STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155222	A. BUILDING 00 B. WING	06/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
KOKOMO HEALTHCARE CENTER	429 W LINCOLN RD KOKOMO, IN 46902

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00410238. Complaint IN00410238 - Federal/State deficiency related to the allegations is cited at F690. Survey date: June 14, 2023 Facility number: 000127 Provider number: 155222 AIM number: 100291430 Census bed type: SNF/NF: 72 Total: 72 Census payor type: Medicare: 4 Medicaid: 62 Other: 6 Total: 72 This deficiency reflects state findings cited in accordance with 410 IAC 16.2-3.1. Quality review was completed on June 22, 2023.	F 0000	Please accept this plan of correction as the provider's credible allegation of compliance. The provider respectfully requests a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	
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.			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Sydnie Reed	Executive Director	07/07/2023

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	§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 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 ensure a resident's catheter drainage bag was not touching the floor for 1 of 3 residents reviewed for suprapubic catheters. (Resident B) Finding includes: An anonymous complaint sent to the Indiana Department of Health indicated there were issues with catheter bags at the facility. On 6/14/23 at 11:12 a.m., Resident B's suprapubic catheter (a catheter surgically inserted into the	F 0690	Please accept this plan of correction as the provider's credible allegation of compliance. The provider respectfully requests a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance. Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: Facility immediately	07/11/2023

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	bladder through the abdominal wall to drain urine from the bladder) drainage bag was observed secured to the bed frame and lying on the floor. At that time, CNA 1 entered the resident's room and indicated the catheter bag should not be lying on the floor. CNA 1 was asked to empty the resident's catheter bag. She indicated there was 1000 ml (milliliters) in the catheter bag. CNA 1 indicated she emptied catheter bags when she noticed they needed emptied. At that time, Resident B indicated she was admitted to the facility in February 2023, and she had been hospitalized March 6 through 13, for what they thought was a drug overdose, but the diagnosis ended up being a severe UTI (Urinary Tract Infection), then she was hospitalized again in April or May for a couple of days for urosepsis. Resident B's record was reviewed on 6/14/23 at 12:32 p.m. Diagnoses included, but were not limited to, multiple sclerosis, Methicillin Resistant Staphylococcus Aureus Infection (MRSA), sepsis, UTI, metabolic encephalopathy, neuromuscular dysfunction of bladder, systemic lupus erythematous (autoimmune disease), rheumatoid arthritis (autoimmune disease), fibromyalgia (autoimmune disease) and presence of urogenital implants. The progress notes were reviewed, which included, but were not limited to, the following: On 2/9/23 at 1:36 p.m., a physician's progress note indicated the visit was for a comprehensive visit. The resident was a new resident to the facility. She had a diagnosis of UTI, multiple sclerosis, and systemic lupus erythematous. On 3/14/23 at 9:45 a.m., the resident was in a lethargic state. She indicated she was not feeling well and felt nauseated and requested to be sent		placed a basin under Resident B's catheter bag during the survey. Resident B's care plan was updated immediately to include basin. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: All residents with a catheter have the potential to be affected. Facility completed a whole house audit of residents with catheters and no other residents were found to be affected by the alleged deficient practice Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: The DON/Designee will complete education with all staff in regards to catheter care practices with emphasis on ensuring no catheter drainage bags are touching the floor. How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The DON/Designee will conduct an audit by observation of catheter care for 5 residents per week for 4 weeks, 3 residents per week for 4 weeks then, 1 resident per week for 4 months to compliance. The results of the audit observations will be reported, reviewed and trended for compliance thru the facility Quality Assurance Committee for a minimum of six	

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	to the hospital for further evaluation. On 3/14/23 at 5:31 p.m., the resident returned from the hospital with documentation indicating she had an infection in her urine. On 3/16/23 at 7:00 p.m., a physician's progress note indicated the resident was readmitted to the facility for metabolic encephalopathy. She was seen and examined for medical necessity for readmission to the facility for metabolic encephalopathy after being sent to the hospital for lethargy. On 3/25/23 at 5:35 p.m., the resident was transferred to the hospital ER (Emergency Room) due to a migraine with complaints of inability to swallow by mouth due to nausea. She "insisted" on going to the ER to be treated. On 3/25/23 at 10:17 p.m., the resident returned from the hospital with an order for Cephalexin 500 mg (milligrams) (an antibiotic medication used to treat infections) by mouth three times a day for a UTI. On 4/17/23 at 5:34 a.m., the resident requested her suprapubic catheter be changed because she suspected it was clogged. Urine flow was visible from the catheter to the urine drainage bag, so the catheter was flushed with sterile water and patency was confirmed. On 5/4/23 at 7:47 p.m., at 6:20 p.m. the resident's suprapubic catheter was irrigated with 60 ml of prescribed compounded solution, the solution set for 30 minutes, then it was drained. The catheter drainage bag was changed, and the suprapubic catheter site was cleaned.		months then randomly thereafter for further recommendation.	

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	On 5/6/23 at 1:00 p.m., a telehealth progress note indicated the resident stated she had frequent loss of consciousness for the past three years and 'i had no workup done because [sic] no one believed me until now when the CNA saw it,' which lasted for seconds she thinks. She had a pain pump, but she had not taken a bolus from the pain pump today. The resident was observed by video. She was also tachycardic (fast heartrate) and hypotensive (low blood pressure) and was concerned about having an infection and wished to go to the ER. An order was given to send to the ER. On 5/6/23 at 10:30 p.m., an eINTERACT SBAR (Situation, Background, Assessment and Recommendations) Summary for Providers entry document indicated the resident's blood pressure was 90/50 at 10:32 p.m., pulse was 110 and irregular at 10:32 p.m. The primary diagnosis included, but were not limited to, multiple sclerosis, epilepsy, systemic lupus erythematosus, Methicillin Resistant Staphylococcus Aureus infection, metabolic encephalopathy, rheumatoid arthritis with rheumatoid factor, presence of urogenital implants, neuromuscular dysfunction of bladder, and fibromyalgia. Recommendations were to send the resident to the ER. On 5/6/23 at 10:56 p.m., Resident B was sent to the ER. On 5/7/23 at 5:10 a.m., the resident was admitted to the hospital for sepsis and an acute UTI. On 5/7/23 at 6:46 p.m., (late note) on 5/6/23 at 9:00 p.m., the resident indicated she had lost her conscious [sic] many times that particular day, but she had not given herself any boluses from her			

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	pain pump. The nurse contacted the physician group on call and was instructed to send the resident to the ER. On 5/10/23 at 7:07 p.m., the resident returned from the hospital. On 5/13/23 at 2:07 p.m., a physician's progress note indicated the resident was evaluated by a video call with the nurse present. Resident B was slow to respond verbally and indicated her arms and legs felt weighted down and she felt malaise (tired and weak) and fatigued. She indicated she felt similar to the same way when she was septic prior to that day. She was slurring her words and the nurse in the room with her indicated this was a new symptom for her. The concern was for sepsis versus cerebral infarct, so the recommendation was to send her to the ER. On 5/13/23 at 2:39 p.m., the resident was transported to the ER by ambulance. On 5/14/23 at 9:22 p.m., the resident received IV (intravenous) fluids and IV antibiotics for MRSA in her urine. A hospital document, titled "Patient Discharge Instructions," dated 3/25/23 at 7:52 p.m., indicated Resident B's hospital discharge diagnoses included, but were not limited to; nausea and vomiting, abdominal pain and UTI. She was prescribed Cephalexin 500 mg by mouth one capsule every six hours until medication was gone. She was also prescribed prochlorperazine (a medication used for nausea and vomiting) 5 mg by mouth as needed for nausea and vomiting. A hospital document, titled "Patient Summary Report," dated 5/7/23 at 3:26 a.m., indicated			

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	Resident B's admitting diagnosis was UTI. The reason she was admitted to the hospital was for sepsis (the body's overwhelming and life-threatening response to an infection which can lead to tissue damage, organ failure, and death) unspecified organism acute UTI and multiple sclerosis. The organism in her urine was the resistive organism MRSA. Her assessment indicated she had a UTI with a neurogenic bladder and the presence of a suprapubic catheter. She had a history of UTI's. Resident B's urine culture from her urine sample on 3/7/23, had Providencia Rottgeri that grew in it and the urine sample from 3/25/23 had MRSA that grew in it. She was started on two different IV antibiotics and her suprapubic catheter was changed at the hospital. She continued to have a fast pulse rate and a low blood pressure. She had hypoalbuminemia, which the Physician indicated complicated all aspects of her care. During an interview, on 6/14/23 at 12:03 p.m., the Executive Director (ED) and Director of Nursing (DON) were in attendance. The DON indicated Resident B kept her bed in the low position, so her catheter bag laid on the floor as it was secured to her bed frame. The resident had a history of UTI's prior to her admission to the facility, which was the reason her physician had the suprapubic catheter placed, to try to prevent further UTI's. A catheter drainage bag care policy to indicate how the catheter bag was to be secured to prevent it from touching the floor was requested on 6/14/23 at 1:07 p.m. During an interview, on 6/14/23 at 2:40 p.m., the ED indicated the facility did not have a catheter drainage bag care policy to indicate to staff how the catheter bag should be secured to prevent it			

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	from touching the floor. This Federal tag relates to Complaint IN00410238. 3.1-41(a)(2)			