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	12/07/2022

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 included a State Residential Licensure Survey. This visit also included the Investigation of Complaints IN00379823, IN00389008, IN00388766, IN00392390, IN00394256 and IN00394417. Complaint IN00379823 - Substantiated. Federal deficiencies related to the allegations are cited at F583. Complaint IN00389008 - Substantiated. Federal deficiencies related to the allegations are cited at F580, F692, F725 and F842. Complaint IN00388766 - Substantiated. Federal deficiencies related to the allegations are cited at F677 and F725. Complaint IN00392390 - Substantiated. Federal deficiencies related to the allegations are cited at F725 and F760. Complaint IN00394256 - Substantiated. Federal deficiencies related to the allegations are cited at F686. Complaint IN00394417 - Substantiated. Federal deficiencies related to the allegations are cited at F677, F686, F690 and F725. Survey dates: November 28, 29, 30 and December 1, 2, 5, 6 and 7, 2022. Facility number: 013153 Provider number: 155819 AIM number: 201254360	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.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Amorette Dunkle	Executive Director	12/29/2022

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	Census Bed Type: SNF/NF: 11 SNF: 46 Residential: 30 Total: 87 Census Payor Type: Medicare: 28 Medicaid: 4 Other: 25 Total: 57 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review was completed on December 14, 2022.			
F 0550 SS=D Bldg. 00	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment			

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	source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. Based on observation, interview and record review, the facility failed to ensure a resident was treated with dignity when the staff failed to ensure her clothing covered her exposed skin for 1 of 1 resident reviewed for dignity. (Resident G) Finding includes: During an observation, on 11/29/22 at 10:27 a.m., Resident G was sleeping, in her high back wheelchair, in the lounge. The resident's shirt was pulled up exposing her bare abdomen. There were two residents sitting in the lounge and staff walking in the hallway. During an observation, on 11/30/22 at 3:51 p.m., the resident was sitting in the lounge. The resident's right shirt sleeve was pulled down	F 0550	F550- Resident Rights/Exercise of Rights 1. Resident G remains in the campus and did not have any adverse effects from alleged deficient practice. 2. All residents have the potential to be affected by the alleged deficient practice. All clinical staff have been educated on resident rights. 3. As a measure of ongoing compliance, the DHS or designee will round to ensure all residents are dressed appropriately 3 times weekly x 4 weeks, then 2 times weekly x 4 weeks, then weekly x 4 weeks, then monthly x 3 months	12/29/2022

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	approximately 5 inches exposing her right bare shoulder. There were three residents in the lounge and staff walking in the hallway. The record for Resident G was reviewed on 11/30/22 at 2:27 p.m. Diagnoses included, but were not limited to, Alzheimer's disease, dementia (without behavioral disturbance, psychotic disturbance, and anxiety), anxiety disorder, and depressive disorder. A Quarterly Minimum Data Set (MDS) assessment, dated 9/14/22, indicated the resident had a Brief Interview for Mental Status (BIMS) score of 3 which indicated a severe cognitive impairment. During an interview, on 12/01/22 at 9:10 a.m., CNA 2 indicated Resident G would get fidgety and pull on her clothes. The staff would have to fix the resident's clothing. A current policy, titled "Resident Right Guidelines," dated as revised on 5/11/17 and received upon entrance indicated "...To ensure resident rights are respected and protected and provide an environment in which they can be exercised...Residents shall not leave their individual personalities or basic human rights behind when they move to a health campus. The following is a list of rights recognized by staff at [name of facility]: Our residents have the right to...be treated with dignity and respect...Be treated fairly, courteously and with respect by all staff...." 3.1-3(t)		or until 100% compliance is maintained. 4. As a quality measure, the Executive Director (ED) or designee will review any findings and corrective action at least quarterly in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted and will continue until 100% compliance is maintained.	
F 0578 SS=D Bldg. 00	483.10(c)(6)(8)(g)(12)(i)-(v) Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir			

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	§483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in			

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	place to provide the information to the individual directly at the appropriate time. Based on record review and interview, the facility failed to obtain a physician's order for a code status to reflect the do not resuscitate form for 1 of 1 resident reviewed for advanced directives. (Resident P) Finding includes: The record for Resident P was reviewed on 11/30/22 at 2:31 p.m. Diagnoses included, but were not limited to, hypothyroidism, chronic osteoarthritis with pain, left sided colitis, lower gastrointestinal bleed, history of hypertension, and chronic leg wounds. An "Out of Hospital Do Not Resuscitate" form, dated 11/24/22, signed by the resident, witnesses, and the physician, indicated the resident requested a do not resuscitate status. A physician's order, dated 1/24/22, indicated a full code status. A care plan for code status was not located in the electronic record. During an interview, on 12/2/22 at 3:40 p.m., the Clinical Support Nurse indicated the order for the code status was a full code and should have been a do not resuscitate. A current policy, titled "Guidelines for Advanced Directives," dated 5/22/18 and received from the Clinical Support Nurse on 12/7/22 at 5:35 p.m., indicated "...the nursing staff would obtain an order from the attending physician for the desired code status...designation of code status and obtainment of the physician's order would be part	F 0578	F578- Request/Refuse/Discontinue treatment; formulate adv directive 1. Resident P remains in the campus and did not experience any adverse effects from alleged deficient practice. 2. All residents have the potential to be affected by this. An audit was completed on advanced directives for all residents with no further issues noted. Licensed staff and admissions team educated on advance directives. 3. As a measure of ongoing compliance, DHS or designee to complete a record review to ensure desired advance directive is in place on 5 residents 3 times weekly x 4 weeks, then 2 times weekly x 4 weeks, then weekly x 4 weeks, then monthly x 3 months or until 100% compliance is maintained. 4. As a quality measure, the Executive Director (ED) or designee will review any findings and corrective action at least quarterly in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted and will continue until 100% compliance is maintained.	12/29/2022

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	of the medical record...." 3.1-4(f)(4)(A)(ii)			
F 0580 SS=E Bldg. 00	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in			

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	paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).			
	Based on interview and record review, the facility failed to notify the physician of significant weight changes, for not administering a long-acting insulin, and for low blood sugar readings for 7 of 7 residents reviewed for notification. (Residents L, T, S, C, M, K and Q) Findings include: 1. The record for Resident L was reviewed on 12/5/22 at 2:50 p.m. Diagnoses included, but were not limited to, altered mental status, type 2 diabetes mellitus, hearing loss, and generalized muscle weakness. A physician's order, dated 5/23/22, indicated CCHO (consistent carbohydrate) mechanical soft diet with thin liquids. A physician's order, dated 11/21/22, indicated a weekly weight on Mondays. The resident had the following weights: a. On 4/19/22, the weight was 154.4 pounds.	F 0580	F580- Notify of Changes 1. Residents L, T, S, C, M, K remain in the campus. 2. All residents have the potential to be affected by this. Record review completed on all residents for significant weight changes and corresponding physician notification. All required notifications have since been made. Licensed staff educated on physician notification. 3. As a measure of ongoing compliance, DHS or designee to review 5 residents weights to ensure physician notification if applicable 3 times weekly x 4 weeks, then 2 times weekly x 4 weeks, then weekly x 4 weeks, then monthly x 3 months or until 100% compliance is maintained. As a measure of ongoing compliance, DHS or designee to review 5 residents MAR for	12/29/2022

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	b. On 5/3/22, the weight was 146.5 pounds which was a significant weight loss of 5.05% in 14 days. c. On 5/19/22, the weight was 140.2 pounds which was a 9.3% weight loss in one month. d. On 6/7/22, the weight was 150.8 pounds which was a significant weight gain of 7.56% in 19 days. e. On 6/8/22, the weight was 142 pounds which was a significant weight loss of 5.8% in one day. f. On 7/8/22, the weight was 152 pounds which was a significant weight gain of 7.04% in one month. A RD (Registered Dietician) note, dated 4/29/22 at 4:31 p.m., indicated the resident was admitted for a left hip fracture and was on a CCHO diet. There was no edema noted upon admission. The resident was at a risk for malnutrition related to inadequate intake. The resident's current weight was 154 pounds. Medpass 90 ml (milliliter) two times daily for nutrition support was recommended. The plan of care would be continued, and recommendations made as appropriate. There was no note in the EHR (electronic health record) to indicate the physician was notified of the significant weight loss on 5/3/22 and 5/19/22. There was no note in the EHR to indicate the physician was notified of the significant weight gain on 6/7/22 or if the weight on 6/7/22 was inaccurate. There was no note in the EHR to indicate the physician was notified of the significant weight gain on 7/8/22. 2. The record for Resident T was reviewed on 11/30/22 at 2:39 p.m. Diagnoses included, but were not limited to, macular degeneration, weakness,		compliance 3 times weekly x 4 weeks, then 2 times weekly x 4 weeks, then weekly x 4 weeks, then monthly x 3 months or until 100% compliance is maintained. As a quality measure, the Executive Director (ED) or designee will review any findings and corrective action at least quarterly in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted and will continue until 100% compliance is maintained.	

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	repeated falls, and cardiomegaly. A physician's order, dated 5/17/22, indicated to weigh on Thursday. The resident had the following weights: a. On 6/30/22, the weight was 155.7 pounds. b. On 7/7/22, the weight was 138 pounds which was a 11.37% weight loss in 7 days. c. On 7/8/22, the weight was 128.4 pounds which was an additional 6.96% weight loss in one day for a total of 17.16% weight loss in 8 days. d. On 7/22/22, the weight was 131.2 pounds which was a 15.35% weight loss since 6/30/22. During an interview, on 12/1/22 at 11:10 a.m., the Clinical Support Nurse indicated she did not see any notes in the EHR where the physician was notified of the resident's significant weight loss. 3. The record for Resident S was reviewed on 12/1/22 at 4:03 p.m. Diagnoses included, but were not limited to, congestive heart failure, type 2 diabetes mellitus, and chronic kidney disease. A physician's order, dated 11/22/22, indicated to give Levemir (a long-acting insulin) 70 units twice a day. A MAR (Medication Administration Record) for December 2022, indicated on 12/2/22 the Levemir insulin was not administered in the a.m. due to a low blood sugar reading of 97. A normal blood sugar reading can range from 90-130. During an interview, on 12/6/22 at 11:43 a.m., the Director of Health Services (DHS) indicated there were no physician orders to hold the Levemir			

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	insulin and no documentation to the physician of the Levemir insulin not being administered. During an interview, on 12/6/22 at 11:45 a.m., the Clinical Support Nurse indicated there was no order to hold the Levemir insulin. There was no reason to have held the insulin since a blood sugar of 97 would not determine the need to hold a long-acting insulin and there was no documentation the physician was notified. 4. The record for Resident C was reviewed on 12/1/22 at 4:34 p.m. Diagnoses included, but were not limited to, displaced intertrochanteric fracture of the left femur, covid 19, chronic obstructive pulmonary disease, atrial fibrillation, and dysphasia (difficulty in swallowing). A care plan, dated 11/11/22, indicated the resident had impaired swallowing related to a dysphagia diagnosis. The interventions included, but were not limited to, notify the physician of a significant weight loss. The resident had the following weights: a. On 11/4/22, the weight was 101.8 pounds. b. On 11/20/22, the weight was 93.8 pounds which was a 7.86% weight loss in 16 days. c. On 11/28/22, the weight was 89.6 pounds which was a 11.98% weight loss in 24 days. During an interview, on 12/5/22 at 12:33 p.m., the Clinical Support Nurse indicated there was no documentation in the EHR of notification to the physician for the significant weight loss. There was not a nutrition note after the significant weight loss occurred. The IDT team should review significant weight losses, decide if a re-weight was needed, notify the physician, and make referrals to the RD. 5. The record for Resident M			

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	was reviewed on 11/30/22 at 2:15 p.m. Diagnoses included, but were not limited to, dementia, pseudobulbar affect (inappropriate involuntary laughing and crying due to a nervous system disorder), metabolic encephalopathy (chemical imbalance in the blood), and anoxic brain damage (lack of oxygen to the brain). A care plan, dated 10/28/22, indicated the resident required tube feeding to meet their nutrition and hydration needs and to support overall metabolic demand. Interventions included, but were not limited to, administer tube feeding as ordered by the physician, check proper placement of tube feeding prior to every feeding, provide free water flushes as ordered, and weight as ordered. A care plan, dated 11/28/22, indicated the resident was at risk for aspiration due to having a tube feeding, and a history of swallowing issues. Interventions included, but were not limited to, diet as ordered, dietician to evaluate, monitor and record meal intake, notify physician and family of significant weight changes, administer enteral feeding per physician's order, check placement and patency of feeding tube, and observe for signs of malnutrition. A dietician note, dated 10/28/22, indicated the resident was NPO (nothing by mouth) and ordered Glucerna (name of enteral feeding) 1.2 through a gastric tube (a tube inserted through the abdomen to bring nutrition directly to the stomach). The resident would receive 275 (milliliters) ml five times a day A dietician note, dated 11/20/22, indicated the resident passed a swallow study. The resident's diet was upgraded to a Controlled Carbohydrate (CCHO) with regular thin liquids. The resident was			

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(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
	to continue the enteral feedings of Glucerna 1.2 at 50 ml for 10 hours with water flushes of 20 ml an hour for 10 hours. The feedings were scheduled from 8:00 p.m., to 6:00 a.m. A physician's order, dated 11/29/22, indicated to discontinue the gastric tube feedings. Resident M had the following weights: a. On 10/19/2022, the weight was 227.9 pounds b. On 11/21/2022, the weight was 240.6 pounds which was a 5.57% weight gain in 1 month. During an interview, on 12/06/22 at 9:24 a.m., LPN 5 was not aware of Resident M's weight gain. The resident was no longer getting tube feedings and was eating about 50-75% of meals. The physician was not notified of the resident's significant weight gain.6. The record for Resident K was reviewed on 11/30/22 at 5:16 p.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus, unspecified dementia without behavioral disturbance, psychotic disturbance, mood disturbance, anxiety, acute respiratory failure with hypoxia, chronic obstructive pulmonary disease, pleural effusion, and osteoarthritis. A physician's order, dated 5/12/22, indicated to obtain weight daily. A physician's order, dated 10/28/22, indicated Glucerna (liquid protein supplement) twice daily. A physician's order, dated 10/27/22, indicated a controlled carbohydrate diet, regular consistency with thin liquids. A care plan, dated 10/24/22, indicated the			

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	155819	A. BUILDING 00 B. WING	12/07/2022

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	potential for alteration in nutritional status related to diagnoses, medications, fluid imbalance, diet, intake, physical activity, and metabolic demands. Interventions included, but were not limited to, weigh as ordered or needed. A nutritional quarterly/re-admission note, dated 6/26/22 at 9:06 a.m., indicated the resident remained on a controlled carbohydrate diet with average intakes of greater than 75% in 7 days. An order for Glucerna for nutrition support was initiated. Mirtazapine was ordered and may help with appetite and intake. Weight was 165. Resident K had the following weights: a. On 7/21/22, the weight was 164.6 pounds. b. On 7/22/22, the weight was 153.8 pounds which was a 7.2% weight loss in one day. There were no dietitian progress notes in the electronic record for weight loss on 7/22/22. There were no progress notes in the electronic record to indicate the physician was notified of the weight loss on 7/22/22. 7. The record for Resident Q was reviewed on 11/30/22 at 3:12 p.m. Diagnoses included, but were not limited to, angina, old heart attack, history of cerebral infarct (stroke), chronic obstructive pulmonary disease, type 2 diabetes, and bipolar disorder. A care plan, dated 11/28/22, indicated the resident was at risk for hypoglycemia (low blood sugar) or hyperglycemia (high blood sugar). Interventions included, but were not limited to, monitor blood sugars per physician's order, observe for symptoms of hypoglycemia and hyperglycemia, registered dietitian consult as needed, and follow			

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	recommendations. A progress note, dated 12/2/22 at 1:30 p.m., indicated the resident complained of not feeling well and the blood sugar was 54 per glucometer. The resident was given orange juice with sugar, and she ate her lunch. A progress note, dated 12/2/22 at 2:06 p.m., indicated a re-check of the blood sugar after eating her lunch was 78. A progress note, dated 12/3/22 at 6:28 p.m., indicated the resident's blood sugar was 60, a snack was given, and the staff would recheck the blood sugar. There were no progress notes indicating a blood sugar was re-checked. There were progress notes to indicate the physician was notified of the low blood sugars. The Medication Administration Record (MAR), dated 12/1/22 to 12/5/22, indicated on 12/2/22 from 3:30 p.m., to 5:00 p.m., the blood sugar was 64. The MAR, dated 12/1/22 to 12/5/22, indicated on 12/2/22 from 10:30 a.m., to 12:00 p.m., the blood sugar was 68. The MAR, dated 12/1/22 to 12/5/22, indicated on 12/4/22 from 4:00 a.m., to 6:00 a.m., the blood sugar was 65. There was no documentation the physician was notified of the low blood sugars. A current policy, titled "Guidelines for Weight Tracking," indicated "...the physician, resident representative and dietitian she be notified of a weight variance of 5% in 30 days, 7.5% in 90 days,			

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	and 10% in 180 days...." A current policy, titled "Physician-Provider Notification," dated 12/1/21 and received from the Clinical Support Nurse on 12/6/22 at 2:24 p.m., indicated "...the provider should be notified of critical lab results or an immediate need by phone as soon as the results are known...during non-office hour times the nurse should notify the physician or provider by phone of abnormal lab results or the need for physician or provider intervention...." A current policy, titled "Medication Administration-General Guidelines," dated 1/17 and received from the Clinical Support Nurse on 12/6/22 at 2:24 p.m., indicated "...if the dose of a regularly scheduled medication is withheld, refused, not available, or given at time other than the scheduled time...it is documented on the medication administration record or in the electronic health record...an explanatory note is also entered...." This Federal tag relates to Complaint IN00389008. 3.1-5(a)(2)			
F 0582 SS=D Bldg. 00	483.10(g)(17)(18)(i)-(v) Medicaid/Medicare Coverage/Liability Notice §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the			

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	facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility.			

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	(v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. Based on record review and interview, the facility failed to document the resident or family member's choice regarding end of therapy services on the skilled nursing facility advance beneficiary notice of non-coverage (SNF-ABN) form for 2 of 3 residents reviewed for beneficiary notices. Findings include: 1. A SNF-ABN for Resident 111, dated 9/13/22, indicated the family representative was contacted by phone on 9/13/22, informing the family member therapy services were to end on 9/19/22. A notation at the bottom of the form indicated the Social Service Director contacted the family member. The form contained 3 options for the resident or family to choose from for payment when services end. The options were not marked, and the note written by the Social Service Director did not indicate the resident or family had chosen an option. 2. A SNF-ABN for Resident 112, dated 10/3/22, indicated the family representative was contacted by phone on 10/3/22, informing the family member therapy services were to end on 10/5/22. A notation at the bottom of the form indicated the Social Service Director contacted the family member. The form contained 3 options for the resident or family to choose from for payment when services end. The options were not marked, and the note written by the Social Service Director did not indicate the resident or family had chosen an option. A SNF-ABN for Resident 112, dated 11/2/22,	F 0582	F582- Medicaid/Medicare Coverage/Liability notice 1. Residents 111 and 112 were effected. 2. All residents have the potential to be affected by alleged deficient practice. SSD completed an audit of all NOMNC/ABN issued in the past 90 days, with all deficiencies corrected. SSD educated on policy and procedure for issuing NOMNC/ABN. 3. As a measure of ongoing compliance, ED or designee to review all NOMNC/ABN for a minimum of 6 months or until 100% compliance is maintained. 4. As a quality measure, the Executive Director (ED) or designee will review any findings and corrective action at least quarterly in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted and will continue until 100% compliance is maintained.	12/29/2022

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	indicated the family representative was contacted by phone on 10/30/22, informing the family member therapy services were to end 11/2/22. A notation at the bottom of the form indicated the Social Service Director contacted the family member. The form contained 3 options for the resident to choose from for payment when services end. The options were not marked, and the note written by the Social Service Director did not indicate the resident or family had chosen an option. During an interview, on 12/06/22 at 2:52 p.m., the Executive Director and the Social Service Director indicated the SNF-ABN form did not designate the option chosen. A current policy, titled "NOMNC: Completion SOP," dated 6/22/21 and received from the Executive Director on 12/7/22 at 10:04 a.m., indicated "...if a resident is within their 100 day benefit period and facility is notifying them that their coverage is ending...for residents receiving therapy under Medicare part A social services will deliver Notice of Medicare Non Coverage...the resident has Medicare A days remaining and is staying on campus after therapy discharge...social services would issue the SNF-ABN form in addition to the NOMNC...." 3.1-4(f)(2) 3.1-4(f)(3)			
F 0583 SS=D Bldg. 00	483.10(h)(1)-(3)(i)(ii) Personal Privacy/Confidentiality of Records §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records.			

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	§483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. Based on observation and interview, the facility failed to ensure residents confidential information was placed out of sight for 17 of 32 rooms on the 200 front hall which was reviewed for privacy. (Rooms 218 to 234) Finding includes: During an observation, on 12/02/22 at 10:57 a.m.,	F 0583	F583-Personal Privacy/confidentiality of Records 1. No residents were affected by alleged deficient practice. 2. All residents have the potential to be affected. All clinical staff educated on maintaining privacy and confidentiality of records.	12/29/2022

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	the front cart on the 200 hall had a resident information paper on top of the medication cart. The cart was unlocked and unattended. During an observation, on 12/02/22 at 10:59 a.m., the computer in the lounge across from the nurse's station was open with resident information on the screen. During an interview, on 12/2/22 at 10:57 a.m., CNA 8 indicated RN 9 was working the front cart on the 200 hall and was on a lunch break. CNA 8 walked over to the unattended cart and indicated the cart should be locked. The form on top of the cart was a form used by the nurses for their shift notes and should be covered due to privacy. During an interview, on 12/2/22 at 11:02a.m., CNA 3 indicated she was charting resident information on the computer in the lounge. She went to answer a call light and did not log off the computer. The policy for using the computer was to log off when finished or the computer was unattended. A current policy, titled "Medication Storage in the Facility," dated as revised on 1/17 and received from the Clinical Support Nurse on 12/2/22 at 9:51 p.m., indicated "...Medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. The medication supply is accessible only to licensed facility personnel, pharmacy personnel, or staff members lawfully authorized to administer medications (such as medication aids) are permitted to access medications. Medication rooms, carts, and medication supplies are locked when not attended by persons with authorized access...."		3. As a measure of ongoing compliance, DHS or designee to round and ensure resident privacy and confidentiality of records is maintained through visual inspection 3 times weekly x 4 weeks, then 2 times weekly x 4 weeks, then weekly x 4 weeks, then monthly x 3 months or until 100% compliance is maintained. 4. As a quality measure, the Executive Director (ED) or designee will review any findings and corrective action at least quarterly in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted and will continue until 100% compliance is maintained.	

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	A current policy, titled "Resident Rights Guidelines," dated as revised on 5/11/17 and received upon entrance, indicated "...to ensure resident rights are respected and protected and provide an environment in which they can be exercised...Have their records containing personal and financial information kept confidential...." This Federal tag relates to Compliant IN00379823. 3.1-3(o)			
F 0644 SS=D Bldg. 00	483.20(e)(1)(2) Coordination of PASARR and Assessments §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. Based on interview and record review, the facility failed to ensure a PASARR (Preadmission Screening and Resident Review) was completed when a resident had a new mental health diagnosis added and was prescribed an antipsychotic medication for 2 of 2 residents	F 0644	F644- Coordination of PASARR and Assessments 1. Resident 16 and M remain in the campus and did not experience any adverse effects. 2. Residents receiving	12/29/2022

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	reviewed for PASARR. (Resident 16 and M) Findings include: 1. The record for Resident 16 was reviewed on 11/30/22 at 2:39 p.m. Diagnoses included, but were not limited to, dementia, anxiety disorder, chronic pain, and cognitive communication deficit. A PASARR level I, dated 3/21/22, indicated the resident had no mental health diagnoses, dementia, or neurocognitive disorder. The resident did not have an antianxiety, antipsychotic, or antidepressant medication ordered. A physician's order, dated 11/5/22, indicated fluoxetine (an antidepressant) 60 mg (milligram) capsule by mouth daily. A physician's order, dated 11/9/22, indicated abilify (an antipsychotic) 2 mg capsule by mouth daily. A physician's order, dated 11/9/22, indicated buspirone (an antianxiety) 7.5 mg tablet by mouth daily. During an interview, on 12/6/22 at 2:30 p.m., the Executive Director (ED) indicated the resident should have had a new Level I completed when the resident was started on an antianxiety, antidepressant, and antipsychotic medication. 2. The record for Resident M was reviewed on 11/30/22 at 2:15 p.m. Diagnoses included, but were not limited to, dementia, pseudobulbar affect disorder, metabolic encephalopathy, and an anoxic brain injury.		antipsychotic medications will be reviewed for PASARR completion and documentation and appropriate diagnosis. SSD has been educated on PASARR screening requirements. 3. All referrals will be assessed for a need of a PASARR on admission and will be completed timely per regulations. Any residents with new orders for antipsychotics will have a PASARR completed and ensure they have an appropriate dx for the medication(s). As a measure of ongoing compliance, SSD will review 5 residents 3 times a week for 4 weeks, then 2 times a week for 4 weeks, then weekly x 4 weeks, then monthly x 3 months or until 100% compliance is maintained. 4. As a quality measure, the Executive Director (ED) or designee will review any findings and corrective action at least quarterly in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted and will continue until 100% compliance is maintained.	

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	A PASARR level I, dated 8/19/22, indicated the resident had no mental health diagnoses, dementia, or neurocognitive disorder. The resident did not have an antidepressant or antianxiety medication ordered. A physician's order, dated 10/15/22, indicated olanzapine (an antipsychotic) 5 mg tablet by mouth daily. A physician's order, dated 10/16/22, indicated Lexapro (an antidepressant) 60 mg tablet by mouth daily. A physician's order, dated 11/9/22, indicated buspirone (an antianxiety medication) 7.5 mg by mouth daily. A care plan, dated 10/24/22, indicated the resident was at risk for adverse consequences related to receiving an antipsychotic medication. Interventions included, but were not limited to, gradual dose reduction in two separate quarters, observe and report signs of sedation, and extrapyramidal symptoms. During an interview, on 12/06/22 at 2:25 p.m., the ED indicated a new Level I should have been completed and was not. A current policy, titled "PASRR Quick Sheet," undated and received from Clinical Support Nurse on 12/6/22 at 10:30 a.m., indicated "...Below are items that can/will trigger a Level II PASRR. You will need to review the status of each item below when doing an admission or significant change to see if it warrants contacting the PASRR Office to request a Level II evaluation OR a Response to Referral Form...New Admission: If any of the following triggers a positive response, the Level			

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	I...These diagnoses must be given by a Psych MD/ARNP and not by a PCP or some other type of treatment provider other than a psychiatry...Individual has an Intellectual Disability, Major Depression Disorder, Anxiety Disorder, PTSD, etc...." 3.1-16(d)(1)(A) 3.1-16(d)(1)(B)			
F 0657 SS=D Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and			

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	155819	A. BUILDING 00 B. WING	12/07/2022

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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	quarterly review assessments. Based on interview and record review, the facility failed to ensure a comprehensive care plan for the use of an anticonvulsant medication and medical diagnoses were implemented for 1 of 2 residents reviewed for comprehensive care plans. (Resident K) Finding includes: The record for Resident K was reviewed on 11/30/22 at 5:16 p.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus, unspecified dementia without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. A physician's order, dated 8/23/22, indicated Depakote sprinkles (an anticonvulsant medication also used as a mood stabilizer) 125 milligrams three times daily related to delusional disorder, dementia without behaviors, psychotic disturbance, depression, and anxiety. There was no care plan in the electronic record for delusional disorder, dementia without behaviors, psychotic disturbance, or Depakote. There was no care plan in the electronic record to monitor for the side effects of Depakote. There was no care plan in the electronic record to monitor for behaviors related to the psychotic disturbance. During an interview, on 12/05/22 at 12:42 p.m., Certified Resident Care Assistant 4 indicated the resident did not display behaviors to indicate a psychotic disturbance.	F 0657	F657: Care Plan Timing and Revision 1. Resident K was affected. Resident K care plans were not accurate for resident. There was no care plan in the electronic record for delusional disorder, dementia without behaviors, psychotic disturbance, or Depakote. There was no care plan in the electronic record to monitor for the side effects of Depakote. There was no care plan in the electronic record to monitor for behaviors related to the psychotic disturbance. Resident K's care plans were updated to accurately reflect above stated information on 12/07/2022. 2. All residents receiving Depakote and/or have diagnoses of delusional disorder, dementia without behaviors, psychotic disturbance has potential to be affected. All current resident's care plans have been reviewed on 12/07/2022 for accuracy related delusional disorder, dementia without behaviors, psychotic disturbance, side effect monitoring related to Depakote use, and monitoring for behaviors related to psychotic disturbance. No further inaccuracies were found. MDS (Minimum Data Set) Coordinators & Social Service Coordinators were (or will be) educated on 12/07/2022 regarding accurate care plan development per MDS	12/29/2022

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	During an interview, on 12/7/22 at 5:00 p.m., the Clinical Support Nurse indicated the care plans covered sadness and tearfulness but did not cover delusions or a psychotic disturbance. A current policy, titled "Comprehensive Care Plan Guideline," dated 5/22/2018 and received from the Clinical Support Nurse on 12/7/22 at 3:35 p.m., indicated "...a comprehensive care plan will be developed within 7 days of completion of the admission comprehensive assessment...problem areas should identify the relative concerns...interventions should be reflective of the individual's needs and risk influence...the care plan should be reviewed no less than quarterly and revised to reflect changes in the resident's condition...." A current policy, titled "Psychotropic Medication Usage and Gradual Dose Reduction," dated 11/7/22 and received from the Clinical Support Nurse on 12/5/22 at 4:55 p.m., indicated "...residents shall receive psychotropic medications only if necessary by the prescriber...the medical necessity would be documented the resident's medical record and in the care planning process...." 3.1-35(a) 3.1-35(d)(1) 3.1-35(d)(2)		3.0 RAI Manual – Chapter 4; Section 4.7 The RAI and Care Planning and Trilogy Comprehensive Care Plan Guideline Policy and Procedure. 3. As a measure of ongoing compliance, the Director of Health Services or designee will conduct an audit of five residents for care planning accuracy related delusional disorder, dementia without behaviors, psychotic disturbance, side effect monitoring related to Depakote use, and monitoring for behaviors related to psychotic disturbance weekly x4 weeks, then twice per month x2 months, then monthly x3 months. 4. As a quality measure, the MDSC (Minimum Data Set Coordinator) or designee will review any findings and correction actions at least quarterly in the campus Quality Assurance Performance Improvement meetings. The plan will be revised as warranted.	
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	F 0677	F677- ADL Care provided for	12/29/2022

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	review, the facility failed to ensure a resident needing assistance with ADLs (activity of daily living) was provided their scheduled showers for 1 of 1 resident reviewed for activity of daily living. (Resident G) Finding includes: During an observation, on 10/29/22 at 2:27 p.m., Resident G's hair appeared greasy and uncombed. During an observation, on 11/30/22 at 3:51 p.m., the resident was in the lounge with dirty and uncombed hair. During an observation, on 12/1/22 at 11:05 a.m., the resident was sitting at the desk, in the lounge, her hair appeared greasy. During an observation, on 12/2/22 at 11:26 a.m., the resident had greasy hair. During an observation, on 12/6/22 at 4:23 p.m., the resident had on clean clothes and her hair remained greasy. The record for Resident G was reviewed on 11/30/22 at 2:27 p.m. Diagnoses included, but were not limited to, Alzheimer's disease, dementia (without behavioral disturbance, psychotic disturbance, and anxiety), anxiety disorder, and depressive disorder. The MDS (Minimum Data Set) assessment, dated 9/14/22, indicated the resident was a two-person total assist with showers and bathing. A care plan, revised on 3/18/22, indicated to provide showers on Wednesday and Saturday's.		dependent residents 1. Resident G remains in the campus and did not experience any adverse effects related to alleged deficient practice. 2. All residents have the potential to be affected. All resident records have been reviewed to ensure bathing preferences are implemented. All inaccuracies have been corrected. Clinical staff educated on Guidelines for Bathing Preference. 3. As a measure of ongoing compliance, DHS or designee to review 5 residents for compliance with showers/bathing 3 times weekly x 4 weeks, then 2 times weekly x 4 weeks, then weekly x 4 weeks, then monthly x 3 months or until 100% compliance is maintained. 4. As a quality measure, the Executive Director (ED) or designee will review any findings and corrective action at least quarterly in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted and will continue until 100% compliance is maintained.	

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	A care plan, revised on 5/16/22, indicated the resident was at risk for falls. Interventions included, but were not limited to, use a shower chair for showers. A Point of Care History indicated Resident G missed the following showers: a. 5 showers in September b. 6 showers in October. c. 7 showers in November. During an interview, on 12/2/22 at 11:02 a.m., CNA 3 indicated she was unsure when Resident G received showers. During an interview, on 12/6/22 at 4:00 p.m., the Executive Director (ED) indicated the staff did not chart when the resident had their hair washed. A current policy, titled "Guidelines for Bathing Preference," dated as revised 5/11/18 and received from the Clinical Support Nurse on 12/7/22 at 5:35 p.m., indicated "...If the resident is unable to communicate their preference this information shall be obtained from the resident representative based on known history...Bathing shall occur at least twice a week unless resident preference states otherwise...." This Federal tag relates to Complaints IN00388766 and IN00394417. 3.1-38(a)(3)(B)			
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the			

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	comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on interview and record review, the facility failed to determine if a resident was cleared to have showers after a surgical procedure for 1 of 2 residents reviewed for quality of care. (Resident C) Finding includes: During an interview, on 11/29/22 at 1:45 p.m., the resident's family member indicated the resident went three weeks without a shower and the family had questioned the staff if he had received a shower. The record for Resident C was reviewed on 12/1/22 at 4:34 p.m. Diagnoses included, but were not limited to, displaced fracture of the left femur, acute posthemorrhagic anemia, chronic obstructive pulmonary disease, and convulsions. A physician's order, dated 11/2/22, indicated if no drainage for 3 consecutive days, then the incision may remain open, and the resident may start to shower. Monitor three times a day. A Treatment Administration Record (TAR), dated 11/2/22 through 11/30/22, indicated there was a signature every day, three times a day, to show the incision had been checked by the staff. There were no notes to indicate if the incision had drainage or not, if the three consecutive days had occurred without drainage, or if the resident was eligible to receive a shower.	F 0684	F684- Quality of Care 1. Resident C did not experience any adverse effects related to alleged deficient practice. 2. All residents have the potential to be affected. All resident records have been reviewed to ensure bathing preferences are implemented. All clinical staff educated on the guidelines for bathing preference. 3. As a measure of ongoing compliance, DHS or designee to review 5 residents for compliance with showers/bathing 3 times weekly x 4 weeks, then 2 times weekly x 4 weeks, then weekly x 4 weeks, then monthly x 3 months or until 100% compliance is maintained. 4. As a quality measure, the Executive Director (ED) or designee will review any findings and corrective action at least quarterly in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted and will continue until 100% compliance is maintained	12/29/2022

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	A resident profile guide, dated 11/2/22, indicated showers were on Wednesdays and Saturdays according to the resident's preference. A point of care history, dated 11/1/22 through 11/30/22, indicated the resident received a shower on 11/20/22 which was 19 days after admission and no more showers were documented as given. During an interview, on 12/6/22 at 11:16 a.m., the DHS (Director of Health Services) indicated the resident had received two showers while he was in the facility. He did have a dressing on his hip when he arrived. There was no documentation to indicate the resident was cleared to have a shower. During an interview, on 12/6/22 at 11:18 a.m., the Clinical Support Nurse indicated there was no documentation to show when the incision was dry for 3 consecutive days and no documentation of when the showers could start. A current policy, titled "Guidelines for Bathing Preference," dated 5/11/16 and received from the Clinical Support Nurse on 12/7/22 at 5:35 p.m., indicated "...The resident will determine their preferences for bathing upon admission...Day of the week...Time of day...Type of bathing...tub bath, bed bath or shower...Bathing shall occur at least twice a week unless resident preference states otherwise...." 3.1-37(a)			
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity			

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	§483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on observation, interview and record review, the facility failed to assess a resident's skin for new wounds and pre-medicate a resident prior to a dressing change for 1 of 5 residents reviewed for pressure wounds. (Resident O) Finding includes: During an observation, on 12/1/22 at 12:13 p.m., Resident O was having a left heel dressing change by the facility wound nurse and the Assistant Director of Health Services (ADHS). Resident O was crying out in pain when they moved her left leg. The wound nurse requested RN 5 give the resident pain medication during the dressing change. The pain medication was given, and the wound nurse removed the old dressing from the left foot. The wound on the left heel had bone exposed. The resident continued to cry out in pain when the staff moved her left leg. The wound nurse cleansed the wound with normal saline, applied an iodoflex pad (absorbs fluids, removes debris, and kills bacteria) to the wound bed, and covered the area with a dressing pad. The resident cried out in pain and stated, "it hurts." The left foot was wrapped with one roll of Kerlex (gauze	F 0686	F686- Treatment/Services to prevent/heal pressure ulcer 1. Resident O had no adverse effects related to alleged deficient practice. 2. All residents with wounds have the potential to be affected by alleged deficient practice. Pain assessments completed on residents with wounds and intervention provided if necessary. Licensed staff educated on pain management. 3. As a measure of ongoing compliance, DHS or designee to review all residents with wounds through record review or interview to ensure appropriate pain control 3 times weekly x 4 weeks, then 2 times weekly x 4 weeks, then weekly x 4 weeks, then monthly x 3 months or until 100% compliance is maintained. 4. As a quality measure, the Executive Director (ED) or designee will review any findings	12/29/2022

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	dressing) and the Kerlex was wrapped with an ace wrap to secure the dressing in place. During an interview, on 12/1/22 at 12:13 p.m., the wound care nurse indicated Resident O had a Stage 4 pressure ulcer and it was considered a facility acquired pressure wound. The resident had a lot of pain during the dressing change and should have had pain medication prior to the dressing change. The record for Resident O was reviewed on 11/30/22 at 2:47 p.m. Diagnoses included, but were not limited to, flaccid hemiplegia left dominant side, dysphasia, aphasia, pressure ulcer of left buttock, pressure ulcer of left heel, and contractures to the left and right lower legs. Resident O's physician's orders included, but were not limited to, weekly skin assessments, offloading boots to the bilateral heels as tolerated three times a day, the resident was to wear a Prevalon boot to the left heel at all times as tolerated three times a day, to apply skin prep to the right heel three times a day, to cleanse the left heel wound with wound cleanser or normal saline and apply iodoflex pad to wound bed, and cover with kerlix (gauze) and secure with an ace wrap daily, tramadol (for pain) 50 mg (milligram) tablet give three times a day for pain, and Morphine concentrate (for pain) 5 mg solution give 0.25 ml every 3 hours when needed for pain. A TAR (Treatment Administration Record), dated 5/1/22 through 7/6/22, indicated there were no new skin impairments on the weekly skin assessments. A progress note, dated 2/23/22 at 4:00 p.m., indicated the left heel pressure ulcer was healed and preventative treatment remained in place.		and corrective action at least quarterly in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted and will continue until 100% compliance is maintained	

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	A wound clinic note, dated 7/6/22 at 9:24 a.m., indicated the resident's left heel wound had reopened. She did not have the Prevalon boot on which the wound clinic had dispensed at a previous visit. She had a smaller offloading heel protector on. A progress note, dated 7/6/2022 at 10:21 a.m., indicated Resident O returned from the wound center. The resident had a new pressure ulcer to the left heel. The treatment orders were for silver alginate. A progress note, dated 7/6/22 at 1:09 p.m., indicated the resident had a new stage III wound on her left heel. The dressing was silver alginate, gauze and to wrap with kerlix. The dressing would be changed daily. A wound note, dated 7/6/22 at 9:11 p.m., indicated the following: a. length 3.8 cm (centimeters). b. no depth was noted. c. no exudate was noted. d. no wound odor was present. e. the wound was Stage III. f. no undermining was present. g. no sinus tract/tunneling was present. h. granulation tissue was 100%. i. tissue type was slough. j. the wound edges/margins were irregular. A progress note, dated 7/8/22 at 12:46 p.m., indicated the left heel dressing was changed. The heel wound was declining, and it looked worse since the visit to the wound care center. Applied silver alginate to the open area and wrapped the foot in kerlix.			

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	A care plan, dated 7/8/22, indicated the resident had a pressure ulcer to the left heel. Interventions included, but were not limited to, administer analgesic per physician's order, observe for and report signs of pain, off-loading boots, and treatment per physician's orders. During an interview, on 12/2/22 at 11:55 a.m., the facility wound care nurse indicated she started working at the facility the end of June or the first of July 2022. She was told the resident had a deep tissue injury and the Director of Health Services (DHS) was doing the wound care. During an interview, on 12/2/22 at 4:01 p.m., the DHS indicated the facility did not have a wound nurse when she was hired. She started at the end of April and was going through orientation. The Interim DHS was documenting wound care. When she was off orientation, the Interim DHS left. When asked who was taking care of the wounds from when the Interim DHS left and the wound care nurse started, she had no response. During an interview, on 12/07/22 at 12:05 p.m., the wound care nurse indicated she found the wound on 7/6/22 at 6:00 a.m., when she was doing her skin assessment. She wrapped her heel with gauze and the resident went to the wound clinic. She did not document her note until later. The resident returned from the wound care center with new orders for her left heel and the wound clinic staged her wound at a Stage III. The last weekly skin assessment was documented on 6/30/22. The stage III pressure wound was noted 6 days after the weekly skin assessment. A current policy, titled "Guidelines for weekly skin observation," dated on 1/7/19 and received from			

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	Clinical Support Nurse on 12/1/22 at 4:52 p.m., indicated "...To monitor the effectiveness of intervention for pressure reduction, identify areas of skin impairment in the early development stage and implement other preventative and/or treatment measures as indicated...A full body observation shall be completed weekly by the licensed nurse...Upon admission the admitting nurse shall include as part of the admission orders a week skin observation. The order shall read: "Weekly skin observation on day of the week. 0=no areas of skin impairment. 1=new area of impairment (see wound event). 2= existing area of impairment (see wound management tool and/or event) The date the observation should be completed shall be assessed to the DHS or designee and indicated by the corresponding date on the treatment administration record (TAR). The nurse completing the weekly skin check shall indicate the appropriate number (0, 1, 2) medication note. Initiate applicable Wound Event if a new area of impairment is identified. This may not include incidental bruises, hemosiderin staining, petechia and senile purpura. In addition to the Weekly Observation by the licensed nurse, the nursing assistant shall observe skin for areas of impairment with the bathing and daily dressing and pericare and notify the nurse if an area is identified...." A current policy, titled "Dressing Changes," not dated and received from Clinical Support Nurse on 12/5/22 at 4:55 p.m., indicated "...To ensure measures that will promote and maintain good skin integrity while maintaining standard measures that will minimize/control contamination. Place plastic bag or trash can near to dispose the soiled dressing. Create a clean field. Remove old adhesive with adhesive remover, if necessary, taking care not to get solution into wound. Wash			

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	hands with soap and water. provide weekly documentation of wound, wash hands with soap and water, open dressing pack, put on first pair of disposable gloves...Remove gloves and discard. Wash hands with soap and water. Assist resident to comfortable position with call light in reach...." This Federal Tag relates to Complaintss IN00394256 and IN00394417. 3.1-40(a)(2)			
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview and record review, the facility failed to monitor a resident for a concussion and to monitor a hematoma which occurred after a fall for 1 of 3 residents reviewed for accidents. (Resident T) Finding includes: During an observation, on 11/29/22 at 11:32 a.m., the resident had a large bruise on her nose, a bruise on the right upper face (the size of a 50 cent piece) and a large abrasion on the forehead (the size of two 50 cent pieces). The resident indicated she fell while she was waiting for help to go to the bathroom.	F 0689	F689- Free of Accident Hazards/Supervision/Devices 1. Resident T remains in the campus and did not experience any adverse effects related to alleged deficient practice. 2. All residents have the potential to be affected. All resident falls were reviewed for completion and appropriate skin events opened. Licensed staff educated on completing Neurological Checks and monitoring skin impairments. 3. As a measure of ongoing compliance, DHS or designee to	12/29/2022

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	155819	A. BUILDING 00 B. WING	12/07/2022

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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	During an observation, on 11/30/22 at 4:05 p.m., the resident was sitting up, in a wheelchair, in her room. She had a scabbed area on the left eyebrow, purplish to yellowish bruising on both sides of her face, a purplish bruise on the top of her nose and a reddened abrasion on her forehead. The record for Resident T was reviewed on 11/30/22 at 2:39 p.m. Diagnoses included, but were not limited to, contusion of the right knee, pain in the right lower leg, macular degeneration, weakness, repeated falls, and difficulty in walking. A progress note, dated 11/27/22 at 12:27 a.m., indicated the resident had fallen onto the floor and was trying to get up on her own. The resident had a skin tear to the left side of her face and a large hematoma to the forehead. There was an order to send the resident to the ER for evaluation and treatment. A progress note, dated 11/27/22 at 12:42 a.m., indicated the resident returned to the facility from the emergency room with no new orders. An ER visit report, dated 11/27/22 at 3:25 a.m., indicated because the injury was to the resident's head, it was possible a concussion [mild brain injury] could result. Symptoms of a concussion could show up later. Be alert for the signs and symptoms of a concussion which could include, headache, nausea or vomiting, sensitivity to light or noise, personality changes, vision changes, loss of consciousness, unusual sleepiness or grogginess, and confusion. An interdisciplinary note, dated 11/28/22 at 3:04 p.m., indicated the resident had fallen onto the floor while she was trying to get up on her own. She had a skin tear to the left side of her face and		review all falls for completion of neuro checks and skin impairment monitoring, if applicable, 3 times weekly x 4 weeks, then 2 times weekly x 4 weeks, then weekly x 4 weeks, then monthly x 3 months or until 100% compliance is maintained. As a quality measure, the Executive Director (ED) or designee will review any findings and corrective action at least quarterly in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted and will continue until 100% compliance is maintained	

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	a large hematoma to the forehead. She was sent to the ER for evaluation and treatment. During an interview, on 12/1/22 at 11:10 a.m., the Clinical Support Nurse indicated the resident did not have documentation of the condition of the hematoma after the fall and there was no documentation of neuro checks being completed after the resident returned from the ER with the instructions to monitor for a concussion. A current policy, titled "Guidelines for Neurological Checks," dated as revised on 3/16/22 and received from the Clinical Support Nurse on 12/7/22 at 4:45 p.m., indicated "...Guidelines for Neurological Checks...To evaluate the level of consciousness, evaluate pupil response, motor function, and vital signs that may alert staff for potential head injury or seizure activity...Residents having a fall should be evaluated for injury...Consciousness will be identified by observation of the resident, speech and responsiveness. Is the resident...Alert...Drowsy...Stuporous...Comatose... ." A current policy, titled "Falls Management Program Guidelines," dated as reviewed 3/16/22 and received from the Clinical Support Nurse on 12/1/22 at 4:52 p.m., indicated "...Trilogy health services [THS} strives to maintain a hazard free environment, mitigate fall risk factors and implement preventative measures...Should the resident experience a fall the attending nurse shall complete the 'Fall Event'...This includes an investigation of the circumstances surrounding the fall to determine the cause of the episode, a reassessment to identify possible contributing factors, interventions to reduce the risk of repeat episodes and a review of the IDT to evaluate			

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	thoroughness of the investigation and appropriateness of the interventions...Nursing staff will monitor and document continued resident response and effectiveness of interventions for 72 hours...." 3.1-45(a)(1)			
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's			

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	comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. Based on interview and record review, the facility failed to obtain a physician's order for the use of a Foley catheter and to identify the cause of worsening urinary symptoms for 2 of 4 residents reviewed for urinary tract infections (UTI) and urinary catheter use (Resident B and D). Findings include: 1. During an interview, on 12/1/22 at 10:23 a.m., an anonymous complainant indicated the resident's urinary catheter had come out at the facility and there was no notification from the facility. The record for Resident B was reviewed on 11/30/22 at 4:57 p.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease, chronic kidney disease stage 3, type 2 diabetes mellitus, dementia, and anxiety. During an interview, on 12/5/22 at 12:12 p.m., the DHS (Director of Health Services) indicated the resident did not have any orders for an indwelling Foley (a type of urinary catheter) catheter. During an interview, on 12/5/22 at 12:14 p.m., the Clinical Support Nurse indicated the record was confusing since the resident was marked as incontinent although the admission assessment indicated the resident had an indwelling Foley catheter. During an interview, on 12/5/22 at 12:52 p.m., the [name of hospice] case manager indicated the resident had a Foley catheter at the facility and it	F 0690	F690- Bowel/Bladder Incontinence Care/UTI 1. Residents B and D did not experience any adverse effects related to alleged deficient practice. 2. All residents have the potential to be affected. All residents with a catheter reviewed for physicians order with no further issues. Licensed staff educated on urinary catheters and signs/symptoms of a urinary tract infection. 3. As a measure of ongoing compliance, DHS or designee to review all residents with catheters weekly x 6 months or until 100% compliance is maintained to ensure all appropriate orders and care plans are in place. As a measure of ongoing compliance, DHS or designee to review records for signs and symptoms of a UTI to ensure appropriate treatment for 5 residents 3 times weekly x 4 weeks, then 2 times weekly x 4 weeks, then weekly x 4 weeks, then monthly x 3 months or until 100% compliance is maintained. 4. As a quality measure, the Executive Director (ED) or designee will review any findings and corrective action at least quarterly in the campus Quality	12/29/2022

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	was still in place the morning prior to discharge from the facility. The following day the family indicated the Foley catheter was dislodged. The case manager did not know if the catheter was dislodged before or after the discharge from the facility. During an interview, on 12/7/22 at 12:40 p.m., the Clinical Support Nurse indicated there was no physician's order for the urinary catheter during the stay at the facility and there should have been a physician's order. 2. During an interview, on 11/29/22 at 3:45 p.m., Resident D indicated she currently had a urinary tract infection (UTI). The record for Resident D was reviewed on 11/30/22 at 2:51 p.m. Diagnoses included, but were not limited to, hypertensive heart, chronic kidney disease stage 3, acute and chronic systolic heart failure, type 2 diabetes, and dehydration. A progress note, dated 10/15/22 at 9:16 p.m., indicated the hospice nurse called the facility to inform them of a new order for Bactrim (an antibiotic) twice daily for 7 days to treat a UTI. A progress note, dated 11/7/22 at 11:16 a.m., indicated an order for Macrobid (an antibiotic) 100 milligrams twice daily for 7 days for a UTI. A progress note, dated 11/7/22 at 2:14 p.m., indicated the resident complained of pain with urination, pelvic discomfort, and increased confusion. A progress note, dated 11/11/22 at 1:21 p.m., indicated the resident continued to complain of burning with urination despite antibiotic treatment. A telephone call was placed to inform hospice.		Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted and will continue until 100% compliance is maintained	

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	A progress note, dated 11/14/22 at 4:20 p.m., indicated the resident complained of pain with urination. Hospice and family were made aware. A new order for a urinalysis and urine culture and sensitivity was obtained. A urinalysis report, dated 11/17/22 at 3:12 p.m., indicated the color of urine was orange, cloudy, nitrites were positive, leukocytes were 2+, white blood cells were 10-50, bacteria was 1+, and a note from the Nurse Practitioner was to wait for the culture. A urine culture report, dated 11/17/22 at 7:27 p.m., indicated 10,000 to 100,000 mixed fora. Suggest appropriate recollection if clinically indicated. A progress note, dated 11/18/22 at 12:19 a.m., indicated the Nurse Practitioner visited, reviewed the urinalysis and was awaiting results of the urine culture. A progress note, dated 11/21/22 at 5:02 p.m., indicated the hospice nurse visited and wrote new orders to repeat urinalysis and urine culture. A progress note, dated 11/21/22 at 11:14 p.m., indicated a urine sample was collected. A progress note, dated 11/23/22 at 9:25 p.m., indicated a urine sample was collected. A urinalysis report, dated 11/24/22 at 2:44 p.m., indicated cloudy yellow urine, leukocytes 3+, white blood cell counts 10-50, and bacteria 1+. A progress note, dated 11/25/22 at 12:54 p.m., indicated a new order for Macrobid 100 milligrams twice daily for 10 days.			

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A urine culture report, dated 11/26/22 at 9:25 p.m., indicated the bacteria was enterococcus faecalis.

A progress note, dated 11/30/22 at 3:20 p.m., indicated the resident revoked hospice to be evaluated and treated for urinary tract infection symptoms.

A progress note, dated 11/30/22 at 9:28 p.m., indicated the resident returned from the emergency room with new order for levofloxacin (antibiotic). An indwelling catheter was placed in the emergency room and a referral was made to urology.

An emergency room report, dated 11/30/22 at 7:03 p.m., indicated the resident's complaint was a urinary tract infection for 2-3 months, antibiotics were not working and there was burning on urination. A urinalysis was obtained and confirmed a urinary tract infection and a culture was ordered. The granddaughter reported to the physician, the resident had been on multiple antibiotics in the past 2-3 months and symptoms never fully resolved. The granddaughter expressed fear of the resident developing sepsis. The resident chose to have foley catheter inserted and start Levaquin (an antibiotic)

A care plan for the urinary tract infections or the antibiotic usage was not located in the record.

During an interview, on 11/29/22 at 4:00p.m., a Certified Resident Care Assistant indicated the resident had revoked hospice and requested to go the emergency room for recurrent urinary tract infections.

A current policy, titled "Infection," indicated

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	"...Surveillance activities to identify, investigate control and prevent the spread of infection...infections shall be tracked per hall/unit, type of infection and monitor lab reports to identify infections...." This Federal tag relates to Complaint IN00394417. 3.1-41(a)(1) 3.1-41(a)(2)			
F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. Based on interview and record review, the facility failed to ensure resident's weights were monitored and interventions were in place for significant weight changes for 3 of 5 residents reviewed for nutrition. (Residents L, T, and C)	F 0692	F692- Nutrition/Hydration status maintenance 1. Residents L, T, C did not experience any adverse effects related to alleged deficient	12/29/2022

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	Findings include: 1. The record for Resident L was reviewed on 12/5/22 at 2:50 p.m. Diagnoses included, but were not limited to, altered mental status, type 2 diabetes mellitus, hearing loss, and generalized muscle weakness. A physician's order, dated 5/23/22, indicated CCHO (consistent carbohydrate) mechanical soft diet with thin liquids. A RD (Registered Dietician) note, dated 4/29/22 at 4:31 p.m., indicated the resident was admitted for a left hip fracture and was on a CHHO diet. There was no edema noted upon admission. The resident was at a risk for malnutrition related to inadequate intake. The resident's current weight was 154 pounds. Medpass 90 ml (milliliter) two times daily for nutrition support was recommended. The plan of care would be continued, and recommendations made as appropriate. The resident had the following weights: a. On 4/19/22, the weight was 154.4 pounds. b. On 5/3/22, the weight was 146.5 pounds which was a significant weight loss of 5.05% in 14 days. c. On 5/19/22, the weight was 140.2 pounds which was a 9.3% weight loss in one month. d. On 6/7/22, the weight was 150.8 pounds which was a significant weight gain of 7.56% in 19 days. e. On 6/8/22, the weight was 142 pounds which was a significant weight loss of 5.8% in one day. f. On 7/8/22, the weight was 152 pounds which was a significant weight gain of 7.04% in one month. g. On 7/25/22, the weight was 155.6 pounds. h. On 7/26/22, the weight was 158.2 pounds.		practice. 2. All residents have the potential to be affected. Record review completed on all residents for significant weight changes and corresponding physician notification. All required notifications have since been made. All nurses have been educated on ensuring the attending physician is notified of any significant weight changes. Nurses have been educated to document notification in electronic record of respective resident. 3. As a measure of ongoing compliance, the Director of Health Services (DHS), or designee, will complete audits of 5 resident to ensure that residents attending physician was notified of any significant weight changes per ordered 3x weekly x4 weeks, then 2 times weekly x 4 weeks, then weekly x 4 weeks, then monthly x3 months or until 100% compliance is maintained. 4. As a quality measure, the Executive Director (ED) or designee will review any findings and corrective action at least quarterly in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted and will continue until 100% compliance is maintained	

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	i. On 8/1/22, the weight was 161 pounds which was a significant weight gain of 5.92% in less than one month. There was no RD note, no progress notes and no new interventions implemented on 5/3/22 when the significant weight loss of 5.05% occurred. There was no RD note, no progress notes and no new interventions when the resident had a continued weight loss on 5/19/22 of 9.3% in one month. A NP (Nurse Practitioner) note, dated 6/9/22, indicated the resident's weights had been stable. The resident weights had not been stable and included significant weight loss. 2. The record for Resident T was reviewed on 11/30/22 at 2:39 p.m. Diagnoses included, but were not limited to, macular degeneration, weakness, repeated falls, and cardiomegaly. A physician's order, dated 5/17/22, indicated to weigh on Thursdays every week. A physician's order, dated 5/19/22, indicated to give hydrochlorothiazide (a diuretic) 12.5 mg (milligram) to administer if the systolic blood pressure was greater than 160 once a day. The Medication Administration Records (MAR), from 5/19/22 through 12/2/22, were reviewed and the resident received no doses of the hydrochlorothiazide. A physician's order, dated 11/30/22, indicated a regular diet, mechanical soft food, and thin liquids on a divided plate.			

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	The resident had the following weights: a. On 6/30/22, the weight was 155.7 pounds. b. On 7/7/22, the weight was 138 pounds which was a 11.37% weight loss in 7 days. c. On 7/8/22, the weight was 128.4 pounds which was an additional 6.96% weight loss in one day for a total of 17.16% weight loss in 8 days. d. On 7/22/22, the weight was 131. 2 pounds which was a 15.35% weight loss since 6/30/22. A RD note, dated 6/29/22, indicated the resident weighed 156 pounds. The resident had weight fluctuations due to diuretic use. A RD note, dated 7/13/22, indicated the resident triggered for a significant weight loss in 30 days and a re-weight was recommended for accuracy. A RD note, dated 8/28/22, indicated the resident had triggered for a significant weight loss for 90 days although had regained weight. The weight fluctuations were due to diuretic use. No new recommendations as the resident had stable weights. During an interview, on 12/1/22 at 11:10 a.m., the Clinical Support Nurse indicated the RD had noted the resident's significant weight loss was due to the use of diuretics and the resident had not received any diuretics since she had been at the facility. 3. The record for Resident C was reviewed on 12/1/22 at 4:34 p.m. Diagnoses included, but were not limited to, displaced intertrochanteric fracture of the left femur, covid 19, chronic obstructive pulmonary disease, atrial fibrillation, and dysphasia (difficulty in swallowing).			

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	A care plan, dated 11/11/22, indicated the resident had impaired swallowing related to a dysphagia diagnosis. The interventions included, but were not limited to, notify the physician of a significant weight loss. A RD note, dated 11/14/22 at 9:36 a.m., indicated the resident was admitted for a left hip fracture and was covid positive. Bilateral lower extremity edema was noted upon admission. The weight fluctuations were related to edema. Fortified shakes with meals were recommended for nutritional support. The resident had the following weights: a. On 11/4/22, the weight was 101.8 pounds b. On 11/20/22, the weight was 93.8 pounds which was a 7.86% weight loss in 16 days. c. On 11/28/22, the weight was 89.6 pounds which was a 11.98% weight loss in 24 days. There were no new interventions in place after the resident had the significant weight loss. During an interview, on 12/5/22 at 12:33 p.m., the Clinical Support Nurse indicated there was no documentation in the EHR of notification to the physician for the significant weight loss. There was not a nutrition note after the significant weight loss occurred. The IDT team should review significant weight losses, decide if a re-weight was needed, notify the physician, and make referrals to the RD. A current policy, titled "Guidelines for Weight Tracking," dated as reviewed 3/16/22 and received from the Clinical Support Nurse on 12/1/22 at 11:59 a.m., indicated "Residents will have their weight taken and recorded upon admission to establish a baseline...Unless otherwise indicated or ordered			

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	155819	A. BUILDING 00 B. WING	12/07/2022

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	by the physician the resident will have their weight taken and recorded monthly...The facility dietician or representative will review the resident's nutritional status, usual body weight and current weight to implement a nutritional program when warranted...To the extent possible the same scale, same person, same wheelchair [if applicable] should be used to ensure consistency...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 dietician shall be notified of a weight variance of 5% in 30 days, 7.5% in 90 days, and 10% in 180 days...Residents with a significant weight change can be added to Clinically At Risk...." This Federal tag relates to Complaint IN00389008. 3.1-46(a)(1)			
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 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 observation, interview and record review, the facility failed to ensure physician's orders were followed for oxygen usage, to have a physician's order for supplemental oxygen, and to date the oxygen tubing when it was changed for 2 of 2 residents reviewed for respiratory care.	F 0695	F695- Respiratory/Tracheostomy Care and Suctioning 1. Residents 155 and 204 did not experience any adverse effects related to alleged deficient practice.	12/29/2022

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	(Resident 155 and 204) Findings include: 1. During an observation, on 11/30/22 at 4:15 p.m., Resident 155 was sitting in her recliner wearing oxygen via nasal cannula. The resident's oxygen concentrator liter flow was at 3 liters. The oxygen tubing did not have a date which indicate when the tubing was changed. The record for Resident 155 was reviewed on 11/30/22 at 4:10 p.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD), acute and chronic respiratory failure, anxiety disorder, and shortness of breath. A physician's order, dated 1/7/18, indicated the resident was to receive 2 liters (2 L/min) via nasal cannula (NC) continuous and to check every shift. A physician's order, dated 9/1/18, indicated to change oxygen tubing the first of the month between 10:00 p.m., and 6:00 a.m. A care plan, dated as revised on 10/19/22, indicated the resident was at risk for shortness of breath while lying flat. Interventions included, but were not limited to, administer oxygen per physician's order. During an interview, on 11/30/22 at 4:02 p.m., RN 10 indicated the oxygen tubing had no date on the tubing to indicated when it was changed. The tubing should have a date written clearly when the tubing was changed. Resident 155 had the oxygen flow at 3L, and it should be on 2L.2. During an observation, on 11/29/22 2:13 p.m., Resident 204 was sitting in her wheelchair with oxygen at 2 liters per nasal cannula.		2. All residents requiring the use of respiratory equipment have the potential to be affected. All residents receiving oxygen were reviewed, all equipment labeled correctly and physicians orders in place. Clinical staff educated on oxygen administration. 3. As a measure of ongoing compliance, DHS or designee to round on all residents receiving respiratory interventions to ensure all equipment is labeled and dated per policy and in place as ordered 5 times weekly x 4 weeks, then 2 times weekly x 4 weeks, then weekly x 4 weeks, then monthly x 3 months or until 100% compliance is maintained. 4. As a quality measure, the Executive Director (ED) or designee will review any findings and corrective action at least quarterly in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted and will continue until 100% compliance is maintained	

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	During an observation, on 12/1/22 at 10:15 a.m., the resident was sitting in a recliner, in her room, without oxygen on. During an observation, on 12/2/22 at 3:34 p.m., the resident was sitting in her room, in her recliner, with her feet elevated and no oxygen on. Oxygen equipment remained in the room. The record for Resident 204 was reviewed on 11/30/22 at 2:31 p.m. Diagnoses included, but were not limited to, hypothyroidism, chronic osteoarthritis and pain, history of hypertension, and chronic lower extremity wounds. A progress note, dated 11/24/22 at 10:41 p.m., indicated the resident had oxygen on. A care plan, dated 12/1/22, indicated the resident had a potential for complications, functional and cognitive status decline related to the resident required oxygen at times. Interventions included, but were not limited to, administer oxygen per physician orders, and assess for level of consciousness and coherency. There was no order for oxygen in the electronic record. During an interview, on 12/1/22 at 10:15 a.m., the resident indicated she did not have to use the oxygen any longer. During an interview, on 12/1/22 at 10:30 a.m., Licensed Practical Nurse 6 indicated the resident's oxygen was no longer in use. No order was in the electronic record to discontinue oxygen.			

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	A current policy, titled "Guidelines for Medication Orders," dated 12/1/21 and received from the Clinical Support Nurse on 12/4/22 at 2:24 p.m., indicated "...a current list of orders will be maintained in the electronic record of each resident...when recording oxygen orders specify...rate of flow, route and rationale...." 3.1-47(a)(6)			
F 0725 SS=E Bldg. 00	483.35(a)(1)(2) Sufficient Nursing Staff §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a			

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	charge nurse on each tour of duty. Based on interview and record review, the facility failed to ensure adequate staff were available to assess a resident after a fall, to ensure a resident received the physician ordered pain medication, a resident's intake was recorded, a resident received showers, a resident received physician ordered blood pressure medication and to address the resident council concerns about call lights for 4 of 4 residents and the resident council group reviewed for sufficient staffing. (Resident T, H, C, D, and the Resident Council Group) Findings include: 1. During an observation, on 11/29/22 at 11:32 a.m., Resident T had a large bruise on her nose, a bruise on the right upper face about the size of a 50 cent piece, and a large abrasion to her forehead about the size of two 50 cent pieces. The resident indicated she fell while she was waiting for help to go to the bathroom. It sometimes would take a while for the staff to answer call lights. The resident had a fall on 11/27/22 which resulted in a hematoma to her head and an ER visit. The facility staff did not document if the hematoma had worsened or improved and did not complete assessments for a concussion as instructed by the ER discharge documents. A physician's order for Resident T, dated 5/19/22 and open ended, indicated to administer hydrochlorothiazide (a medication to treat high blood pressure and fluid retention) 12.5 mg (milligram) once a day if the systolic blood pressure was greater than 160. The Medication Administration Records (MAR), dated 5/1/2022 through 11/30/22, indicated no	F 0725	F725- Sufficient Nursing Staff 1. No residents were affected by alleged deficient practice. 2. All residents have the potential to be affected by alleged deficient practice. All staff educated on answering call lights. 3. As a measure of ongoing compliance, DHS or designee to audit call light wait times on 5 residents on various shifts 3 times weekly x 4 weeks, then 2 times weekly x 4 weeks, then weekly x 4 weeks, then monthly x 3 months or until 100% compliance is maintained. As a quality measure, the Executive Director (ED) or designee will review any findings and corrective action at least quarterly in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted and will continue until 100% compliance is maintained	12/29/2022

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	hydrochlorothiazide had been administered. The resident should have had 29 doses of HCTZ which were not administered. 2. During an interview, on 11/28/22 at 4:38 p.m., Resident H indicated he had requested pain medication and it took over 1 and 1/2 hours to get them. Another time it took over 2 hours before he received the pain medications. The resident's medication for pain had been transcribed incorrectly, on 11/12/22, to be given just as needed instead of routinely as was ordered by the physician and was not corrected until 11/17/22. 3. During an interview, on 4/30/22 at 4:41 p.m., an anonymous complainant indicated Resident J went without food a couple of times including not getting supper on 8/24/22. The resident also had several accidents while waiting for his call light to be answered. The facility failed to document the resident food intakes for dinner (the evening meal) for 8/24/22 and on 9 other days. 4. During an interview, on 11/29/22 at 1:45 p.m., Resident C's family member indicated the resident went three weeks without a shower and the family had questioned the staff if he received a shower. A point of care history, dated 11/1/22 through 11/30/22, indicated the resident received a shower on 11/20/22 which was 19 days after admission and no more showers were documented as given. During an interview, on 12/2/22 at 10:47 a.m., the facility scheduler 6 indicated the staffing was			

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	getting better and it was so bad for a while, some of the CNAs were quitting to go to another place to make more money. The QMAs (Qualified Medication Aides) had to work as CNAs and management staff would have to cover the medication carts. The scheduler, the DHS (Director of Health Services), the wound care nurse and the two MDS staff would help cover. The residents were complaining a lot about call lights in the 100 and 200 halls. The residents would call their family members on their cellular phones to tell them they had to wait on call lights. During an interview, on 12/6/22 at 11:15 a.m., the DHS indicated call light audits were completed sporadically. The DHS would go into a resident room and turn on the call light and stay in the room until the call light was answered. The facility system did not have the capability to monitor call light waiting times. There had been improvement lately on call light wait times which would depend on the census and the staff to resident loads. There was low CNA staffing and the QMAs would have to cover the floor and the administrative staff would have to cover the medication carts. The management staff would have to fill in 2-3 times weekly. 5. During a resident council meeting, on 12/1/22 at 2:00 p.m., Resident D indicated the facility was short staffed and needed more CNAs. The resident was almost sliding out of her wheelchair, turned on her call light and waited over 20 minutes before staff came to help. She had almost slid out of her wheelchair. Her roommate Resident K had ambulated to the nurse's station to look for help and there was staff sitting and standing at the nurses station and were ignoring the call lights. During a review of the resident council meeting			

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	minutes the council had voiced the following concerns: a. On 1/25/22, call light waiting times and the attitudes of CNAs. b. On 3/29/22, call light waiting times. c. On 5/25/22, wait time for medications. d. On 8/19/22, call lights. e. On 11/15/22, call light waiting times. There was no response to the concerns about the call lights documented in the resident council meeting minutes. 6. During a review of the Resident Concern Log, dated 5/18/22 through 11/27/22, there were 21 concerns about call light waiting times and 22 concerns about resident grooming/bathing. The facility responses to the grievances included, apologies, education to staff and assurance to residents their call lights would be answered. During an interview, on 12/7/22 at 4:15 p.m., the Executive Director (ED) indicated the Director of Health Services was doing spot checks on call light responsiveness by walking into a room and pushing the call light to wait to see how long it took staff to answer the light. The new staff had a difficult time transitioning to the normal flow such as assisting residents to the dining room. The other staff had been in a routine during covid when the residents stayed in their room and now the residents were going to the dining room. The staff were used to providing all the resident care on the units. A current policy, titled "Resident Rights Guidelines," dated as reviewed 12/1/2021 and received from the DHS upon admission, indicated "...To ensure residents rights are respected and			

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	protected and provide an environment in which they can be exercised...Residents shall not leave their individual personalities or basic human rights behind when they move to a health campus...Our residents have a right to...Be treated with dignity and respect...Freedom to talk with staff and express concerns/grievances without fear of reprisal...Be treated fairly, courteously and with respect by all staff...." This Federal tag relates to Complaints IN00394417, IN00392390, IN00389008, and IN00388766. 3.1-17(a)			
F 0726 SS=E Bldg. 00	483.35(a)(3)(4)(c) Competent Nursing Staff §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning			

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	and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. Based on interview and record review, the facility failed to ensure a staff member had the appropriate competencies and skills sets when a Certified Resident Care Aide (CRCA) performed the duties of a Certified Resident Medication Aide (CRMA) for 123 days of the 226 days worked. (CRCA 19) Finding includes: During a review of the employee files, on 12/5/22, CRCA 19 was listed as a CRMA who was hired on 9/18/2021. A review of the staff licenses provided by the facility indicated CRCA only held a CNA certificate. During an interview, on 12/5/22 at 3:15 p.m., the Executive Director (ED) indicated CRCA 19 came to Indiana from another state and had taken the QMA course however she had not received her certificate from the state of Indiana yet. The Aide Training, Certification, & Investigations Director from IDOH was contacted, on 12/6/22, for assistance to determine the status of the license for CRCA 19. An email received from [name of college], dated	F 0726	F726- Competent Nursing Staff 1. No residents were affected by alleged deficient practice. 2. All residents have the potential to be affected. All staff requiring licensure and/or certifications reviewed. No further inaccuracies noted. Accounts Payable/Payroll manager educated on required licensure. 3. As a measure of ongoing compliance, Executive Director or designee to review all new hires for required licensure/certifications. ED or designee to review all staff requiring licensure/certifications monthly x 6 months or until 100% compliance is maintained. 4. As a quality measure, the Executive Director (ED) or designee will review any findings and corrective action at least quarterly in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted and will continue until 100% compliance is maintained	12/29/2022

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	12/7/22 at 10:41 a.m., indicated "The Congratulations letter that you sent is a CNA congratulations letter, not a QMA congratulations letter. The only application we have on file for this candidate is an out of state (OR) CNA application. Our testing system shows the candidate was delivered a CNA exam on 12/20/21, the date of the congratulations letter (attached). We submitted the CNA results to IDOH on February 21, 2022. No other scores or applications are in our system for this candidate." A working schedule for CRCA 19 indicated she worked 123 days of her 226 days worked as a QMA. A job description for a CRMA was signed and dated by CRCA 19 on 5/16/22 and indicated "...attend and participate in continuing education programs deigned to keep you abreast of changes in your profession, as well as to maintain your certification on a current status...Must be a Certified Medication Aide, having successfully completed a state approved training program and any necessary examination, and must provide documentation of such certification upon application for the position...." A review of the Medication Administration Record (MAR) and Treatment Administration Record (TAR) for Resident 6, 16, and 17, indicated CRCA 19 administered medications which included controlled substance medications and insulin. The MARs and TARs also indicated CRCA 19 had monitored for targeted behaviors, signs and symptoms of shortness of breath (SOB), signs and symptoms of bleeding along with monitoring for the adverse side effects of antianxiety medications, antidepressant medications, anticonvulsant medications, and			

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	antipsychotic medications. During an interview, on 12/7/22 at 10:50 a.m., the ED indicated CRCA 19 had worked as a CRMA since she was hired on 9/28/21. She had worked as both a QMA and CNA equally. During an interview, on 12/7/22 at 12:36 p.m., the Clinical Support Nurse indicated she could not answer how CRCA 19 came to work as a QMA when she was only had a CNA certificate. During an interview, on 12/7/22 at 12:46 p.m., the ED indicated she was the person who interviewed CRCA 19. CRCA 19 was from another state and indicated she transferred her license to Indiana. When the ED requested and received the form from Ivy Tech, she assumed it was for a QMA certification. In order for a QMA to administer insulin, a special certification was needed. It was normally obtained via Ivy Tech college and would be indicated on the QMA's license. She under the impression CRCA 19 had obtain the extra insulin certification also because this was what CRCA 19 indicated. During an interview, on 12/7/22 at 3:16 p.m., the ED indicated a QMA can complete a medication administration and complete simple treatments such as tropical creams. A QMA should not monitor or assess since it was outside their scope of practice. An Indiana Administration Code Article 2. Qualified Medication Aides indicated "...Scope of Practice...The following tasks are within the scope of practice for the QMA unless prohibited by the facility...Observe and report to the facility's nurse reactions and side effect to medication exhibited by a resident...Administer regularly prescribed			

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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

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	medication which the QMA has been trained to administer only after personally preparing (setting up) the medication to be administered...Count, administer, and document controlled substances...Conduct finger stick blood glucose testing (specific to the glucose meter used), reporting result to the licensed nurse...." 3.1-14(j) 3.1-14(s)			
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;			

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	§483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order 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 residents had an appropriate diagnosis for the use of psychotropic medications and to complete an Abnormal Involuntary Movement Scale (AIMS) assessment for 3 of 6 residents reviewed for psychotropic medications. (Resident 16, M, and K) Findings include: 1. The record for Resident 16 was reviewed on 11/30/22 at 2:39 p.m. Diagnoses included, but were not limited to, dementia, anxiety disorder, chronic pain, and cognitive communication deficit. A PASARR level I, dated 3/21/22, indicated the resident had no mental health diagnoses, dementia, or neurocognitive disorder. The resident did not have an antianxiety,	F 0758	F758- Free from Unnecessary Psychotropic meds/PRN use 1. Residents 16, M, K did not experience any adverse effects related to alleged deficient practice. 2. All residents receiving psychotropic medications are at risk. All residents receiving psychotropics reviewed for appropriate diagnosis, gradual dose reduction attempts per regulations, and AIMS assessment completed per policy. GDR initiated if indicated and AIMS assessment updated as necessary. SSD educated on Psychotropic medication usage and gradual dose reductions.	12/29/2022

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	antipsychotic or antidepressant medication ordered. A physician's order, dated 11/9/22, indicated abilify (an antipsychotic) 2 mg (milligram) capsule by mouth daily. An AIMS assessment was not located in the resident's medical record. 2. The record for Resident M was reviewed on 11/30/22 at 2:15 p.m. Diagnoses included, but were not limited to, dementia, pseudobulbar affect disorder, metabolic encephalopathy, and an anoxic brain injury. A PASARR level I, dated 8/19/22, indicated the resident had no mental health diagnoses, dementia, or neurocognitive disorder. The resident did not have an antidepressant or antianxiety medication ordered. A physician's order, dated 10/15/22, indicated olanzapine (an antipsychotic) 5 mg tablet by mouth daily. A care plan, dated 10/24/22, indicated the resident was at risk for adverse consequences related to receiving an antipsychotic medication. Interventions included, but were not limited to, gradual dose reduction in two separate quarters, observe and report signs of sedation and extrapyramidal symptoms. During an interview, on 12/6/22 at 2:30 p.m., the Executive Director (ED) indicated the resident should have had a new Level I completed when the resident was started on an antianxiety, antidepressant and antipsychotic medication, and an AIMS assessment should have been		3. As a measure of ongoing compliance, SSD to review all residents receiving psychotropic medications to ensure gradual dose reduction has been completed or contraindication containing risk vs benefit analysis has been documented monthly x 6 months or until 100% compliance is maintained. As a quality measure, the Executive Director (ED) or designee will review any findings and corrective action at least quarterly in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted and will continue until 100% compliance is maintained	

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	completed and it was not.3. The record for Resident K was reviewed on 11/30/22 at 5:16 p.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus, unspecified dementia without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. A physician's order, dated 8/23/22, indicated Depakote (a mood stabilizer) sprinkles 125 milligrams three times daily related to delusional disorder, dementia without behaviors, psychotic disturbance, depression, and anxiety. There was no order set in the electronic record to monitor for behaviors related to psychotic disturbance, delusional disorder, or dementia without behaviors. There were no progress notes in the electronic record for behaviors. A pharmacy recommendation, dated 6/14/22 at 6:36 p.m., indicated the resident had been receiving Depakote since 10/20/21. It was time to review the medication to ensure she was receiving the lowest effective dosage. There was no documentation of behavior issues. Consider a reduction to 125 mg twice daily. A pharmacy recommendation, dated 8/28/22 at 7:33 p.m., indicated the resident was receiving psychoactive medications due for gradual dose reduction for mirtazapine and Depakote. The doses were in place since 10/28/21. There was no care plan in the electronic record for delusional disorder, dementia without behaviors, psychotic disturbance, or Depakote. There was no care plan in the electronic record to			

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	monitor for behaviors related to psychotic disturbance, dementia without behaviors, or delusional disorder. During an interview, on 12/05/22 at 12:42 p.m., Certified Resident Care Assistant 4 indicated the resident did not display behaviors to indicate a psychotic disturbance. During an interview, on 12/7/22 at 5:00 p.m., the Clinical Support Nurse indicated the care plans covered sadness and tearfulness but did not cover delusions or psychotic disturbance. A recent publication of "PDR.net" indicated "...Depakote was indicated for the treatment of bipolar disorder including mania...the black box warning indicated antipsychotics are not approved for the treatment of dementia-related psychosis in geriatric patients and the use of Depakote in this population should be avoided if possible due to an increase in morbidity and mortality..." A current policy, titled "Guidelines for: Abnormal Involuntary Movement Scale (AIMS)," dated as revised on 5/22/18 and received from the Clinical Support Nurse on 12/6/22 at 10:30 p.m., indicated "...To assess residents that have prescribed antipsychotic medication to identify symptoms that may indicate the presence of Tardive Dyskinesia; a neurologic disorder characterized by abnormal involuntary movements which may occur as undesired effect of dopamine blocking medications as well as other medications such as Reglan and Levsin...A licensed nurse will completed an AIMS scale assessment on all residents on antipsychotic medications and or other medications known to cause Tardive Dyskinesia...The AIMS assessment will be			

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	completed if possible, prior to the resident beginning this type of medication, or at the earliest possible time; either after admission; after medications listed above are prescribed, and with dosage changes...The AIMS assessment score will be communicated to the attending physician if positive for signs and or symptoms of Tardive Dyskinesia...." A current policy, titled "Psychotropic Medication Usage and Gradual Dose Reduction," dated 11/7/22 and received from the Clinical Support Nurse on 12/5/22 at 4:55 p.m., indicated "...residents shall receive psychotropic medications only if necessary, by the prescriber, with appropriate documentation to support usage...the medical necessity would be documented the resident's medical record and in the care planning process...."' 3.1-48(a)(2) 3.1-48(a)(3) 3.1-48(a)(4)			
F 0760 SS=D 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 residents were free of significant medication errors for pain medication, blood pressure medication and insulin administration for 3 of 3 residents reviewed for medication errors. (Resident T, S and H) Findings include: 1. The record for Resident T was reviewed on 11/30/22 at 2:39 p.m. Diagnoses included, but were	F 0760	F760- Residents are free of significant med errors 1. Residents T, S, and H did not experience any adverse effects related to alleged deficient practice. 2. All residents have the potential to be affected by alleged deficient practice. All controlled substance medications have been reviewed to ensure prescription	12/29/2022

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	not limited to, hypertension, cardiomegaly, localized swelling of the right lower limb, and weakness. A physician's order, dated 5/19/22 and open ended, indicated to administer hydrochlorothiazide (a medication to treat high blood pressure and fluid retention) 12.5 mg (milligram) once a day if the systolic blood pressure was greater than 160. The Medication Administration Records (MAR), dated 5/1/2022 through 11/30/22, indicated no hydrochlorothiazide had been administered. The Vitals report, dated 5/1/22 through 11/21/22, indicated the resident had the following blood pressure readings: 1. On 5/20/22, BP (blood pressure) was 195/68. 2. On 5/24/22, BP was 186/98. 3. On 5/26/22, BP was 165/94. 4. On 5/28/22, BP was 172/74. 5. On 6/2/22, BP was 183/84. 6. On 6/4/22, BP was 164/82. 7. On 6/9/22, BP was 162/92. 8. On 6/14/22, BP was 162/80. 9. On 6/23/22, BP was 169/83. 10. On 7/3/22, BP was 177/94. 11. On 7/10/22, BP was 170/80. 12. On 7/15/22, BP was 174/88. 13. On 7/17/22, BP was 161/88. 14. On 7/18/22, BP was 168/71. 15. On 7/27/22, BP was 163/84. 16. On 7/29/22, BP was 178/85. 17. On 8/19/22, BP was 176/64. 18. On 8/21/22, BP was 165/75. 19. On 9/4/22, BP was 173/74. 20. On 9/13/22, BP was 170/99. 21. On 9/19/22, BP was 162/85. 22. On 9/26/22, BP was 174/90.		and physicians order match. No further inaccuracies noted. All PRN blood pressure medications have been reviewed to ensure required vital signs parameters are attached to order. All licensed staff educated on medication administration. 3. As a measure of ongoing compliance, DHS or designee to observe medication administration for accuracy on 5 residents 3 times weekly x 4 weeks, then 2 times weekly x 4 weeks, then weekly x 4 weeks, then monthly x 3 months or until 100% compliance is maintained. As a quality measure, the Executive Director (ED) or designee will review any findings and corrective action at least quarterly in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted and will continue until 100% compliance is maintained	

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	23. On 9/27/22, BP was 188/82. 24. On 9/29/22, BP was 167/89. 25. On 10/3/22, BP was 177/78. 25. On 10/25/22, BP was 179/74. 26. On 10/26/22, BP was 163/71. 27. On 11/4/22, BP was 181/74. 28. On 11/10/22, BP was 176/94. 29. On 11/14/22, BP was 171/77. The resident should have had 29 doses of HCTZ which were not administered. During an interview, on 12/1/22 at 11:10 a.m., the Clinical Support Nurse indicated the resident had an order for hydrochlorothiazide (HCTZ) once a day for systolic blood pressure greater than 160 and the resident had not received any of the medication when the blood pressure reading was greater than 160. The daily blood pressure had not been linked to the medication. 2. The record for Resident S was reviewed on 12/1/22 at 4:03 p.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus, chronic kidney disease stage 4 and pressure ulcer of the left buttock stage 2. A physician's order, dated 11/22/22, indicated to give Levemir (a long-acting insulin) 70 units twice a day. The MAR, for December 2022, indicated on 12/2/22 the Levemir insulin was not administered in the a.m., due to a low blood sugar reading of 97. A normal blood sugar reading could range from 90-130. During an interview, on 12/6/22 at 11:43 a.m., the Director of Health Services (DHS) indicated there			

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	were no physician orders to hold the Levemir insulin and no documentation to the physician of the Levemir insulin not being administered. During an interview, on 12/6/22 at 11:45 a.m., the Clinical Support Nurse indicated there was no order to hold the Levemir insulin. There was no reason to have held the insulin since a blood sugar of 97 would not determine to the need to hold a long-acting insulin and there was no documentation the physician was notified. 3. During an interview, on 11/28/22 at 4:38 p.m., Resident H indicated he had requested pain medication and it took over 1 and 1/2 hours to receive the medication and another time it took over 2 hours. The record for Resident H was reviewed on 12/1/22 at 3:36 p.m. Diagnoses included, but were not limited to, spinal stenosis of the cervical region, hypertensive heart disease with heart failure, chronic obstructive pulmonary disease, osteoarthritis, and type 2 diabetes mellitus with diabetic neuropathy. A New Prescription Summary, written 11/12/22, indicated the physician's order was for hydrocodone (an opioid pain medication) 5 mg-acetaminophen 325 mg tablet, one every 6 hours by mouth for 7 days. The quantity of the medication was 28 tablets. A progress note, dated 11/12/22 at 9:23 a.m., indicated the resident had complained of pain of a 9 out of 10 and the physician gave a new order for hydrocodone 5-acetaminophen 325 mg four times a day as needed. The MAR, dated 11/1/22 through 11/30/22,			

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	indicated the hydrocodone 5 mg-acetaminophen 325 mg was one tablet every 6 hours as needed. The original prescription, dated 11/12/22, was written every 6 hours and not as needed. A Synchrony Pharmacy Controlled Drug Use Record, dated 11/12/22, indicated hydrocodone 5 mg-acetaminophen 325 mg one tab by mouth every 6 hours. A progress note, dated 11/17/22 at 6:04 p.m., indicated there was a new order to change the hydrocodone-acetaminophen from as needed to routine. This was not a change as the original prescription was for routine and not for an as needed administration. During an interview, on 12/5/22 at 12:30 p.m., the Clinical Support Nurse indicated the order for the hydrocodone-acetaminophen should have been clarified since the progress noted stated the medication was written as needed and the physician order was routine and not as needed. A current policy, titled "Guidelines for Medication Orders," dated as reviewed on 12/1/2021 and received from the Clinical Support Nurse on 12/4/22, indicated "...To establish guidelines in the receiving and recording of medication orders...When recording medication orders specify...They type, route, dosage, frequency, strength of the medi[c]ation and reason for the order...Telephone or verbal orders for drugs must include...The name and strength of the drug...The quantity or specific duration of the drug...The dosage and frequency of administration...Route of administration...Diagnosis for use...Date and time			

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	order received...Telephone or verbal orders shall be countersigned by the physician as designated by state regulation...." A current policy, titled "Medication Administration General Guidelines," dated as revised on 01/17 and received from the Clinical Support Nurse on 12/6/22 at 2:24 p.m., indicated "...Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so...FIVE RIGHTS...Right resident, right drug, right dose, right route and right time, are applied for each medication being administered...." This Federal tag relates to Complaint IN00392390. 3.1-25(b)(9) 3.1-48(c)(2)			
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide			

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	separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, interview and record review, the facility failed to ensure refrigerator temperature logs were completed, the thermometer in the freezer was working, and a resident self-administering medications, insulins and eye drops were labeled and stored in a locked area for 1 of 1 medication room and 1 of 1 resident reviewed for medication storage. (Resident 205) Findings include: 1. During an interview, on 12/1/22 at 11:14 a.m., Resident 205 indicated he kept his eye drops, in his room, in medication bottles which were not labeled. He was administering his own insulin and kept the insulin in his drawer. During an observation, on 12/1/22 at 11:14 a.m., three medication bottles with the labels removed were sitting on the resident's bedside table with eye drops and ointments in them. A plastic pencil box was in the opened drawer of the bedside table with insulin. A biohazard box was sitting on top of the bedside table with old insulin pen needles in it. The record for Resident 205 was reviewed on 12/1/22 at 1:30 p.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus with chronic kidney disease, and unspecified cataract.	F 0761	F761- Label/Store drugs and biologicals 1. Resident 205 did not experience any adverse effects related to alleged deficient practice. 2. All residents have the potential to be affected by alleged deficient practice. All medication refrigerators reviewed to ensure thermometer in place and temperature logs completed. All residents self-administering medications reviewed for proper storage with no further concerns. Licensed clinical staff educated on medication storage. 3. As a measure of ongoing compliance, DHS or designee to review refrigerator/freezer temperature logs utilized for medication storage for completion 3 times weekly x 4 weeks, then 2 times weekly x 4 weeks, then weekly x 4 weeks, then monthly x 3 months or until 100% compliance is maintained. As a measure of ongoing compliance, DHS or designee to round on all residents self-administering medications to ensure proper	12/29/2022

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	155819	A. BUILDING 00 B. WING	12/07/2022

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	A physician's order, dated 11/11/22, indicated erythromycin ointment (antibiotic) 5 milligram/gram 0.5 inches to eye, resident may keep at bedside. A physician's order, dated 11/11/22, indicated plateau drops (glaucoma medication) 0.5% one drop to right eye daily, resident may keep at bedside. A physician's order, dated 11/11/22, indicated Thera tears drops (artificial tears) one drop hourly as needed, resident may keep at bedside. A physician's order, dated 11/11/22, indicated Humalog (insulin) Kwik pen insulin 100 units/milliliters, amount per sliding scale four times daily. May keep at bedside. A physician's order, dated 11/11/22, indicated Humalog Kwik pen insulin 100 units/milliliters, 4 units subcutaneous before meals. May keep at bedside. A physician's order, dated 11/11/22, indicated Lantus Solostar (insulin) insulin pen 100 units/milliliter 20 units at bedtime A self-administration assessment, dated 11/11/22 at 5:02 p.m., indicated insulins were appropriately labeled and stored in the medication cart. The resident was determined to be appropriate for self-administration. A self-administration assessment, dated 11/11/22 at 8:45 a.m., indicated eye drops were appropriately labeled and stored in the room. The resident was determined to be appropriate for self-administration.		storage of medications 3 times weekly x 4 weeks, then 2 times weekly x 4 weeks, then weekly x 4 weeks, then monthly x 3 months or until 100% compliance is maintained. 4. As a quality measure, the Executive Director (ED) or designee will review any findings and corrective action at least quarterly in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted and will continue until 100% compliance is maintained	

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	There was no care plan for self-administration of medication. During an interview, on 12/3/22 at 11:30 a.m., the Assistant Director of Health Services indicated the eye medication prescribed were in unlabeled bottles without labels or open dates on the medications. The insulin pens were in the bedside table which was not a locked drawer, in a plastic pencil box, and the insulins were not labeled. He was not aware of a policy requiring the medications to be locked.2. During an observation, on 12/01/22 at 11:23 a.m., LPN 5 indicated the refrigerator had a locked box inside it which contained lorazepam (antianxiety medication). The medication storage room refrigerator temperature was 32 degrees, and the freezer had a thermometer without a battery. The temperature log was missing dates for March, April, May, June and missing sheets for July, August, September, October, November, and December 2022. During an interview, on 12/01/22 at 11:26 a.m., the Director of Health Services indicated her expectations was for the staff to fill out the temperature logs for the medication room freezer and refrigerator A current policy, titled "Guidelines for Self-Administration of Medications," dated 5/22/18 and received from the Clinical Support Nurse on 12/2/22 at 9:56 a.m., indicated "...residents requesting self-medicate...shall be assessed ...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 or AMA (qualified medication aide)...."			

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	A current policy, titled "Medication Storage in the Facility," dated 1/17 and received from the Clinical Support Nurse on 12/2/22 at 9:51 a.m., indicated "...all medications dispensed by the pharmacy are stored in the container with the pharmacy label...." A current policy, titled "Storage of Medications," dated as revised on 5/2017 and received from the Clinical Support Nurse on 12/2/22 at 9:51 a.m., "...Medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. The medications supply is accessible only to licensed facility personnel, pharmacy personnel, or staff members lawfully authorized to administer medications...Only licensed nurses, pharmacy personnel, and those lawfully authorized to administer medications (such as medication aides) are permitted to access medications. Medications rooms, carts, and medication supplies are locked when not attended by persons with authorized access...Except for those requiring refrigeration or freezing, medications intended for internal use are stored in a medication cart or other designated area...." 3.1-25(j) 3.1-25(m)			
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.			

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	§483.70(i) Medical records. §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			

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	(ii) Five years from the date of discharge when there is no requirement in State law; or (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 interview and record review, the facility failed to document a resident's food intake for 1 of 3 residents reviewed for complete and accurate documentation. (Resident J) Finding includes: During an interview, on 4/30/22 at 4:41 p.m., an anonymous complainant indicated the resident went without food a couple of times including not getting supper on 8/24/22. The record for Resident J was reviewed on 11/30/22 at 3:46 p.m. Diagnoses included, but were not limited to, aortic abdominal aneurysm repair graft, abscess of the abdominal wall, type 2 diabetes mellitus, chronic obstructive pulmonary disease, and anxiety disorder. A care plan, dated 8/11/22, indicated the resident was at a risk for dehydration and fluid imbalance.	F 0842	F842- Resident Records-Identifiable information 1. Resident J did not experience any adverse effects from alleged deficient practice. 2. All residents have the potential to be affected by alleged deficient practice. All residents reviewed for completion of meal documentation with records updated as needed per policy. All clinical staff educated on meal consumption documentation. 3. As a measure of ongoing compliance, MDSC or designee to audit meal consumption documentation for completion 5 days a week x 4 weeks, then 3 days a week x 4 weeks, then weekly for a minimum of 4 months or until 100% compliance is	12/29/2022

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	The interventions included, but were not limited to, observe and report to the physician and registered dietician any decreases in intakes. A care plan, dated 8/11/22, indicated the resident was at a risk of malnutrition related to diagnoses, inadequate intakes, and/or metabolic demands. The interventions included, but were not limited to, assist with meals as needed, offer alternate food and beverage items as needed, and provide diet as ordered. A care plan, dated 8/11/22, indicated the resident had an impairment in functional status. The interventions included, but were not limited to, the resident required supervision and assistance with eating. A summary of breakfast, a.m. snacks, lunch, p.m. snacks, dinner, bedtime snacks, supplement, and fluid record, from 8/5/22 through 91/3/22, showed the resident had no documentation for the following meals: a. No documentation of lunch on 8/7/22 b. No documentation of dinner on 8/9/22 c. No documentation of dinner on 8/24/22 d. No documentation of dinner on 8/25/22 e. No documentation of dinner on 8/26/22 f. No documentation of lunch on 8/27/22 g. No documentation of lunch on 8/29/22 h. No documentation of breakfast, lunch, or dinner on 8/30/22 i. No documentation of dinner on 9/9/22. j. No documentation of dinner on 9/11/22. The electronic record did not have documentation if the resident received the meals and did not eat them or if the resident did not receive the meals. Upon exit, the facility had not presented a policy		maintained. As a quality measure, the Executive Director (ED) or designee will review any findings and corrective action at least quarterly in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted and will continue until 100% compliance is maintained	

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	on documentation of food intakes. This Federal tag relates to Complaint IN00389008. 3.1-50(a)(1) 3.1-50(a)(2)			
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other			

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	persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. Based on observation, interview and record	F 0880	F880	12/29/2022

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	review, the facility failed to develop and implement written policies and procedures for infection control, to contain the spread of infections including the Covid-19 virus, when the facility failed to ensure doors remained closed during and after an aerosol treatment and staff wore Personal Protective Equipment (PPE) when administering an aerosol treatment to 1 of 5 residents reviewed for medication administration. (Resident 155) Finding includes: During an observation, on 12/1/22 at 10:05 a.m., RN 5 indicated she was giving Resident 155 her aerosol treatment. She entered the resident's room without putting on Personal Protective Equipment (PPE), started the resident's aerosol treatment and exited the room without shutting the door. There were no PPE storage bins outside of the resident's room. During an observation, on 12/1/22 at 2:30 p.m., five isolation bins were added to the hallway for residents with aerosol treatments for Rooms 203, 206, 208, 220 and 231. The record for Resident 155 was reviewed on 11/30/22 at 4:10 p.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease, acute and chronic respiratory failure, anxiety disorder, and shortness of breath. A physician's order, dated 4/26/22, indicated to give Perforomist (formoterol fumarate) (a bronchodilator) 20 mcg(micrograms/2ml(milligrams) solution for nebulization two times a day. A physician's order, dated 5/2/22, indicated to		1.Resident 1 did not experience any adverse effects related to alleged deficient practice. 2.All residents have the potential to be affected. Clinical staff to be educated, following CDC and facility policy. The Executive Director (ED), Director of Health Services (DHS), Campus Infection Preventionist (IP), and consultant Infection Preventionists to complete a root cause analysis (RCA). Along with RCA, the same team will review the Long-Term Care Facility Self-Assessment for determination of accuracy with adjustments made as needed. Additional education to be scheduled based on review of the RCA and Facility Self-Assessment. 3.As a measure of ongoing compliance, DHS or designee to audit all residents receiving aerosol treatments to ensure bins are in place daily x 6 weeks. DHS or designee to observe donning/doffing of PPE per guidance on 3 staff members daily x 6 weeks. DHS or designee to observe donning/doffing of PPE per guidance on 3 staff members daily x 6 weeks. 4.The results of the audit observations will be reported, reviewed and trended for compliance through the facility Quality Assurance Committee for a minimum of 6 months to ensure substantial compliance is	

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	give 0.5mg/2ml budesonide (a steroid) solution for nebulization two times a day. During an interview, on 12/1/22 at 10:08 a.m., RN 5 indicated she did not shut the door after she started Resident 155's aerosol treatment. She thought the door was supposed to be shut during the aerosol treatment and 30 minutes after the treatment was finished. She did not think PPE was needed. She would have to double check. During an interview, on 12/1/22 at 10:10 a.m., the Director of Health Services (DHS) indicated she would have to check the aerosol treatment policy to be sure. She thought the resident's door should remain shut during the treatment and 30 minutes after. During an interview, on 12/1/22 at 10:12 a.m., RN 5 indicated she checked the policy, and the door was to be shut during the treatment and 1 hour after the treatment. She indicated she shut the resident's door. During an interview, on 12/1/22 at 10:25 a.m., the DHS indicated the door was to be kept shut 1 hour after a treatment. During an interview, on 12/02/22 at 9:08 a.m., the Clinical Support Nurse indicated the isolation bins were placed because the residents were on Transmission Based Precaution (TBP). The signs were also placed on the resident's door because of the TBP. The doors were to remain closed for 1 hour post treatment. A current policy, titled "Infection Prevention and Control Program (IPCP)," dated as revised on 11/10/17 and received upon entrance, indicated "...To establish and maintain an infection		maintained. Ongoing monitoring will continue past 6 months if warranted until 100% compliance met.	

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	preventionist and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections...The campus has a system for preventing, identifying, reporting, investing, and controlling infections and communicable diseases that: Covers all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement...Follows acceptable national standards...Reviews each department's policies and procedures annually for their adherence to infection control principles. Including nursing..." 3.1-18(b)			
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey. This visit also included the Investigation of Nursing Home Complaints IN00379823, IN00389008, IN00388766, IN00392390, IN00394256 and IN00394417. Complaint IN00379823 - Substantiated. Federal deficiencies related to the allegations are cited at F583. Complaint IN00389008 - Substantiated. Federal deficiencies related to the allegations are cited at F580, F692, F725 and F842. Complaint IN00388766 - Substantiated. Federal deficiencies related to the allegations are cited at F677 and F725. Complaint IN00392390 - Substantiated. Federal	R 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	

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	deficiencies related to the allegations are cited at F725 and F760. Complaint IN00394256 - Substantiated. Federal deficiencies related to the allegations are cited at F686. Complaint IN00394417 - Substantiated. Federal deficiencies related to the allegations are cited at F677, F684, F690 and F725. Survey dates: November 28, 29, 30, December 1, 2, 5, 6 and 7, 2022. Facility number: 013153 Residential Census: 30 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review was completed on December 14, 2022.		respectfully requests from the department a desk review for substantial compliance.	
R 0217 Bldg. 00	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the			

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	155819	A. BUILDING 00 B. WING	12/07/2022

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
	resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided.			
	Based on interview and record review, the facility failed to ensure service plans were signed and dated by the resident or resident's representative for 7 of 7 residents reviewed for service plans. (Resident 331, 311, 314, 329, 328, 320 and 309) Findings include: 1. The record for Resident 331 was reviewed on 12/1/22 at 11:56 a.m. Diagnoses included, but were not limited to, hypertension, and hypokalemia. A service plan, dated as recorded on 9/27/22, was not signed and dated by the resident or resident's representative. 2. The record for Resident 311 was reviewed on 12/1/22 at 12:38 p.m. Diagnoses included, but were not limited to, bradycardia, hyperlipidemia, and insomnia. A service plan, dated as completed on 11/30/22, was not signed and dated by the resident or resident's representative.	R 0217	R217- Evaluation 1. Residents 331, 311, 314, 329, 328, 320, 309 did not experience any adverse effects related to alleged deficient practice. 2. All residents have the potential to be affected. All service plans reviewed and signed as warranted. Director of AL educated on Service Plan Guidelines. 3. As a measure of ongoing compliance, DHS or designee to review service plans for completion and timeliness on all new admissions and 5 residents weekly x 3 months, then monthly x 3 months or until 100% compliance is maintained. 4. As a quality measure, the Executive Director (ED) or designee will review any findings and corrective action at least quarterly in the campus Quality	12/29/2022

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	3. The record for Resident 314 was reviewed on 12/1/22 at 3:25 p.m. Diagnoses included, but were not limited to, anemia, back pain, adult failure to thrive, and acute kidney disease. A service plan, dated as completed on 9/7/22, was not signed and dated by the resident or resident's representative. 4. The record for Resident 329 was reviewed on 12/1/22 at 3:59 p.m. Diagnoses included, but were not limited to, hypertension. A service plan, dated as completed on 9/7/22, was not signed and dated by the resident or resident's representative. 5. The record for Resident 328 was reviewed on 12/2/22 at 10:42 a.m. Diagnoses included, but were not limited to, hypertension, diabetes mellitus, pacemaker, and anxiety. A service plan, dated as completed on 9/7/22, was not signed and dated by the resident or resident's representative. 6. The record for Resident 320 was reviewed on 12/2/22 at 11:11 a.m. Diagnoses included, but were not limited to, anxiety, rheumatoid arthritis, weakness, and hyperkalemia. A service plan, dated as completed on 01/10/22, was not signed and dated by the resident or resident's representative. 7. The record for Resident 309 was reviewed on 12/2/22 at 11:36 a.m. Diagnoses included, but were not limited to, hypertension and hypercholesteremia.		Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted and will continue until 100% compliance is maintained	

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	A service plan, dated as completed on 05/4/22, was not signed and dated by the resident or resident's representative. During an interview, on 12/6/22 at 4:50 p.m., the Clinical Support Nurse indicated service plans should be signed by the resident or the resident's representative. A current facility policy, titled "AL-Evaluation and Service Plan Guidelines," dated as reviewed on 3/24/22 and received by the Clinical Support Nurse on 12/5/22 at 3:00 p.m., indicated "...A service plan shall be identified and implemented in response to the resident's evaluation and in collaboration with the resident and/or responsible party...."			
R 0296 Bldg. 00	410 IAC 16.2-5-6(b) Pharmaceutical Services - Noncompliance (b) The facility shall maintain clear written policies and procedures on medication assistance. The facility shall provide for ongoing training to ensure competence of medication staff. Based on observation, interview and record review, the facility failed to ensure staff were competent in insulin administration for 2 of 2 residents reviewed for insulin administration. (Resident 328 and 332) Findings include: 1. On 12/5/22 at 11:15 a.m., QMA 20 was observed to administer Novolog FlexPen (an insulin) 6 units to Resident 328. QMA 20 did not prime the pen prior to administration. A physician's order, dated 6/30/20, indicated to	R 0296	R296- Pharmaceutical Services 1. Resident 328 and 332 did not experience any adverse effects related to alleged deficient practice. 2. All residents requiring insulin administration are at risk. All insulin trained staff observed administering insulin pen as ordered for proper procedure. All insulin trained staff educated on insulin administration. 3. As a measure of ongoing compliance, DHS or designee to	12/29/2022

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	administer Novolog FlexPen U-100 insulin subcutaneously per sliding scale. 2. On 12/5/22 at 11:45 a.m., QMA 20 was observed to administer Humalog FlexPen (an insulin) to Resident 332. QMA 20 did not prime the pen prior to administration. A physician's order, dated 7/27/21, indicated to administer Humalog U-100, 8 units before meals subcutaneously in addition to the sliding scale. During an interview, on 12/5/22 at 11:55 a.m., QMA 20, when asked about priming the pens before administering insulin, indicated "should I have primed it with 1 unit?" During an interview, on 12/5/22 at 4:50 p.m., the Clinical Support Nurse indicated insulin pens should be primed before being administered. A current facility document, titled "User Manual KwikPen pre-filled insulin pen" dated July 2020 and received from the Clinical Support Nurse on 12/5/22 at 4:50 p.m., indicated "Priming your pen means removing the air from the Needle and Cartridge that may collect during normal use and ensures that the Pen is working correctly. If you do not prime before each injection, you may get too much or too little insulin...To prime your Pen, turn the Dose Knob to select 2 units...Hold your Pen with the needle pointing up. Tap the Cartridge Holder gently to collect air bubbles at the top...Continue holding your Pen with Needle pointing up. Push the Dose Knob in until it stops, and "0" is seen in the Dose window. Hold the Dose Knob in and count to 5 slowly. You should see insulin at the tip of the Needle...."		observe insulin administration on 3 residents 3 times weekly x 4 weeks, then 2 times weekly x 4 weeks, then weekly x 4 weeks, then monthly x 3 months or until 100% compliance is maintained. 4. As a quality measure, the Executive Director (ED) or designee will review any findings and corrective action at least quarterly in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted and will continue until 100% compliance is maintained	