoxia, acute embolism, and thrombosis of unspecified deep veins of lower extremity, bilateral, hypotension, and type 2 diabetes mellitus with hyperglycemia. The discharge instructions from the hospital, dated 12/22/2022, indicated the resident was to call and schedule an appointment with hematology in 2 weeks: a referral to discuss your blood clot and blood thinner. The discharge medication record from the hospital, dated 12/22/2022, indicated the resident was to receive Eliquis (a blood thinning medication used to prevent blood clots) 5 mg (milligrams) tablets, take 2 tablets (10 milligrams) twice daily for 3 days (12/22, 12/23, and 12/24/2022).	F 0760	1. Resident B was affected. 2. All residents have the potential to be affected. Audit completed for all residents on anticoagulants. Audit completed for all new admissions in last 30 days on anticoagulants to ensure correct order transcription. Licensed staff education completed related to physician orders. Education completed with the Admissions LPN. 3. As a measure of ongoing compliance, 2nd nurse will verify all admission orders. DHS or designee will complete 3rd check on admissions with anticoagulants. DHS or designee will complete audit for all residents receiving anticoagulants for 5 residents 1x/week for 4 weeks, then 5 residents every other week for 4 weeks, then 5 residents/month for 4 months. 4. As a quality measure, the ED or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan	03/31/2023

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	The discharge medication record from the hospital, dated 12/22/2022, indicated the resident was to receive apixaban (also known as Eliquis) 5 mg tablet twice a day starting on 12/24/2022 for 30 days. The Medication Administration Record (MAR) indicated Resident B received Eliquis 5 mg on 12/22/2022 instead of 20 mg. The MAR indicated Resident B received Eliquis 5 mg on 12/23/2022 instead of 20 mg. The MAR indicated Resident B received Eliquis 10 mg on 12/24/2022 instead of 20 mg. The MAR indicated Resident B received Eliquis 10 mg on 12/25/2022, the correct dose. The MAR indicated Resident B did not receive Eliquis 10 mg on 12/26, 12/27, 12/28, 12/29, 12/30, 12/31/2022, 1/1/2023, 1/2, and 1/3. The MAR indicated the following medications were not given on 12/23/2022: 1. Nexium (to treat heartburn) 40 mg capsule, give one capsule once daily (QD). 2. Rosuvastatin (to treat high cholesterol) 20 mg tablet, give 1/2 tablet QD. 3. Restasis (to treat chronic dry eyes) 0.5%, give 1 drop to the affected eye twice a day (BID). 4. Trulicity pen injector (used once weekly to improve blood sugar) 4.5 mg/0.5 ml, give 0.5 ml subcutaneous QD on Friday (12/23/2022 was a Friday). 5. Vitamin D3 (a supplement) 25 mcg/1000 units tablet, give one tablet QD. 6. Vitamin B6 (a supplement) 1.5 mg tablet, give one tablet QD. 7. Wellbutrin XL (an antidepressant) 300 mg		will be reviewed and updated as warranted.	

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	tablet, give one tablet QD. 8. Hydrochlorothiazide (to treat blood pressure and edema) 25 mg tablet, give one tablet BID (additionally this medication was not given on 12/22/2022). 9. Jardiance (used to lower blood sugar) tablet 10 mg, give one tablet QD. 10. Klor-Con (a supplement) M20 tablet, give one tablet QD. 11. Lantus Solostar U-100 Insulin pen, give 10 units subcutaneous QD. 12. Balsalazide (an anti-inflammatory) capsule 750 mg, give 3 capsules BID. 13. Cetirizine (an antihistamine) 10 mg tablet, give one tablet QD. 14. Meloxicam (a nonsteroidal anti-inflammatory) 15 mg tablet, give one tablet QD (additionally this medication was not given on 12/30, 12/31/2022, 1/1/2023, 1/2 and 1/3/2023). A nursing note, dated 12/23/2022 at 2:44 p.m., indicated medications were pulled from the EDK (emergency drug kit), 5 mg of Eliquis was given but not documented. Augmentin (an antibiotic), aspirin, and metoprolol (a blood pressure medication) were given. Resident B was sent to the Emergency Room (ER) on 1/3/2023 with shortness of breath (SOB) and chest pain. Diagnoses from the ER indicated Acute Pulmonary Embolism (PE)/bilateral DVTs, and failed anticoagulation. The hospital note indicated the resident was admitted to the hospital PCU (progressive care unit) for close monitoring, it was unclear whether the resident had residual thromboembolism verse a new PE (pulmonary embolism). During an interview, on 03/08/2023 at 1:28 p.m., the complainant indicated the resident had not			

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	been receiving her Eliquis medication from the facility which had been ordered daily. The resident told her she had not received her pink pill like she was used to getting for her blood clots. The resident also told her she had not received any medication on 12/23/2022. The complainant told the facility she had a concern regarding medication administration and asked the facility to investigate the situation. The facility told her the resident did not get some of her medications on 12/23/2022 because of the snowstorm and the facility pharmacy refused to deliver medications on 12/23/2022. The Eliquis medication had not been given to the resident since 12/25/2022. The Director of Nursing (DON) indicated there had been a transcription error which caused the resident to not get her Eliquis medication. During an interview, on 3/8/2023 at 11:55 p.m., the Executive Director (ED) indicated the facility was not aware until 1/4/2023, the resident had not been receiving her Eliquis medication as per MD admission order. An investigation found the MD admission order had been transcribed incorrectly. The order transcribed discontinued the Eliquis medication on 12/25/2022. The medication error was not reported to the state because it had been a transcription error which caused the medication error. During an interview, on 3/8/2023 at 12:55 p.m., the DON indicated the facility was not aware until 1/4/2023, the resident had not been receiving her Eliquis medication as per MD admission order. An investigation found the MD admission order had been transcribed incorrectly. The order transcribed discontinued the Eliquis medication on 12/25/2022. The medication error was not reported to the state because it had been a transcription error which caused the medication			

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	error. The medications were not given on 12/23/2022 because of their unavailability. The facility pharmacy would not deliver during a snowstorm. No other pharmacies were contacted for the medications not given. During a telephone interview, on 3/7/2023 at 2:30 p.m., Staff Member 2 indicated on 1/3/2023, the resident complained of SOB and chest pain. The nurse practitioner evaluated the resident and treated her with medication. The resident was then sent to the ER. The facility investigation, dated 1/4/2023, indicated Staff Member 3 admitted to not putting in the Eliquis orders correctly. A current policy, titled "Guidelines for Medication Orders," dated as reviewed 12/31/2022 and received from the ED on 3/8/2023 at 2:30 p.m., indicated "...4. Medication orders a. When recording medication orders specify...The type, route, dosage and frequency, strength of the medication and reason for the order...." This Federal tag relates to Complaint IN00402582. 3.1-48(c)(2)			