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	02/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WELLBROOKE OF KOKOMO	2200 SOUTH DIXON ROAD KOKOMO, IN 46902

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit also included a Residential Licensure Survey. Survey dates: February 8, 9, 12, 13, and 14, 2024 Facility number: 013153 Provider number: 155819 AIM number: 201254360 Census Bed Type: SNF/NF: 10 SNF: 46 Residential: 29 Total: 85 Census Payor Type: Medicare: 26 Medicaid: 10 Other: 20 Total: 56 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on February 27, 2024.	F 0000	The submission of this plan of correction does not indicate an 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 0554 SS=D Bldg. 00	483.10(c)(7) Resident Self-Admin Meds-Clinically Approp §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. Based on observation, interview and record review, the facility failed to ensure a resident had a self medication administration assessment and	F 0554	1. Resident 159 was affected. No adverse effects noted. Self-Administration observation	03/08/2024

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

Amorette Dunkle | Executive Director | 03/08/2024

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	an order for the resident to keep the medication at the bedside prior to leaving eye drops in the room for the resident to self administer for 1 of 1 residents observed for medication administration. (Resident 159) Findings include: During an observation, on 2/8/24 3:35 p.m., Resident 159 had four bottles of eye drops without pharmacy labels on the resident's over bed table. The clinical record for Resident 159 reviewed on 2/12/24 at 3:35 p.m. The diagnoses included, but were not limited to, diabetes mellitus, depression, anxiety disorder and urinary retention. During an interview, on 2/8/24 at 3:35 p.m., Resident 159 indicated the eye drops on the table belonged to him. The resident gave his own eye drops. A physician's order, dated 1/17/24, indicated brimonidine(for glaucoma) drops 0.2 % to give 1 drop in both eyes twice a day. A physician's order, dated 1/17/24, indicated lananoprost 0.005% (for glaucoma) to give 1 drop in the left eye at bedtime. There were no physician orders for the dorozamide hcl 2% (for glaucoma) ophthalmic solution and the systane complete PF propylene glycol (to relieve dry, irritated eyes). During an interview, on 2/08/24 at 3:35 p.m., the Qualified Medical Assistant(QMA) 6 indicated residents need an order to give their own medication. Resident 159's bottles of eye drops		completed immediately upon finding. Resident was provided with a lock box to safely store medications at bedside. 2. All residents that self-administer their medications have the potential to be affected. All resident rooms rounded on to ensure that no medications are left at bedside without a lock box. All nurses will be educated on medication self-administration observation completion and medication storage by 3/5/24. All residents requesting to self-administer medications will be reviewed for completion of the self-administration observation by 3/5/24. Residents that self-administer medications will be provided with a lock box to safely store medications as warranted by 3/5/24. 3. As a measure of ongoing compliance, the Director of Health Services (DHS) or designee will audit self-administration observations for completion and medication storage during rounding to ensure that observation is completed and medications are stored according to policy. Audit to consist of five residents, weekly x4 weeks, then twice monthly x2 months, then monthly x3 months during rounding for appropriate medication administration. 4. As a quality measure, the ED or designee will review any	

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	should not be left in his room on the table. During an interview, on 2/08/24 at 3:45 p.m., the Director of Health Services (DHS) indicated residents need a physician's order to give their on medication. The bottles of eye drop should not be left in the room. The resident does not have an order to keep the medication at the bedside or a self medication administration assessment completed. A current policy, titled, "Guidelines for Self-Administration of Medications," dated 12/31/23, received from clinical support, on 2/12/24 at 4:06 p.m., indicated "...residents requesting self-medicate or has self-medication as a part of their plan of care shall be assessed using the observation -Self Administration of Medication within the electronic health record. Results of the assessment will be presented to the physician for evaluation and an order for self-medication...The order should include the type of medication(s) the resident is able to self-medicate...all medications including injection, oral, inhalers, drops...The medication will be kept in a locked drawer in the residents' room. The resident will maintain the key, as well as, a key will be maintained by the licensed nurse and or QMA...A Self-Medication plan of care will be initiated and updated as indicated...The assessment will be documented in the EHR...." 3.1-11(a)		findings and corrective actions at least quarterly in the campus Quality Assurance Performance Improvement meetings for six months or longer if 100% compliance is not achieved. The plan will be revised as warranted.	
F 0636 SS=D Bldg. 00	483.20(b)(1)(2)(i)(iii) Comprehensive Assessments & Timing §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of			

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	each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the			

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	timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. Based on observation, interview, and record review, the facility failed to observe and evaluate for appropriate and safe use of fall prevention interventions for 1 of 4 residents reviewed for accidents (Resident 48). Finding includes: During an observation, on 2/8/24 at 2:50 p.m., the resident's bed was in the lowest position with mats on both sides of the bed. The resident was noted to walk from the bed to the chair independently. The clinical record for Resident 48 was reviewed on 02/09/24 03:59 p.m. The diagnoses included, but were not limited to, dementia, sequelae of cerebral infarction, depression, and anxiety. A physician's order, dated 1/5/24, indicated the bed was to be in the lowest position. A physician's order, dated 1/5/24, indicated to place a mat at bedside.	F 0636	1. Resident 48 was affected. No adverse effects noted. Resident 48 discharged from facility same day. 2. All residents with fall interventions in place have the potential to be affected. All nurses will be educated on fall interventions and device consent observation completion. Full census audit of fall interventions to be completed to ensure intervention is appropriate and consent for devices are completed by 3/5/24. 3. As a measure of ongoing compliance, the Assistant Director of Health Services (ADHS) or designee will conduct an audit of 3 residents to ensure device assessment and consent are complete weekly x 4 weeks, then twice per month x2 months, then monthly x3 months. 4. As a quality measure, the ED	03/08/2024

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	A care plan, dated 1/8/24, indicated resident wandered without purpose. A care plan, dated 1/8/24, indicated there was a profile care guide to communicate resident care needs. The interventions included, but were not limited to, bed in low position with mat when occupied, wander guard to right ankle, and dycem (a non-slip material) to the wheelchair. A care plan, dated 1/8/24, indicated the resident was a risk for falls related to decreased mobility, dementia with behavioral disturbances, auditory and visual hallucinations, coronary artery disease, cerebral vascular accident, anemia, hypertension, delirium, psychosis, anxiety, depression, seizures, and convulsion. The interventions included, but were not limited to, bed in low position with mat when occupied, and ensure the floor was free of liquids and foreign objects. An alarm and restrictive device evaluation, dated 2/8/24 at 6:10 p.m., indicated the type of alarm or restrictive device evaluation was for a bed in low position. The resident needed an alarm or restrictive device to identify patterns or routines. An alarm or device informed consent, dated 2/8/24 at 6:12 p.m., indicated the consent was for a bed in low position with a mat at bedside. The benefits for implementing alarm and or device was functional ability, including strength and balance. The risks for implementing the device were accidental hazards, barrier to residents from safety getting out of bed and/or chair, physical restraint, other potential physical outcomes, and other potential negative psychosocial outcomes. The alarm and/or device was being used as an enabler. Verbal consent was obtained from the daughter.		or designee will review any findings and corrective actions at least quarterly in the campus Quality Assurance Performance Improvement meetings for six months or longer if 100% compliance is not achieved. The plan will be revised as warranted.	

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	During an interview, dated 02/12/24 4:34 p.m., clinical support indicated the family had requested the bed with low mat at admission on 1/5/24. The staff performed a device sweep on 2/8/24 and had completed consents and assessments not done prior to the 2/8/24. A current policy titled, "Guidelines for Restraint/Enabler Use," received from clinical support, on 2/13/23 at 2:30 p.m., indicated " ...the purpose of the policy is to ensure completion of observation and evaluation for appropriate and safe use of restraints/enablers for each resident ...each resident shall have an individualized nursing observation upon admission, quarterly and prn (as needed) that shall address the need for a safety device, medical symptom for use of the device and identification of whether the device restricts movement or limits the resident from doing something they could previously do ...the interdisciplinary team shall evaluate all factors leading to consideration of a device, determine that resident needs are being met and the need to restrain is not the result of an unmet need, investigate alternatives to restraints and determine that all alternative measures have been exhausted and found to be unsuccessful, weigh the risk and benefits of restraint/enabler use, develop measures to minimize the risks and resident decline, make decisions that the device is the most appropriate for the situation ...assess the resident to determine functional status ...consideration should be taken to determine what the level of function is ...." 3.1-31(a) 3.1-31(d)			

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F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on observation, interview, and record review the facility failed to ensure a resident's facial hair was shaved for 1 of 2 residents reviewed for activities of daily living (Resident 11) and failed to provide denture care for 1 of 2 residents reviewed for activities of daily living (Resident 108). Findings include: 1. During an observation on 2/9/24 at 11:11 a.m., Resident 11 was sitting in her chair in her room. She had facial hair, approximately 1/2 inch long, on her chin. The clinical record for Resident 11 was reviewed on 02/12/24 at 09:45 a.m. The diagnoses included, but were not limited to, hypertensive congestive heart failure, supraventricular tachycardia (rapid heart rate), paroxysmal a fib (irregular heartbeat), pulmonary fibrosis, spondylolistheses cervical region (displacement of vertebra), disc degeneration lumbar, delirium due to known physiological condition, repeated falls, and chronic pain syndrome. A Minimum Data Set (MDS) assessment, dated 12/22/23, indicated the resident required partial and/or moderate assistance with upper body performance. A care plan, dated 12/21/23, indicated the resident had a potential for decline in functional status	F 0677	1. Residents 11 and 108 were affected. No adverse effects noted. Resident 11 discharged from facility same day. Care profile for resident 108 was immediately updated to include partial denture and oral care was provided. No adverse effects noted for either resident. 2. All residents have the potential to be affected. Full census audit completed of resident with dentures to ensure profiles include dentures as indicated. All residents have been reviewed for the need for facial hair removal and oral care. All nursing staff to be educated on facial hair removal and oral care by 3/5/24. 3. As a measure of ongoing compliance, the DHS or designee will complete rounding to ensure facial hair removal and oral care is completed on 5 residents weekly for 4 weeks, then twice per month for 2 months, then monthly for 3 months. The Minimum Data Set Coordinator (MDSC) will audit resident records to ensure that dentures are included on the profile for 5 residents weekly x4 weeks, then every other week x2 months, then monthly x3 months.	03/08/2024

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	related to decrease mobility, weakness, and falls. The goal was to be free of complications of functional decline. The interventions include, but were not limited to, offering facial shaving on shower days, as needed (PRN) or as requested and notify nursing of refusals. A review of shower sheets (forms that indicated what type of shower/bath and skin assessment on scheduled shower days), dated 12/22/23 to 2/13/24, did not include shaving had occurred or refused. There was no documentation by the nurse or certified resident care aide of refusals to be shaved. A care profile located on the electronic health record did not include shaving the resident. There were no progress notes the resident had refused to be shaved.2. During an observation on 2/8/24 at 2:49 p.m., Resident 108 was leaning back in a recliner in the common area close to the nurse's station, his mouth was wide open, and it appeared he was missing some teeth on the top and the bottom of his mouth. The clinical record for Resident 108 was reviewed on 2/12/24 at 9:30 a.m. The diagnoses included, but were not limited to, multiple fractures of the ribs on the left side, laceration of the spleen, fall, cerebral ischemia, depression, and type 2 diabetes mellitus. A care plan, dated 1/23/24, indicated the resident required staff assistance to complete self-care and mobility tasks completed and safely. The approaches included, but were not limited to, offer facial shaving on shower days and provide nail care on shower days.		4. As a quality measure, the ED or designee will review any findings and corrective actions at least quarterly in the campus Quality Assurance Performance Improvement meetings for six months or longer if 100% compliance is not achieved. The plan will be revised as warranted.	

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	The care plan did not include any type of mouth care or denture care. A Profile Guide, dated 1/23/24, indicated for the category of glasses, dentures, and hearing aids that the resident had glasses. The Profile Guide did not include the documentation of the resident having upper and lower partial dentures. During an interview and observation, on 2/12/24 at 2:57 p.m., Certified Nursing Assistant (CNA) 8 indicated Resident 108 did not have dentures. If the resident had dentures it would be listed in the care plan. CNA 8 went to the resident's room and observed Resident 108 had a partial denture on the top and the bottom. The resident did not have a denture cup in the room. CNA 8 indicated the resident must not take the partial dentures out of his mouth. During an interview, on 2/12/24 at 3:07 p.m., the Director of Health Services (DHS) indicated the CNAs would ask their nurse or look at the assignment sheet to know if a resident had dentures. The resident's assignment sheet did not include if the resident had dentures. The resident's profile guide also did not include if the resident had dentures. The profile guide should have included the dentures and who would be taking care of the dentures. During an interview, on 2/13/24 at 11:15 a.m., the Clinical Support Nurse indicated the resident's upper and lower partial dentures were not listed on the resident's profile guide. This was where the information should be located so the staff would know if they needed to care for the dentures or if the resident would care for the dentures on their			

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	own. A Caregiver New Hire Checklist, dated 3/22/23, and received from the Clinical Support Nurse on 2/13/24 at 3:45 p.m., indicated, "The Caregiver New Hire Checklist should be completed within the first...days of employment with the guidance of a Caregiver Preceptor. Upon completion, the CRCA[Certified Resident Care Aide] and DHS [Director of Health Services] will sign acknowledging these items were covered and the CRCA is prepared to serve the residents in the campus...AM CARE...Dentures...Oral care...Facial Hair[male and female]...PM CARE...Dentures...Oral Care...." 3.1-38(a)(3)(C) 3.1-38(a)(3)(D)			
F 0684 SS=G 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 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 record review and interview, the facility failed to ensure significant weight changes were identified and timely interventions were implemented for 2 of 5 residents reviewed for changes in weight (Resident 109 and 19). This deficient practice resulted in Resident 109 experiencing two events of significant weight gain which required hospitalization for fluid overload and Resident 19 experiencing significant weight	F 0684	1. Residents 109 and 19 was affected by the alleged deficient practice. Assessment of each resident was completed immediately. Weight orders were reviewed for accuracy. Notifications completed to provider with appropriate interventions in place. Residents were free of	03/08/2024

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	loss which required hospitalization for altered mental status and dehydration. Finding includes: 1. The clinical record for Resident 109 was reviewed on 2/12/24 at 4:19 p.m. The diagnoses included, but were not limited to, sepsis, acute and chronic respiratory failure, acute on chronic congestive heart failure, acute kidney failure, type 2 diabetes mellitus, and unspecified dementia. A care plan, dated 12/28/23, indicated the resident had a potential for cardiovascular distress related to a diagnosis of hypertension, congestive heart failure, anemia and coronary artery disease. The goal indicated the resident would be free from signs and symptoms of cardiovascular distress. The approaches included, but were not limited to, observe and report signs and symptoms of cardiovascular distress and to obtain vital signs as needed. A care plan, dated 12/28/23, indicated the resident had chronic kidney disease stage 4. The goal was for the resident not to exhibit signs of fluid volume excess. The approaches included but were not limited to, assess for fluid excess including weight gain, edema, shortness of breath; and to monitor the weight as ordered. A physician order, dated 12/28/23 through 1/5/24, indicated to weigh the resident daily between 6:00 a.m. and 2:00 p.m. A physician order, dated 2/2/24, indicated the diet was a consistent carbohydrate (CCHO), no added salt with regular texture and thin liquids. The resident had the following weights		adverse reactions related to alleged deficiency. Both residents have returned to the campus post hospital stay with ongoing monitoring and no significant weight changes notes. 2. All residents have the potential to be affected. All census audit completed for resident weight orders for accuracy in order placement. All residents have been reviewed for significant weight changes with immediate notifications and interventions placed if warranted. All nursing staff to be educated on obtaining and documenting resident weights by 3/5/24. All nurses educated on notifying physician of significant weight changes by 3/5/24. 3. As a measure of ongoing compliance, the DHS or designee, will complete audits of 5 resident to ensure that daily weights are documented in the Electronic Medication Administration Record (eMAR) accurately 5x weekly x4 weeks, then 3x weekly x4 weeks, then 1x weekly x4 weeks, then every other week x 4 weeks, then monthly x2 months. The DHS or designee will complete and audit for significant weight changes to ensure that notifications are completed and interventions are implemented on 3 residents, as available, weekly x4 weeks, every other week x2 months, then monthly x 3 months. 4. As a quality measure, the ED	

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	155819	A. BUILDING 00 B. WING	02/14/2024

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	documented in the vitals report: a. On 12/27/23 the weight was 228.2 pounds. b. On 12/30/23 the weight was 240.4 pounds which was a 12.2 pound significant weight gain of 5.35% in 3 days. There was only one weight documented in the EHR for 12/30/23. c. On 12/31/23 the weight was 241.8 pounds which was an additional weight gain of 1.4 pounds. This was a significant weight gain of 5.96% in 4 days. d. On 1/1/24 the weight was 242. 8 pounds which was an additional weight gain. This was a significant weight gain of 6.4% in 5 days. e. On 1/2/24 the weight was 244.4 pounds which was a total weight gain of 16.2 pounds in 6 days. This was a significant weight gain of 7.10% in 6 days. f. On 1/4/24 the weight was 245.2 pounds which was a total weight gain of 17 pounds in 7 days. This was a significant weight gain of 7.71% in 8 days. A Registered Dietitian (RD) progress note, dated 12/30/23, indicated the resident had a questionable weight gain since admission. The resident had documented excellent meal and snack intake. Daily weights were ordered. The current regimen would be continued. A progress note, dated 1/4/24 at 3:03 p.m., indicated the resident had an 18 pound weight gain since admission on 12/27/23. The weight upon admission was 228.2 pounds. The physician wrote an order on 1/3/24 to add Lasix (diuretic medication) 20 milligrams (mg) daily. The order indicated the staff should continue to monitor the resident and obtain daily weights. A progress note, dated 1/5/24 at 12:56 p.m., indicated the resident's weight was 255 pounds. The resident's weight yesterday was 245 pounds.		or designee will review any findings and corrective actions at least quarterly in the campus Quality Assurance Performance Improvement meetings for six months or longer if 100% compliance is not achieved. The plan will be revised as warranted.	

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	The resident complained of slight shortness of breath and edema was noted throughout the body. The Emergency Medical Services (EMS) was called. From the documented weights from 1/4/24 and 1/5/24, the resident had gained an additional 10.4 pounds in one day. From 12/27/23 until 1/5/24, the resident had a significant weight gain of 11.7%. A progress note, dated 1/5/24 at 6:22 p.m., indicated the resident was admitted to a local hospital for a diagnosis of fluid overload. A progress note, dated 1/17/24 at 1:13 p.m., indicated the resident was re-admitted to the facility from the hospital. The local hospital discharge report, printed 1/17/24, indicated the resident had a diagnosis of heart failure. The discharge instructions indicated to notify the physician for a weight gain of 3 pounds overnight or 5 pounds in one week. Rapid weight gain was probably a sign of fluid retention and a sign of worsening heart failure. If the resident has swelling in the legs, feet or abdomen the medical doctor should be called. A physician's order, dated 1/18/24 through 1/26/24, indicated staff should weigh Resident 109 daily to monitor signs and symptoms of congestive heart failure. The resident had the following weights on the vitals report: a. On 1/17/24 at 1:33 p.m., the re-admission weight was 217.8 pounds. b. On 1/17/24 at 8:56 p.m., the weight was 219.4 pounds. c. On 1/22/24 the weight was 231.8 pounds which			

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	was a 12.4 pound significant weight gain of 5.65% in 5 days. There were no daily weights documented in the Electronic Health Record (EHR) between 1/18/24 and 1/21/23 and no weights documented between 1/23/24 and 1/26/24. There were no interventions for the 12.4 pounds significant weight gain on 1/22/24 until 1/26/24. A late entry NP note dated 1/22/24 and entered into the EHR on 1/25/24 at 1:02 p.m.. indicated the resident was admitted to the facility on 12/27/23 following hospitalization for sepsis. She returned to the hospital on 1/5/24 for fluid overload. The resident's weight on 1/22/24, was 231.8 pounds. The assessment and plan included the resident had a history of congestive heart failure a had fluid overload which hospitalization for diuresis. The resident was to continue to have daily weights. The NP late entry note lacked documentation to include the resident's weight of 231.8 was identified as a significant weight gain of 12. 4 pounds in 5 days of 5.65%. A progress note, dated 1/26/24 at 12:39 p.m., indicated the resident had a weight gain with edema which was reported to the Nurse Practitioner (NP) and staff were awaiting orders. A progress note, dated 1/26/24 at 1:10 p.m., indicated the resident's oxygen saturations were between 83% and 88%. Oxygen at 2 Liters(L) per minute by nasal cannula was added and the oxygen saturation improved to 95%. The resident had increased edema and weight gain. Lasix (a diuretic) was given intramuscularly (IM) earlier. The NP was aware.			

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	A progress note, dated 1/26/24 at 7:52 p.m., indicated the resident reported chest pain. The oxygen saturations were 86-88% on 3L of oxygen per nasal cannula. The resident had gained 12 pounds in 5 days according to recent weights. EMS was called for transport to the emergency room for evaluation and treatment. A hospital ER exam and disposition note, dated 1/26/24, indicated the resident had a history of congestive heart failure, chronic kidney disease stage 4 and Alzheimer's. The resident was from a nursing care facility and had gained several pounds of weight with leg swelling over the last several days. The resident had been complaining of a cough and feeling more short of breath. When EMS arrived at the facility the resident's oxygen saturation was 89% on room air. The diagnoses included hypoxic respiratory failure and acute on chronic congestive heart failure. The resident would be admitted to the hospital. A progress note, dated 1/27/24 at 2:55 a.m., indicated the resident was admitted to the Intensive Care Unit with a diagnosis of congestive heart failure and acute renal failure. During an interview, on 2/14/24 at 12:16 p.m., the Clinical Support Nurse indicated there were no notifications made to the physician, NP or resident representative between 1/22/24 and 1/26/24 for the significant weight gain. There was a physician order for daily weights and no weights were documented in the EHR after 1/22/24 through 1/26/24. The NP saw the resident on 1/22/24 and did not document there was a significant weight gain. During an interview, on 2/14/24 at 2:33 p.m., the Clinical Support Nurse indicated around 1/22/24			

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	there was a lot of staff out with COVID-19 including the Certified Nursing Assistant (CNA) mentor. The CNA mentor would do the daily weights and document them in the EHR. The daily weights were completed on paper although could not be entered into the EHR since they were more than 14 days past the time. The facility only had 14 days to complete a late entry. The facility did not have a policy or protocol for CHF. It was up to the physician to decide on the orders. During an interview, on 2/15/24 at 1:40 p.m., the NP 9 indicated she was not concerned about the resident's weight since the weight prior to the first hospitalization was 255.6 pounds. She did not document the previous weight on 2/17/24 in her progress notes and should have documented it. The resident was a chronic snacker and it was not always healthy snacks. The resident gained fluid quickly. The weights reviewed were in the EHR and not documented on paper. She did not look at the weights charted on paper. She was not aware the daily weights between 1/23/24 and 1/26/24 were not documented in the EHR. She would not have changed the treatment even though the resident had been in the hospital for fluid overload. If she was quick to treat the resident, it could put the resident in worsening renal failure. 2. The clinical record for Resident 19 was reviewed on 2/13/24 at 4:04 p.m. The diagnoses included, but were not limited to, Alzheimer's disease, type 2 diabetes mellitus, major depressive disorder and anxiety disorder. A physician's order, dated 5/123 through 1/17/24, indicated to weigh the resident monthly on the first Wednesday of the month. A physician's order, dated 1/25/24, indicated the			

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	resident was to receive a consistent carbohydrate diet (CCHO) with regular texture and thin liquids. A care plan, dated 10/1/22 and last reviewed on 1/29/24, indicated the resident had a potential for an alteration in nutritional status related to her diagnoses, medications, fluid balance, intake, physical activity and metabolic demands. The goal indicated the resident would maintain her weight at a healthy range without any unwarranted significant weight changes. The approaches included, but were not limited to, assist with meals as needed, obtain weight as ordered or needed, provide the diet, supplements, medications and adaptive equipment as ordered. A care plan, dated 9/28/22 and last updated on 1/29/24, indicated the resident received diuretic medication related to hypertension. The goal was that the resident would not exhibit signs/symptoms of low potassium or dehydration. The approaches included, but were not limited to, encourage fluids throughout the day if not contraindicated, observe for dehydration including dizziness on sitting/standing, change in mental status, decreased urine output, concentrated urine, dry lips, dry mucous membranes and report symptoms of low potassium including confusion, irritability, low heart rate and anorexia. The resident had the following weights: a. On 11/15/23 the weight was 153 pounds. b. On 12/6/23 the weight was 158.3 pounds. c. On 1/3/24 the weight was not taken. d. On 1/17/24 at 8:26 p.m. the weight was 140.2 pounds. This was a loss of 18.1 pounds in 28 days which was a 11.43% significant weight loss. e. On 1/17/24 at 8:37 p.m. the weight was 140.2 pounds.			

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	A late entry progress note, dated 1/17/24 at 2:06 p.m. and entered on 1/21/24 at 10:08 a.m., indicated there was a noted rash to the right side of the resident's forehead. The medical doctor (MD) gave an order for acyclovir (an antiviral) 800 milligram (mg) 5 times a day for 7 days with a diagnosis of shingles. The resident was placed in contact isolation. A Registered Dietitian progress note, dated 1/18/24, indicated a re-weight was requested to validate the significant weight change. There was no re-weight completed between 1/18/24 and 1/23/24. The electronic health record did not include the resident's representative was notified of the significant weight loss. A progress note, dated 1/20/24 at 2:12 p.m., indicated the resident's treatment for shingles continued and the resident remained in isolation. The rash continued to the right side of the forehead and into the eye. Resident 19 had increased weakness and poor appetite. The significant weight loss of 11.43% occurred on 1/17/24 and the acyclovir was prescribed on 1/17/24. A Nurse Practitioner (NP) progress note, dated 1/22/24 at 10:19 a.m., indicated the resident had shingles over the right eye and was being treated with acyclovir. The resident denied any problems although she had significant cognitive impairment. The weight on 1/22/24 was 140.2 pounds. The assessment and plan included to continue the acyclovir until completion. The NP note did not include documentation to			

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	show the NP was aware Resident 19 had experienced a significant weight loss of 18.1 pounds which was 11.43% in 28 days. There was no documentation to include interventions to prevent further weight loss were implemented. A progress note, dated 1/23/24 at 9:18 a.m., indicated the resident was not responsive and the EMS was called. A progress note, dated 1/23/24 at 1:47 p.m., indicated the resident was admitted to the hospital with a diagnosis of dehydration and had not been eating the last 2 to 3 days. A hospital history and physical, dated 1/23/24, indicated the resident had a history of dementia. When the resident presented to the emergency room she had a urinary tract infection and acute kidney injury from dehydration and prerenal azotemia (dehydration as result of failure to ingest fluids or fluid loss from diarrhea). The assessment and plan indicated the following: a. metabolic encephalopathy (damage to the brain) and the resident would likely be back to baseline in 1 to 2 days. b. advanced dementia and in hospice condition. c. prerenal azotemia/acute kidney injury with plan to hydrate slowly. d. dehydration/cystitis(inflammation of the bladder usually caused by infection) and treat with Rocephin (an antibiotic). The resident was hospitalized from 1/23/24 through 1/25/24. During an interview, on 2/14/24 at 4:49 p.m., the Clinical Support Nurse indicated the resident's hospital history and physical indicated the resident had encephalopathy (damage to the			

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	brain), dehydration and acute kidney injury (sudden episode of kidney damage common in elderly which could be caused by severe dehydration). The resident had significant weight loss on 1/17/24 and the RD asked for a re-weight. The re-weight was not done since the resident was in isolation for shingles and did not feel well. There were no interventions implemented for the significant weight loss. Drug information from Mayo Clinic was provided by the Clinical Support Nurse on acyclovir which showed it caused dehydration. The resident had been consuming adequate intake. There was no documentation to show the resident's representative had been notified of the significant weight loss. A current policy, titled, "Guidelines for Weight Tracking", reviewed on 12/31/23 and received from the Clinical Support Nurse on 2/12/24 at 4:53 p.m., indicated, "...To ensure resident weight is monitored for weight gain and/or loss to prevent complications arising from compromised nutrition/hydration...Residents will have their weight taken and recorded upon admission to establish a baseline...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 weight should be recorded in the individual resident medical record...Residents who have a weight that seem out of normal range shall be re-weighed to determine the accuracy of the original weight...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 [unless on a planned weight loss or gain program]...Residents with a significant weight change can be added to Clinically At Risk...."			

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	A current policy, titled, " Physician-Provider Notification Guidelines", reviewed on 12/31/23 and received from the Clinical Support Nurse on 2/14/24 at 5:24 p.m., indicated, "...To ensure the resident's physician or practitioner [may include NP, PA, or clinical nurse specialist] is aware of all diagnostic testing results or change in condition in a timely manner to evaluate condition for need of provision of appropriate interventions for care...Resident assessments for change in condition, suspected injury, event of unknown origin or ordered lab and/or other diagnostic tests should be completed in a timely manner...Attempts to notify the physician/provider and their response should be documented in the resident electronic health record...." A current policy, titled, "Guidelines for Late Entry and Corrections to Medical Record", reviewed on 12/31/23 and received from the Clinical Support Nurse on 2/14/24 at 5:24 p.m., indicated, "...To provide guidelines for entering pertinent information to the medical record out of sequence...Each entry to the medical record shall include the date, time and signature of the staff member recording the data...Late entries should be an exception and not the rule...Late entries to the medical record should be completed within 14 days...." 3.1-37(a)			
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including			

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	tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on interview and record review, the facility failed to ensure there was a physician's order for the use of oxygen and failed to ensure the physician's order was followed for 1 of 1 residents reviewed for oxygen use (Resident 30). Finding includes: The clinical record for Resident 30 was reviewed on 2/14/24 at 2:00 p.m. The diagnoses included, but were not limited to, congestive heart failure(CHF), chronic kidney disease, and edema. A physician's order, dated, 12/29/23, indicated to give continuous oxygen at 3 liters(L). A Vital Signs Record, dated 12/21/23 through 1/3/24, indicated the following: a. On 12/22/23 at 6:16 p.m., the resident was on 2 liters of oxygen. b. On 12/23/23 at 4:21 p.m., the resident was on 2 liters of oxygen. c. On 12/24/23 at 3:51 a.m., the resident was on 3 liters of oxygen. d. On 12/24/23 at 11:03 a.m., the resident was on 2 liters of oxygen. e. On 12/31/23 at 9:01a.m and 4:39 p.m., the resident was on room air. f. On 1/1/24 at 1:21 a.m., 4:06 p.m., and 4:27 p.m., the resident was on room air. g. On 1/2/24 at 9:08 a.m., the resident was on room air. h. On 1/2/24 at 10:02 a.m., the resident was on 2	F 0695	1. Resident 30 was affected. Resident immediately assessed with no adverse effects noted. Resident oxygen in place per order and orders reviewed in eMAR. 2. All residents that have orders for oxygen have the potential to be affected. All nurses have been educated on following physician orders and accurate documentation of liter flow in the Electronic Health Record (EHR). A house wide audit to ensure that all residents that require oxygen have oxygen in place, accurate orders in place, and liter flow is documented appropriately will be completed by 3/5/24. 3. As a measure of ongoing compliance, the Director of Health Services (DHS), or designee, will complete audits of 3 resident to ensure oxygen orders are being followed and documented accurately in the EHR 3x weekly x4 weeks, then weekly x 4 weeks, then every other week x 4 weeks, then monthly x3 months 4. As a quality measure, the ED or designee will review any findings and corrective actions at least quarterly in the campus Quality Assurance Performance	03/08/2024

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	liters of oxygen. i. On 1/3/24 at 5:38 a.m., 5:39 p.m., and 8:29 p.m., the resident was on room air. A care plan, dated 12/22/23, indicated the resident had a potential for complications related to CHF. Interventions included, but were not limited to, giving oxygen per the physician orders. A care plan, dated 12/22/23, indicated the resident had a potential for shortness of breath while lying down. Interventions included, but were not limited to, administering oxygen per physician orders and as needed. During an interview, on 2/14/24 at 3:45 p.m., the Clinical Support Nurse verified the physician orders for oxygen administration were missing on 12/22/23 and were for 3L continuous on 12/29/23. A current policy titled, "Administration of Oxygen," revised 5/2018, received from clinical support, on 2/14/24 at 5:10 p.m., indicated "...Verify physician's order for the procedure. In cases of emergency oxygen may be administered as a nursing intervention until a physician order may be obtained ...." 3.1-47(a)(6)		Improvement meetings for six months or longer if 100% compliance is not achieved. The plan will be revised as warranted.	
F 0755 SS=D Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the			

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	155819	A. BUILDING 00 B. WING	02/14/2024

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WELLBROOKE OF KOKOMO	2200 SOUTH DIXON ROAD KOKOMO, IN 46902

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	general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.			
	Based on interview and record review, the facility failed to ensure there was a physician's order for the use of oxygen and the physician's order was followed for 1 of 1 residents reviewed for oxygen use (Resident 30). Finding includes: The clinical record for Resident 30 was reviewed on 2/14/24 at 2:00 p.m. The diagnoses included, but were not limited to, congestive heart failure(CHF), chronic kidney disease, and edema. A physician's order, dated, 12/29/23, indicated to	F 0755	1. Resident 30 was affected. Resident immediately assessed with no adverse effects noted. Resident oxygen in place per order and orders reviewed in eMAR. 2. All residents that have orders for oxygen have the potential to be affected. All nurses have been educated on following physician orders and accurate documentation of liter flow in the Electronic Health Record (EHR). A house wide audit to ensure that all	03/08/2024

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	give continuous oxygen at 3 liters(L). A Vital Signs Record, dated 12/21/23 through 1/3/24, indicated the following: a. On 12/22/23 at 6:16 p.m., the resident was on 2 liters of oxygen. b. On 12/23/23 at 4:21 p.m., the resident was on 2 liters of oxygen. c. On 12/24/23 at 3:51 a.m., the resident was on 3 liters of oxygen. d. On 12/24/23 at 11:03 a.m., the resident was on 2 liters of oxygen. e. On 12/31/23 at 9:01a.m and 4:39 p.m., the resident was on room air. f. On 1/1/24 at 1:21 a.m., 4:06 p.m., and 4:27 p.m., the resident was on room air. g. On 1/2/24 at 9:08 a.m., the resident was on room air. h. On 1/2/24 at 10:02 a.m., the resident was on 2 liters of oxygen. i. On 1/3/24 at 5:38 a.m., 5:39 p.m., and 8:29 p.m., the resident was on room air. A care plan, dated 12/22/23, indicated the resident had a potential for complications related to CHF. Interventions included, but were not limited to, giving oxygen per the physician orders. A care plan, dated 12/22/23, indicated the resident had a potential for shortness of breath while lying down. Interventions included, but were not limited to, administering oxygen per physician orders and as needed. During an interview, on 2/14/24 at 3:45 p.m., the Clinical Support Nurse verified the physician orders for oxygen administration were missing on 12/22/23 and were for 3L continuous on 12/29/23. A current policy titled, "Administration of		residents that require oxygen have oxygen in place, accurate orders in place, and liter flow is documented appropriately will be completed by 3/5/24. 3. As a measure of ongoing compliance, the Director of Health Services (DHS), or designee, will complete audits of 3 resident to ensure oxygen orders are being followed and documented accurately in the EHR 3x weekly x4 weeks, then weekly x 4 weeks, then every other week x 4 weeks, then monthly x3 months 4. As a quality measure, the ED or designee will review any findings and corrective actions at least quarterly in the campus Quality Assurance Performance Improvement meetings for six months or longer if 100% compliance is not achieved. The plan will be revised as warranted.	

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	Oxygen," revised 5/2018, received from clinical support, on 2/14/24 at 5:10 p.m., indicated "...Verify physician's order for the procedure. In cases of emergency oxygen may be administered as a nursing intervention until a physician order may be obtained ...." 3.1-47(a)(6)			
F 0758 SS=D Bldg. 00	483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order			

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	unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. Based on interview and record review, the facility failed to ensure as needed (PRN) anxiety medications were prescribed only for 14 days and reviewed for the need to continue use for 1 of 5 resident reviewed for unnecessary medications (Resident 15). Finding includes: The clinical record for Resident 15 was reviewed on 2/9/24 at 12:16 p.m. The clinical diagnoses included, but were not limited to, depression, anxiety disorder, fracture of left pubis (either of a pair of bones forming the two sides of the pelvis) and hypertension. A physician's order, dated 1/23/24 and open ended, indicated to give 1 tablet lorazepam (an anti-anxiety medication) 0.5 milligrams (mg) three times a day when needed.	F 0758	1. Resident 15 was affected. Resident immediately assessed with no adverse effects noted. 2. All residents receiving as needed (PRN) psychotropic medications have the potential to be affected. All residents currently taking PRN psychotropic medications have been reviewed for 14 days stop date in the eMAR. All nurses to be educated on PRN psychotropic medications by 3/5/24. 3. As a measure of ongoing compliance, the DHS, or designee, will complete audits of residents with PRN antipsychotic medication orders and ensure that a 14 day stop date is in place. Audit will be completed 3 times per week, as available, for 4	03/08/2024

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	During an interview, on 2/12/24 at 1:46 p.m., the Director of Nursing (DON) was not aware the PRN lorazepam was not renewed after 14 days. The PRN Ativan should have a 14 day stop date. A current policy titled, "Psychotropic Medication Usage and Gradual Dose Reduction," dated 10/9/17, received from Clinical Support, on 2/12/24 at 4:06 p.m., indicated "...To ensure every effort is made for residents receiving psychoactive medications to obtain the maximum benefit with minimal unwanted side effects through appropriate use, evaluation and monitoring by the interdisciplinary team...Orders for PRN medications will have designated purpose for use...Administration of PRN medications will be documented in the eMAR and indicate prior interventions to include; non-pharmacological interventions...PRN order for psychotropic drugs are limited to 14 days...PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication...." 3.1-48(b)(2)		weeks, then every other week for 2 months, then monthly for 3 months. 4. As a quality measure, the ED or designee will review any findings and corrective actions at least quarterly in the campus Quality Assurance Performance Improvement meetings for six months or longer if 100% compliance is not achieved. The plan will be revised as warranted.	
F 0842 SS=D Bldg. 00	483.20(f)(5), 483.70(i)(1)-(5) Resident Records - Identifiable Information §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records.			

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	§483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or			

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	(iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. Based on record review and interview, the facility failed to ensure the Electronic Health Record (EHR) contained accurate information about a resident's advanced directives for 1 of 1 resident reviewed for advanced directives (Resident 55). Finding includes: The clinical record for Resident 55 was reviewed on 2/13/24 at 12:14 p.m. Diagnoses included, but were not limited to, a fracture of the neck of the left femur, dementia without behavioral disturbance, depression, insomnia, and dependence on supplemental oxygen. The resident's face sheet indicated the resident's code status was do not resuscitate (DNR). A physician's order, dated 11/21/23, the resident was a full code status. An Out of Hospital Do Not Resuscitate	F 0842	1. Resident 55 was affected. No adverse effects noted. Resident was no longer at the campus and was a discharged chart review during survey. 2. All residents have the potential to be affected. House wide code status audit completed to compare orders to signed document. All nurses to be educated on code status orders matching signed code status form by 3/5/24. 3. As a measure of ongoing compliance, the DHS, or designee, will complete audits of resident code statuses to ensure that the order matches the signed document. Audit will be completed 5 times per week, as available, for 4 weeks, then 1x per week for 2 months, then monthly x3 months. 4. As a quality measure, the ED	03/08/2024

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	Declaration and Order, was dated 11/21/23 and signed by the resident's representative and two witnesses on 11/21/23. The physician signed the form on 11/21/23. During an interview, on 2/13/24 at 3:32 p.m., the Clinical Support Nurse indicated she did not know the reason the physician order on 11/21/23 indicated the resident was a full code status. A current policy, titled, "Guidelines for Advanced Directives", revised on 12/14/23 and received from the Clinical Support Nurse on 2/14/24 at 5:24 p.m., indicated, "...To ensure facility staff obtains and follows resident's advanced directives regarding end-of-life care...Advanced Directives will be reviewed with resident and /or resident representative by the Customer Service representative or designee at time of admission, with the quarterly comprehensive assessment and PRN...The resident or representative will advise the CSR[customer services representative]/designee regarding wishes for end of life directives and code status. The 'DNR' form will be completed documenting these desires and scanned into the medical record...The nursing staff will obtain an order from the attending physician for the desired code status...Designation of code status and obtainment of physician order will be part of the medical record...." 3.1-50(a)(2)		or designee will review anyper week and corrective actions at least quarterly in the campus Quality Assurance Performance Improvement meetings for six months or longer if 100% compliance is not achieved. The plan will be revised as warranted.	
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and	R 0000	The submission of this plan of correction does not indicate an admission by Wellbrooke of	

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	State Licensure Survey. Survey dates: February 8, 9, 12, 13 and 14, 2024. Facility number: 013153 Residential Census: 29 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on February 27, 2024.		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.	
R 0214 Bldg. 00	410 IAC 16.2-5-2(a) Evaluation - Deficiency (a) An evaluation of the individual needs of each resident shall be initiated prior to admission and shall be updated at least semiannually and upon a known substantial change in the resident ' s condition, or more often at the resident ' s or facility ' s request. A licensed nurse shall evaluate the nursing needs of the resident. Based on observation, interview, and record review, the facility failed to re-evaluate a physician's order to wear oxygen continuously for 1 of 5 residents reviewed for medication pass (Resident 402). Finding includes:	R 0214	1. Resident 402 was affected. Resident was immediately assessed with oxygen orders updated in The Electronic Medication Record (eMAR) with no adverse effects noted. 2. All residents have the potential to be affected. Nurses educated on resident evaluation for oxygen.	03/08/2024

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	During an interview and observation on 2/12/24 at 9:30 a.m., Resident 402 did not have his oxygen on and said he did not need it. The clinical record for Resident 402 was reviewed on 2/12/24 at 10:15 a.m. Diagnoses included, but were not limited to, type 2 diabetes, unspecified depression and other chronic pain. A physician's order, dated 1/16/24, indicated to wear 2 liters of oxygen continuously. The order was discontinued on 2/12/24 at 11:02 a.m. During an interview, on 2/12/24 at 9:31 a.m., LPN 3 indicated the resident did not wear his oxygen sometimes because he was trying to wean himself off it. He refused his oxygen sometimes. He has been getting better so he did not need it as much. The order should have been changed when he started getting better and no longer needed oxygen continuously. During an interview, on 2/12/24 at 4:15 p.m., the clinical support nurse indicated the resident refused his oxygen sometimes. A Medication Administration Record (MAR), dated 2/1/24 to 2/11/24, the continuous oxygen order was charted as wearing it continuously. No refusals were noted. The facility did not have a policy to update orders.		The Director of Assisted Living (DAL) has been educated on ensuring resident oxygen orders are entered accurately. All residents with oxygen assessed and order placed or discontinued as appropriate. 3. As a measure of ongoing compliance, the DAL or designee will conduct oxygen audits to ensure accuracy of oxygen orders weekly x4 weeks, then every other week x2 months, then monthly x3 months. 4. As a quality measure, the ED or designee will review any findings and corrective actions at least quarterly in the campus Quality Assurance Performance Improvement meetings for six months or longer if 100% compliance is not achieved. The plan will be revised as warranted.	
R 0306 Bldg. 00	410 IAC 16.2-5-6(g)(1-9) Pharmaceutical Services - Noncompliance (g) Medications administered by the facility shall be disposed in compliance with appropriate federal, state, and local laws, and disposition of any released, returned, or			

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	destroyed medication shall be documented in the resident ' s clinical record and shall include the following information: (1) The name of the resident. (2) The name and strength of the drug. (3) The prescription number. (4) The reason for disposal. (5) The amount disposed of. (6) The method of disposition. (7) The date of the disposal. (8) The signature of the person conducting the disposal of the drug. (9) The signature of a witness, if any, to the disposal of the drug. Based on observation and interview, the facility failed to ensure a medication storage cart was free from loose pills and debris for 1 of 1 medication carts reviewed for medication storage. Finding includes: During a medication cart storage observation, on 2/8/24 at 1:45 p.m., there were 28 loose pills observed at the bottom of the medication cart drawer with rubber bands and loose paper debris scattered at the bottom. During an interview, on 2/8/24 at 1:48 p.m., QMA 2indicated she was not sure when the carts were cleaned. The loose pills should be disposed of in the facility drug disposal bottle. A current policy, titled, Assisted Living Pharmacy Guidelines", with a review date of 12/31/23 and received from the clinical support nurse on 2/12/24 at 4:40 p.m., indicated, " ...Medications will be safely stored per state regulatory guidelines ....".	R 0306	1. No residents were affected. All loose medications were immediately disposed of with no adverse effects noted. Rubber bands and paper debris found in the drawers of the cart was removed and disposed of. 2. All residents have the potential to be affected. Licensed clinical staff educated on medication cart cleanliness and disposal of/wasting loose pills. All medication carts have been audited to ensure no loose pills are present. 3. As a measure of ongoing compliance, the DAL or designee will conduct medication cart audits for debris and lose medications weekly x4 weeks, then every other week x2 months, then monthly x3 months. 4. As a quality measure, the ED or designee will review any findings and corrective actions at least quarterly in the campus	03/08/2024

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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
			Quality Assurance Performance Improvement meetings for six months or longer if 100% compliance is not achieved. The plan will be revised as warranted.	