		T		L				
STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPI	COMPLETED	
		155819	B. WING			03/08/2023		
NAME OF E	PROVIDER OR SUPPLIE				ADDRESS, CITY, STATE, ZIP COD			
TWINE OF F	RO VIDER OR BUILDIN			2200 S	OUTH DIXON ROAD			
WELLBR	OOKE OF KOKOM	10		KOKON	MO, IN 46902			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROI	BE	COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	MATE	DATE	
F 0000								
Bldg. 00								
Diag. 00	This visit was for t	ha Investigation of Complaint	F 0/	200	The submission of this who	-4		
		he Investigation of Complaint	F 00)00	The submission of this plan			
	IN00402582.				correction does not indicate			
					admission by Wellbrooke o			
	_	2582 - Federal/state deficiencies			Kokomo that the findings a			
	1	ations are cited at F609 and			allegations contained herei	n are		
	F760.				accurate, true representation	n of		
					the quality of care provided	, and		
	Survey dates: Marc	ch 7 and 8, 2023			the living environment prov	ided to		
					the residents of Wellbrooke			
	Facility number: 01	13153			Kokomo. The facility recogn			
	Provider number: 1				its obligation to provide lega			
	AIM number: 2012				medically necessary care and			
	Allyl humber, 2012	234300			_			
	G D 1 T				services to its residents in a			
	Census Bed Type:				economic and efficient mar			
	SNF/NF: 9				The facility hereby maintair			
	SNF: 37				in substantial compliance w			
	Residential: 27				state and federal requireme	ents		
	Total: 73				governing the managemen	t of this		
					facility. It is thus submitted	as a		
	Census Payor Type	e:			matter of statute only. The			
	Medicare: 20				respectfully requests from t	-		
	Medicaid: 9				department a desk review f			
	Other: 17				substantial compliance.			
	Total: 46				Cabbianiai compilance.			
	10141. 70							
	Those deficient	meflect State Finding 14-1 in						
		reflect State Findings cited in						
	accordance with 41	10 IAC 16.2-3.1.						
	Quality review was	s completed on March 21, 2023.						
F 0609	483.12(b)(5)(i)(A)							
SS=D	Reporting of Alleg							
Bldg. 00	§483.12(c) In res	ponse to allegations of						
	, · · · ·	xploitation, or mistreatment,						
	the facility must:	•						
	112 1230, 111400							
	8483 12(c)(1) Eng	sure that all alleged						
I	§483.12(c)(1) Ensure that all alleged		1		i		1	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Amorette Dunkle Executive Director 03/30/2023

Any defiency statement 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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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA				(X3) DATE	(3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER						COMPL		
155819			B. WING 03/08/2023				2023	
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD			
WELLBR	OOKE OF KOKOM	0			OUTH DIXON ROAD 10, IN 46902			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID PROVIDER'S PLAN OF CORRECTION			(X5)		
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	violations involving							
		treatment, including						
	injuries of unknow							
		of resident property, are						
	-	tely, but not later than 2						
		egation is made, if the						
		the allegation involve abuse						
		s bodily injury, or not later e events that cause the						
		nvolve abuse and do not						
	result in serious b							
		e facility and to other						
		to the State Survey						
	•	protective services where						
		for jurisdiction in long-term						
	· ·	ccordance with State law						
	through established							
	8483 12(c)(4) Ren	oort the results of all						
	- ,,,,	ne administrator or his or						
	_	presentative and to other						
	-	ance with State law,						
		ate Survey Agency, within						
	_	the incident, and if the						
		verified appropriate						
	corrective action r							
	Based on interview	and record review, the facility	F 06	09	1. Resident B was affected.		03/31/2023	
	failed to ensure sigr	nificant medication errors were			2. All residents have the poten	itial		
	_	ana Department of Health			to be affected. Audit complete	d for		
		esidents reviewed for reporting			all residents on anticoagulants	to		
	allegations.				ensure all medication orders w	/ere		
					accurate. Staff			
	Finding includes: The record for Resident B was reviewed on 3/7/2023 at 2:46 p.m. Diagnoses included, but were				education completed related to significant medication errors.	נ		
					Education completed with the			
					Executive Director (ED) and D	HS		
	-	le embolus of pulmonary artery			on reportable guidelines.	0		
		nonale, acute respiratory failure			3. As a measure of ongoing			
	•	embolism, and thrombosis of			compliance, the ED or designe	:e		
					will audit charts to review			
	unspecified deep veins of lower extremity,							

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STATEMENT OF DEFICIENCIES X1)		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENT		IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u>			COMPLETED	
		155819	B. WING 03/08/2023			2023		
				STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF I	PROVIDER OR SUPPLIEF	R			OUTH DIXON ROAD			
WELLER	OOKE OF KOKOM	ın			MO, IN 46902			
VVLLLDI				RORON	10, 114 40302			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	ΓE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
		on, and type 2 diabetes			for significant medication error			
	mellitus with hyper	glycemia.			times per week x4 weeks, ther			
					weekly x2 months, then month	-		
		uctions from the hospital,			x3 months to ensure any findir	ngs		
	·	ndicated the resident was to			have been reported according			
	call and schedule ar				reporting guidelines.			
	<u> </u>	eks: a referral to discuss your			4. As a quality measure, the E	D		
	blood clot and bloo	d thinner.			or designee will review any			
	TEN 1' 1	10 4			findings and corrective action			
	_	ication record from the			least quarterly and ongoing un			
	_	2/2022, indicated the resident			campus achieves one hundred			
		uis (a blood thinning			percent compliance in the cam	•		
		prevent blood clots) 5 mg			Quality Assurance Performand			
		t, take 2 tablets (10 milligrams)			Improvement meetings. The p			
		ys (12/22, 12/23, and			will be reviewed and updated	as		
	12/24/2022).				warranted.			
	The discharge medi	cation record from the						
	_	2/2022, indicated the resident						
	_	aban (also known as Eliquis) 5						
	_	ay starting on 12/24/2022 for 30						
	days.	19 starting on 12/24/2022 for 50						
	days.							
	The Medication Ad	ministration Record (MAR)						
		B received Eliquis 5 mg on						
	12/22/2022 instead							
	The MAR indicated	l Resident B received Eliquis 5						
	mg on 12/23/2022 i	-						
		2						
	The MAR indicated	l Resident B received Eliquis						
		22 instead of 20 mg.						
	The MAR indicated Resident B received Eliquis							
		22, the correct dose.						
	The MAR indicated	l Resident B did not receive						
	Eliquis 10 mg on 12	2/26, 12/27, 12/28, 12/29, 12/30,						
	12/31/2022, 1/1/202	23, 1/2, and 1/3.						

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155819		(X2) MULTIPLE A. BUILDING B. WING	construction 00	COMPLE	(X3) DATE SURVEY COMPLETED 03/08/2023			
NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF KOKOMO			2200	STREET ADDRESS, CITY, STATE, ZIP COD 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		(X5) COMPLETION DATE		
TAG	Resident B was sen on 1/3/2023 with sl chest pain. Diagnos Acute Pulmonary F and failed anticoag indicated the reside PCU (progressive of it was unclear whet thromboembolism embolism). During an interview Executive Director not aware until 1/4/receiving her Eliqu admission order. A admission order has The order transcrib medication on 12/2 was not reported to a transcription error.	at to the Emergency Room (ER) mortness of breath (SOB) and sees from the ER indicated Embolism (PE)/bilateral DVTs, ulation. The hospital note ent was admitted to the hospital eare unit) for close monitoring, there the resident had residual eare a new PE (pulmonary ev., on 3/8/2023 at 11:55 p.m., the (ED) indicated the facility was (2023, the resident had not been is medication as per MD in investigation found the MD deen transcribed incorrectly. The medication error the state because it had been it which caused the medication ev., on 3/8/2023 at 12:55 p.m., the	TAG		NATE	DATE		
	1/4/2023, the reside Eliquis medication investigation found been transcribed in transcribed discont on 12/25/2022. The	facility was not aware untilent had not been receiving her as per MD admission order. An the MD admission order had correctly. The order inued the Eliquis medication emedication error was not						
	transcription error verror. The medicati 12/23/2022 because facility pharmacy versnowstorm. No oth for the medications							
	This rederal tag rel	ates to Complaint IN00402582.						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155819		(X2) MULTIPI A. BUILDIN B. WING	le construction ig <u>00</u>	(X3) DATE SURVEY COMPLETED 03/08/2023				
NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF KOKOMO			STREET ADDRESS, CITY, STATE, ZIP COD 2200 SOUTH DIXON ROAD KOKOMO, IN 46902					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFI TAC	CROSS-REFERENCED TO THE A	HOULD BE COMPLETION	ON		
F 0760 SS=G Bldg. 00	3.1-28(c) 483.45(f)(2) Residents are Free The facility must be §483.45(f)(2) Resisignificant medical Based on interview failed to ensure a reaccording to the host for 1 of 3 residents medication error. (For readmitted to the host for 1 of 3 residents medication error. (For readmitted to the host findings include: The record for Resising 3/7/2023 at 2:46 p.r. not limited to, saddly with acute cor pulm with hypoxia, acute unspecified deep verbilateral, hypotensism mellitus with hyper The discharge instrudated 12/22/2022, in call and schedule are hematology in 2 we blood clot and blood. The discharge medical hospital, dated 12/2/2/2021.	e of Significant Med Errors ensure that its- idents are free of any tion errors. and record review, the facility sident received medications spital discharge instructions reviewed for significant desident B) Resident B was espital. dent B was reviewed on n. Diagnoses included, but were the embolus of pulmonary artery tionale, acute respiratory failure embolism, and thrombosis of ins of lower extremity, on, and type 2 diabetes glycemia. detions from the hospital, indicated the resident was to in appointment with eks: a referral to discuss your	F 0760		ected. ne potential completed for agulants. new days on are correct gensed staff elated to cation missions going e will verify DHS or a 3rd check or designee all residents ats for 5 4 weeks, other week months. The entry of the	023		
	(milligrams) tablets	prevent blood clots) 5 mg , take 2 tablets (10 milligrams) ys (12/22, 12/23, and		least quarterly and ong campus achieves one percent compliance in Quality Assurance Per Improvement meetings	hundred the campus formance			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155819		(X2) MULTIPLE C A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 03/08/2023					
	PROVIDER OR SUPPLIER		2200 \$	STREET ADDRESS, CITY, STATE, ZIP COD 2200 SOUTH DIXON ROAD KOKOMO, IN 46902					
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODE DEFICIENCY)	D BE COMPLETION DATE				
	hospital, dated 12/2 was to receive apix	cation record from the (2/2022, indicated the resident aban (also known as Eliquis) 5 ay starting on 12/24/2022 for 30		will be reviewed and upda warranted.	ted as				
		ministration Record (MAR) B received Eliquis 5 mg on of 20 mg.							
	The MAR indicated mg on 12/23/2022 i	I Resident B received Eliquis 5 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.								
		1 Resident B did not receive 2/26, 12/27, 12/28, 12/29, 12/30, 23, 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.								
	drop to the affected 4. Trulicity pen inje improve blood suga	chronic dry eyes) 0.5%, give 1 eye twice a day (BID). ector (used once weekly to ar) 4.5 mg/0.5 ml, give 0.5 ml in Friday (12/23/2022 was a							
	Friday). 5. Vitamin D3 (a su tablet, give one tablet)	applement) 25 mcg/1000 units let QD.							
	one tablet QD.	an antidepressant) 300 mg							

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155819		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	COM	(X3) DATE SURVEY COMPLETED 03/08/2023			
NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF KOKOMO		2200 S	STREET ADDRESS, CITY, STATE, ZIP COD 2200 SOUTH DIXON ROAD KOKOMO, IN 46902					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE / DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE		
	and edema) 25 mg to (additionally this model to the processive of	gide (to treat blood pressure tablet, give one tablet BID edication was not given on to lower blood sugar) tablet 10 QD. Oplement) M20 tablet, give one U-100 Insulin pen, give 10 QD. anti-inflammatory) capsule 750 a BID. Intihistamine) 10 mg tablet, give consteroidal anti-inflammatory) one tablet QD (additionally this given on 12/30, 12/31/2022, //3/2023). Intihistamine of the EDK and the EDK to th						

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155819		A. BUILDING B. WING	00	COMPLETED 03/08/2023				
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 2200 SOUTH DIXON ROAD KOKOMO, IN 46902					
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
	facility which had be resident told her she like she was used to The resident also to any medication on I told the facility she medication adminision investigate the situal resident did not get 12/23/2022 because facility pharmacy reson 12/23/2022. The been given to the redirector of Nursing been a transcription resident to not get here. During an interview Executive Director not aware until 1/4/2 receiving her Eliqui admission order. An admission order had the order transcribe medication on 12/25 was not reported to a transcription error error. During an interview DON indicated the 1/4/2023, the reside Eliquis medication of investigation found been transcribed discontion 12/25/2022. The reported to the state	Eliquis medication from the een ordered daily. The had not received her pink pill getting for her blood clots. Id her she had not received 2/23/2022. The complainant had a concern regarding tration and asked the facility to tion. The facility told her the some of her medications on of the snowstorm and the fused to deliver medications Eliquis medication had not sident since 12/25/2022. The (DON) indicated there had error which caused the er Eliquis medication. 1, on 3/8/2023 at 11:55 p.m., the (ED) indicated the facility was 2023, the resident had not been s medication as per MD investigation found the MD I been transcribed incorrectly. It is discontinued the Eliquis 5/2022. The medication error the state because it had been which caused the medication 1, on 3/8/2023 at 12:55 p.m., the facility was not aware until not had not been receiving her as per MD admission order. An the MD admission order had correctly. The order nued the Eliquis medication medication error was not because it had been a which caused the medication						

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/19/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER			a. building <u>00</u>			COMPLETED	
155819			B. WING 03/08/2023				
NAME OF P	PROVIDER OR SUPPLIER	<u> </u>			ADDRESS, CITY, STATE, ZIP COD		
WELLBR	OOKE OF KOKOM	0			OUTH DIXON ROAD 10, IN 46902		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID PROVIDER'S PLAN OF CORRECTION				(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL	PREFIX		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		ons were not given on					
		of their unavailability. The vould not deliver during a					
		er pharmacies were contacted					
	for the medications	-					
		5					
	During a telephone	interview, on 3/7/2023 at 2:30					
	-	2 indicated on 1/3/2023, the					
	-	l of SOB and chest pain. The					
		valuated the resident and					
		dication. The resident was then					
	sent to the ER.						
	The facility investig	gation, dated 1/4/2023,					
		nber 3 admitted to not putting					
	in the Eliquis orders						
	-	•					
		led "Guidelines for Medication					
	· ·	viewed 12/31/2022 and					
		D on 3/8/2023 at 2:30 p.m.,					
		ication orders a. When					
	recording medication orders specifyThe type, route, dosage and frequency, strength of the						
	medication and reas	son for the order"					
	This Federal tag rel	ates to Complaint IN00402582.					
	3.1-48(c)(2)						

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