STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155678	A. BUILDING 00 B. WING	11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERFORD PLACE HEALTH CAMPUS	800 ST JOSEPH DR KOKOMO, IN 46901

(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 a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. This visit also included the Investigation of Nursing Home Complaint IN00388949 and Residential Complaint IN00391896. Complaint IN00388949 - Substantiated. Federal/State deficiencies related to the allegations are cited at F561. Complaint IN00391896 - Substantiated. State deficiencies related to the allegations are cited at R217. Survey dates: November 14, 15, 16, 17, 18 and 21, 2022. Facility number: 002667 Provider number: 155678 AIM number: 200300090 Census Bed Type: SNF/NF: 45 SNF: 28 Residential: 65 Total: 138 Census Payor Type: Medicare: 22 Medicaid: 40 Other: 11 Total: 73 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.	F 0000	Waterford Place Health Campus POC due: 12-15-22 Date of Compliance: 12-15-22 The submission of this plan of correction does not indicate and admission by Waterford Place Health Campus 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 Waterford Place Health Campus. 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
Rachel Bishir	Executive Director	12/12/2022

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155678	A. BUILDING 00 B. WING	11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERFORD PLACE HEALTH CAMPUS	800 ST JOSEPH DR KOKOMO, IN 46901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Quality review was completed November 30, 2022.			
F 0561 SS=D Bldg. 00	483.10(f)(1)-(3)(8) Self-Determination §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. Based on interview and record review, the facility failed to assess a resident for the preferred time to get out of bed for 1 of 2 residents reviewed for choices. (Resident B) Finding includes:	F 0561	F561- Self Determination 1. Resident B was affected by alleged insufficient practice. 2. All residents have the potential to be affected by the alleged deficient practice. All	12/20/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155678	A. BUILDING 00 B. WING	11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERFORD PLACE HEALTH CAMPUS	800 ST JOSEPH DR KOKOMO, IN 46901

(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
	During an observation, on 11/15/22 at 11:56 a.m., Resident B was laying, in bed, in her room. During an interview, on 11/15/22 at 2:03 p.m., Resident B indicated she would like to get out of bed earlier although the staff did not usually get her up until 11:00 or 11:30 a.m. During an observation, on 11/16/22 at 10:37 a.m., the resident was still in bed and had on a hospital gown. She indicated she was waiting for the CNA to come in and get her up. During an observation, on 11/17/22 at 10:29 a.m., the resident was laying, in bed, in her room and had on a hospital gown. During an interview, on 11/17/22 at 10:34 a.m., RN 6 indicated the resident liked to get out of bed between 10:00 a.m., and 12:00 p.m. Usually it was the same staff who worked on the unit, and they just knew what time the resident wanted to get up. There was nothing in writing to indicate what time the resident preferred to get out of bed. During an observation, on 11/18/22 at 10:28 a.m., the resident was laying, in bed, in her room and was wearing a hospital gown. The record for Resident B was reviewed on 11/16/22 at 4:12 p.m. Diagnoses included, but were not limited to, acute respiratory failure with hypoxia, morbid obesity, body mass index 70 or greater, chronic pain, depression, mild cognitive impairment, deformity of the right ankle, and paraplegic immobility syndrome. A care plan, dated 3/30/20, indicated the resident had an impairment in functional status related to		clinical staff have been educated on resident preferences and profile care guides 3. As a measure of ongoing compliance, the MDSC or designee to review 5 residents profile care guides and preferences to ensure all preferences are care planned 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.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155678	A. BUILDING 00 B. WING	11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERFORD PLACE HEALTH CAMPUS	800 ST JOSEPH DR KOKOMO, IN 46901

(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
	transfers and bed mobility. The approaches included, but were not limited to, the resident required assistance with transfers and bed mobility. A care plan, dated 3/30/20, indicated the resident presented with a diagnosis of depression and had symptoms of isolating, poor self-care, and poor hygiene. The approaches included, but were not limited to, monitor the resident's participation in ADLs (activities of daily living) and leisure activities. A care plan, dated 3/23/22, indicated the resident demonstrated non-compliance with physician orders and or the plan of care. The approaches included, to encourage the resident to participate in decision making by offering choices. A Profile Care Guide, dated 3/17/22, indicated the resident utilized a motorized scooter for mobility and the Maxi Move (a floor lift designed to enable a single caregiver to transfer or reposition a resident who weighs up to 500 pounds). A resident preference sheet, dated 9/15/22, indicate the resident wanted to wake up at 3:00 a.m. The preference sheet did not include the time the resident wanted to get out of bed. A current policy, titled "Resident Rights Guidelines," dated as revised on 5/11/17 and received from the Clinical Support Nurse on 11/17/22 at 4:17 p.m., 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			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155678	A. BUILDING 00 B. WING	11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERFORD PLACE HEALTH CAMPUS	800 ST JOSEPH DR KOKOMO, IN 46901

(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
	behind when they move to a health campus. The following is a list of rights recognized by staff...Be given the information necessary to participate in decisions which affect them both individually and corporately...Be consulted and encouraged to have input into their care plan which guides the services delivered to the resident...." This Federal tag relates to Complaint IN00388949. 3.1-3(u)(1)			
F 0580 SS=D 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			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155678	A. BUILDING 00 B. WING	11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERFORD PLACE HEALTH CAMPUS	800 ST JOSEPH DR KOKOMO, IN 46901

(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
	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 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 ensure the physician was notified of a significant weight gain for 2 of 2 residents reviewed for notification. (Resident 1 and 47) Findings include: 1. The record for Resident 1 was reviewed on 11/16/22 at 10:25 a.m. Diagnoses included, but were not limited to, type 3 diabetes mellitus, hypertension, and reduced mobility. The resident had the following weights: a. On 5/13/22, the weight was 154 pounds. b. On 7/5/22, the weight was 164.4 pounds. c. On 8/2/22, the weight was 170 pounds which	F 0580	F580- Notify of Changes 1. Residents 1 and 47 physicians were notified of significant weight changes. 2. All residents have the potential to be affected by this. Licensed staff educated on notifications to physicians. 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	12/20/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155678	A. BUILDING 00 B. WING	11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERFORD PLACE HEALTH CAMPUS	800 ST JOSEPH DR KOKOMO, IN 46901

(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
	was a 10.39% weight gain in 81 days. A registered dietician (RD) note, dated 8/27/22 at 11:25 a.m., indicated the resident had a significant weight gain of 10.8% since admission. The note did not include the physician was notified of the significant weight gain. An RD note, dated 10/28/22 at 11:51 p.m., indicated the resident had a significant weight gain since admission. There were no new recommendations. The note did not include the physician was notified of the significant weight gain. An RD note, dated 11/16/22 at 1:20 p.m., indicated the resident triggered for a significant weight loss of 14.3% in the last 180 days. There were no new recommendations. An RD note, dated 11/20/22 at 11:51 p.m., indicated the IDT (interdisciplinary team) reviewed the resident and was noted to have a significant weight loss. There was a new order for weekly weights and the resident would be followed on clinically at risk (CAR) and by the RD as warranted. The physician was notified. The resident had a significant weight gain and not a weight loss. During an interview, on 11/21/22 at 10:42 a.m., the Clinical Support Nurse indicated there was no notification to the physician of the significant weight gain in August. The resident did not have a significant weight loss as was documented on 11/20/22 and the documentation was in error. 2. The record for Resident 47 was reviewed on		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.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155678	A. BUILDING 00 B. WING	11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERFORD PLACE HEALTH CAMPUS	800 ST JOSEPH DR KOKOMO, IN 46901

(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
	11/16/22 at 10:22 a.m. Diagnoses included, but were not limited to, bipolar disorder, schizoaffective disorder (a disorder which affects a person's ability to think, feel and behave clearly), pseudobulbar affect (inappropriate involuntary laughing and crying due to a nervous system disorder), anxiety disorder, cognitive communication deficit, vascular dementia without behavioral disturbance, psychotic disturbance, and mood disturbance. A physician's order, dated 4/14/21, indicated the resident's diet was a Controlled Carbohydrate (CCHO) and regular liquids. Resident 47 had a 12.58% weight gain in 6 months. a. On 5/10/2022, the weight was 244.8 pounds. b. On 11/09/2022, the weight was 275.6 pounds. A dietary note, dated 5/30/22 at 12:32 p.m., indicated the resident's intake was 68% in 7 days. The dietitian was unsure of the cause of the weight gain. The physician was not notified of the resident's significant weight gain. A care plan, dated 5/27/21, indicated the resident had continued weight gain since admission. Interventions included, but were not limited to, assist with meals as needed, dietitian to re-evaluate, offer alternate food and beverages items as needed, provide diet, supplements, medications, and adaptive equipment as ordered. During an interview, on 11/21/22 at 9:12 a.m., the Director of Nursing was not aware Resident 47 gained a significant amount of weight and did not believe the residents edema was being monitored.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155678	A. BUILDING 00 B. WING	11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERFORD PLACE HEALTH CAMPUS	800 ST JOSEPH DR KOKOMO, IN 46901

(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
	A current policy, titled "Guideline for Weight Tracking," dated as revised 1/16/21 and received from the Director of Nursing on 11/17/22 at 2:30 p.m., indicated "...To ensure resident weight is monitored for weight gain and/or loss to prevent complications arising from compromised nutrition/hydration...Residents will have their weight taken and recorded upon admission to establish a baseline...Unless otherwise indicated or ordered by the physician the resident will have their weight taken and recorded monthly...Residents who have a weight that seem out of normal range shall be re-weighed to determine the accuracy of the original weight...The physician, resident representative and dietitian shall be notified of a weight variance of 5% in 30 days, 7.5% in 90 days, and 10% in 180 days (unless on a planned weight loss or gain program...." A current policy, titled "Notification of Change in Condition," not dated and received from the Director of Nursing on 11/17/22 at 2:30 p.m., indicated "...To ensure appropriate individuals are notified of change in condition. The facility must inform the resident, consult with the resident's physician and if known notify the resident's legal representative when: A significant change in the resident's physical, mental or psychosocial status. A need to alter treatment significantly...Documentation of notification attempts should be recorded in the resident electronic health record...." 3.1-5(a)(2)			
F 0637 SS=D Bldg. 00	483.20(b)(2)(ii) Comprehensive Assessment After Signifcant Chg §483.20(b)(2)(ii) Within 14 days after the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155678	A. BUILDING 00 B. WING	11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERFORD PLACE HEALTH CAMPUS	800 ST JOSEPH DR KOKOMO, IN 46901

(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
	facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) Based on interview and record review, the facility failed to complete a comprehensive care plan to reflect a significant change for 1 of 1 resident reviewed for hospice services. (Resident 15) Finding includes: The record for Resident 15 was reviewed on 11/21/22 at 9:30 a.m. Diagnoses included, but were not limited to, coronavirus disease (COVID-19) (an infectious disease caused by the SARS-CoV-2 virus), pneumonia, Alzheimer's disease (type of dementia which affects memory, thinking and behavior), Parkinson's disease (brain disorder which causes unintended or uncontrollable movements, such as shaking, stiffness, and difficulty with balance and coordination), ischemic heart disease (disease in the heart's major blood vessels), and pleural effusion (buildup of fluid between the tissues that line the lungs). The record indicated Resident 15 was on hospice. An Admission Minimum Data Set (MDS) assessment, dated 9/15/22, indicated she was admitted from an acute care hospital, and she was not on hospice.	F 0637	F637 Comprehensive Assessment After Significant Change 1. Resident 15 was identified as not having a significant change assessment completed with admission to hospice. MDS significant change assessment has since been completed. 2. All residents with significant changes are at risk. MDSC has been educated on significant change assessments per RAI manual guidelines by the regional Assessment Support Nurse. 3. As a measure of ongoing compliance, MDSC to review 5 residents to ensure all required assessments are completed 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	12/20/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155678	A. BUILDING 00 B. WING	11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERFORD PLACE HEALTH CAMPUS	800 ST JOSEPH DR KOKOMO, IN 46901

(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
	A physician's order, dated 9/28/22, indicated to contact Hospice for any condition change or medication change requests. A Significant Change in Status MDS assessment, dated 11/15/22, lacked indication she was on hospice. During an interview, on 11/21/22 at 9:58 a.m., the MDS Coordinator indicated the 14-day Significant change assessment for Resident 15 was not completed after she was enrolled into a hospice program. A significant change assessment should have been completed within 14 days of the change in status when Resident 15 was admitted to hospice on 9/28/22. During an interview, on 11/21/22 at 10:00 a.m., the Corporate Support MDS indicated the facility would refer to the RAI for the timing of submissions and a Significant Change in Status should have been completed within 14 days of Resident 15 starting on Hospice. The Centers for Medicare and Medicaid (CMS) Resident Assessment Instrument (RAI) Manual version 3.0, dated 10/19, indicated a Significant Change in Status Assessment must be completed by the end of the 14th calendar day following determination a significant change had occurred. 3.1-31(d)(1)		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 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			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155678	A. BUILDING 00 B. WING	11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERFORD PLACE HEALTH CAMPUS	800 ST JOSEPH DR KOKOMO, IN 46901

(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
	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 new PASARR (preadmission screening and resident review) was completed when an antipsychotic medication and new mental health diagnosis was added for 3 of 3 residents reviewed for PASARR. (Resident 12, 47 and 55) Findings include: 1. The record for Resident 12 was reviewed on 11/15/22 at 4:46 p.m. Diagnoses included, but were not limited to, anxiety disorder, depressive episodes, and unspecified dementia with behavioral disturbance. A PASARR, dated 8/30/22, indicated the resident had depression and there were no known recent or current mental health symptoms. The only medication listed was Zoloft (an antidepressant) for depression. There was no evidence of a serious behavioral health condition. If changes occurred or new information refuted the findings, a new screen must be submitted.	F 0644	F644 coordination of PASARR and Assessments 1. Residents 12, 47, and 55 were reviewed and had PASARR completed. 2. Residents receiving antipsychotic medications will be reviewed for PASARR completion and documentation and appropriate diagnosis. 3. All referrals will be assessed for a need of a PASRR on admission and will be completed timely per regulations. Any residents with new orders for antipsychotics will have a PASRR 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	12/20/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155678	A. BUILDING 00 B. WING	11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERFORD PLACE HEALTH CAMPUS	800 ST JOSEPH DR KOKOMO, IN 46901

(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
	A physician order, dated 9/1/22, indicated Seroquel (an antipsychotic) 50 mg (milligram) once a day. During an interview, on 11/16/22 at 2:19 p.m., the Clinical Support indicated the resident's PASARR, dated 8/30/22, did not include the antipsychotic medication Seroquel or a mental health diagnosis of psychosis. A new PASARR was not completed when the Seroquel was added and should have been. 2. The record for Resident 47 was reviewed on 11/16/22 at 10:22 a.m. Diagnoses included, but were not limited to, bipolar disorder, schizoaffective disorder (a disorder which affects a person's ability to think, feel and behave clearly), pseudobulbar affect (inappropriate involuntary laughing and crying due to a nervous system disorder), anxiety disorder, cognitive communication deficit, vascular dementia without behavioral disturbance, psychotic disturbance, and mood disturbance. A PASARR level I, dated 6/11/21, indicated the resident had a diagnosis of major depressive disorder, bipolar disorder, anxiety disorder and dementia. A physician's order, dated 7/14/22, indicated Seroquel (an antipsychotic medication) 75 mg (milligram) at bedtime for hallucinations. A diagnosis of schizoaffective disorder with hallucinations was added 7/18/2022. During an interview, on 11/21/22 at 10:51 a.m., the Social Service Director indicated Resident 47 did not have a PASARR Level I completed when starting an anti-psychotic medication. The Level I should have been done when the resident started on Seroquel.		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.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155678	A. BUILDING 00 B. WING	11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERFORD PLACE HEALTH CAMPUS	800 ST JOSEPH DR KOKOMO, IN 46901

(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
	3. The record for Resident 55 was reviewed on 11/16/22 at 11:06 a.m. Diagnoses included, but were not limited to, Alzheimer's disease, dementia with behavioral disturbance, anxiety disorder, falls, hallucinations (8/2/22), and hypertension. A PASARR level I, indicated the resident was not on an antipsychotic. A physician's order, dated 11/1/22, indicated Risperdal (an antipsychotic) 1 mg tablet at bedtime for hallucinations. A diagnosis of hallucinations was added 8/2/22. During an interview, on 11/21/22 at 10:51 a.m., the Social Services Director indicated Resident 55 should have had a new PASARR Level I when Risperdal was added for hallucinations. A current policy, titled "PASARR Quick Sheet," undated and received from Clinical Support on 11/16/22 at 4:58 p.m., indicated "...New Admissions: If any of the following triggers a positive response, the Level I (MAP 409) will be check YES on Section I and /or II and contact the PASARR office...Individual has a severe mental illness/behavioral health (BH) diagnosis. ex. Schizophrenia, Bipolar Disorder, Major Depression Disorder, Anxiety Disorder...These diagnoses must be given by a Psych MD/ARNP and not by a PCP or some other type of treatment provider other than psychiatry...If an individual with BH has a Primary Diagnosis of Dementia from a Psychiatrist, the Level I (MAP 409) is marked NO on the Level I and a Response to Referral Form is needed...Provisional Admission to a Nursing Facility (MAP 4093) Is to be completed when an individual needs an emergent nursing			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155678	A. BUILDING 00 B. WING	11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERFORD PLACE HEALTH CAMPUS	800 ST JOSEPH DR KOKOMO, IN 46901

(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
	facility admission from a location other than a hospital, it is completed by a nursing facility representative and individual/family, and the resident is expected to stay less than 14 days...." 3.1-16(d)(1)(B)			
F 0658 SS=D Bldg. 00	483.21(b)(3)(i) Services Provided Meet Professional Standards §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. Based on interview and record review, the facility failed to ensure a resident who was diagnosed with dementia with no previous mental health diagnosis met the criteria for a new diagnosis of schizophrenia for 1 of 6 residents reviewed for professional standards of quality. (Resident 47) Finding includes: The record for Resident 47 was reviewed on 11/16/22 at 10:22 a.m. Diagnoses included, but were not limited to, bipolar disorder, schizoaffective disorder (a disorder which affects a person's ability to think, feel and behave clearly), pseudobulbar affect (inappropriate involuntary laughing and crying due to a nervous system disorder), anxiety disorder, cognitive communication deficit, vascular dementia without behavioral disturbance, psychotic disturbance, and mood disturbance. A PASARR level I, dated 6/11/21, indicated the resident had diagnoses of major depressive disorder, bipolar disorder, anxiety disorder, and dementia.	F 0658	. F658 Services provided meet professional standards 1. Resident 47 was reviewed, and diagnosis list updated. 2. All residents receiving psychotropic medications have the potential to be affected. SSD educated on Psychotropic Medication Usage. 3. As a measure of ongoing compliance, SSD or designee to review all residents receiving psychotropic medications have appropriate supporting diagnosis 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	12/20/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155678	A. BUILDING 00 B. WING	11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERFORD PLACE HEALTH CAMPUS	800 ST JOSEPH DR KOKOMO, IN 46901

(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
	A physician's order, dated 7/14/22, indicated Seroquel (an antipsychotic medication) 75 mg (milligram) at bedtime for hallucinations. A diagnosis of schizoaffective disorder with hallucinations was added 7/18/2022. During an interview, on 11/21/22 at 10:51 a.m., the Social Service Director indicated the resident started Seroquel (an antipsychotic) on 7/14/22. The resident had a diagnosis of schizoaffective disorder. A current policy, titled "Psychotropic Medication Usage and Gradual Dose Reduction," revised 10/9/17 and received from Clinical Support on 11/21/22 at 2:30 p.m., indicated "...To ensure every effort is made for residents receiving psychoactive medications to obtain the maximum benefit with minimal unwanted side effects through appropriate use, evaluation and monitoring by the interdisciplinary team...Residents shall receive psychotropic medications only if designated medically necessary by the prescriber, with appropriate diagnosis or documentation to support its usage. The medical necessity will be documented in the resident's medical record and in the care planning process...Efforts to reduce dosage or discontinue psychotropic medications will be ongoing, as appropriate...Reviews of medication use will be conducted by the consultant pharmacist monthly and will...Monitor psychotropic drug use in the campus to ensure that medications are not used in excessive doses or for excessive duration...." 3.1-35(g)(1)		100% compliance is maintained.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155678	A. BUILDING 00 B. WING	11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERFORD PLACE HEALTH CAMPUS	800 ST JOSEPH DR KOKOMO, IN 46901

(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 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 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 observation, interview and record review, the facility failed to assess and document abnormal mouth movements for 1 of 3 residents reviewed for potential medication side effects. (Resident 1) Finding includes: During an observation, on 11/14/22 at 1:39 p.m., Resident 1 was sitting up, in a chair, in her room. She continuously was moving her tongue in and out of her mouth and her tongue appeared swollen. During on observation, on 11/15/22 at 11:45 a.m., the resident was ambulating in the hallway, with her walker, and her tongue was sticking out. During an observation, on 11/16/22 at 10:34 a.m., the resident was ambulating in the hallway, with her walker, and her tongue was sticking out. During an observation, on 11/17/22 at 10:27 a.m., the resident was ambulating in the hallway, with her walker, her tongue continued to move in and out of her mouth even while the resident was talking.	F 0684	F684 Quality of Care 1. Resident 1 was assessed and had AIMS completed. 2. All residents receiving psychotropic medications or with a history of receiving psychotropic medications have the potential to be affected. Licensed clinical staff educated on completing an admission assessment and AIMS assessment. 3. As a measure of ongoing compliance, DHS or designee to review 5 residents to ensure an accurate assessment completed and/or quarterly 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	12/20/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155678	A. BUILDING 00 B. WING	11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERFORD PLACE HEALTH CAMPUS	800 ST JOSEPH DR KOKOMO, IN 46901

(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
	The record for Resident 1 was reviewed on 11/16/22 at 10:25 a.m. Diagnoses included, but were not limited to, atrial fibrillation, type 2 diabetes mellitus, pain in the right hip, reduced mobility, and stiffness of the right knee. The list of diagnoses did not include anything about the resident's tongue movements or swollen tongue. The face sheet listed the resident's allergies as chlorpromazine (an antipsychotic which can cause uncontrollable movements of any part of the body), codeine and penicillin. An admission observation, dated 5/12/22 at 3:43 p.m., indicated the resident's oral cavity had no ulcers, lesions, halitosis, dry membranes, or bleeding gums. The admission assessment did not include continuous movements of the resident's tongue or swelling of the tongue. A physician's progress note, dated 5/24/22, indicated the resident had macroglossia (an enlarged tongue). The physician note did not include the continuous movements of the tongue in and out of the mouth. The diagnoses list did not include the macroglossia. During an interview, on 11/16/22 at 10:56 a.m., the Social Service Director (SSD) indicated the resident was admitted from another facility and there was nothing in the history about the resident having any psychiatric concerns or using antipsychotics.		warranted and will continue until 100% compliance is maintained.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155678	A. BUILDING 00 B. WING	11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERFORD PLACE HEALTH CAMPUS	800 ST JOSEPH DR KOKOMO, IN 46901

(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
	During an interview, on 11/16/22 at 2:16 p.m., the Executive Director (ED) indicated she did not know how the facility was aware the resident had an allergy to chlorpromazine. During an interview, on 11/16/22 at 5:04 p.m., the SSD indicated she talked to the resident who denied a history of any mental health diagnosis. The resident indicated she had been placed in a state facility for several years and then a new physician came, and she was discharged. The resident did not know where she would have received chlorpromazine. During an interview, on 11/21/22 at 3:18 p.m., the Clinical Support nurse indicated when the physician would add a new diagnosis the facility should have added it to the diagnoses list on the face sheet and the macroglossia was not listed. An AIMS (abnormal involuntary movement scale) assessment would not be completed unless the resident was currently taking an antipsychotic. During an interview, on 11/21/22 at 3:52 p.m., the ADHS (Assistant Director of Health Services) indicated the continuous moving of the resident's tongue in and out of her mouth were a baseline for the resident. There was no documentation to show the resident had the mouth movements upon admission and no documentation to show if the mouth movements were the same, better, or worse. A current policy, titled "Guidelines for: Abnormal Involuntary Movement Scale," dated as revised on 5/22/2018 and received from the Clinical Support Nurse on 11/16/22 at 4:58 p.m., indicated "...To assess residents that have been prescribed antipsychotic medications to identify symptoms that may indicate the presence of Tardive			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155678	A. BUILDING 00 B. WING	11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERFORD PLACE HEALTH CAMPUS	800 ST JOSEPH DR KOKOMO, IN 46901

(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
	Dyskinesia; a neurological disorder characterized by abnormal involuntary movements which may occur as an undesired side effect of dopamine blocking medications as well as other medications such as Reglan and Levsin...A licensed nurse will complete an AIMS scale assessment on all residents on antipsychotic medications and or other medications known to cause Tardive Dyskinesia...The AIMS assessment score will be communicated to the attending physician if positive for signs and or symptoms of Tardive Dyskinesia...." The Nursing Drug Handbook indicated chlorpromazine was indicated for the use of psychosis, mania, nausea, vomiting, intractable hiccups and tetanus. The adverse reactions included tardive dyskinesia and seizures. The nursing considerations included, but were not limited to, monitor for tardive dyskinesia which may not appear until months or years later and may persist for life despite stopping the medication. 3.1-37(a)			
F 0686 SS=G Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §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			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155678	A. BUILDING 00 B. WING	11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERFORD PLACE HEALTH CAMPUS	800 ST JOSEPH DR KOKOMO, IN 46901

(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
	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 ensure a resident at risk for development of pressure ulcers received the necessary care, treatment, and services, consistent with professional standards of practice, to prevent a pressure ulcer and promote healing for 1 of 1 resident reviewed for pressure ulcers. (Resident 23) Resident 23 had developed two pressure ulcers at the facility and the wound was discovered as a stage 2 and unstageable. Finding includes: During the initial tour of the facility, on 11/14/22 at 11:30 a.m., Resident 23 was observed sitting, in her bed, with the head of the bed elevated. A low air loss mattress was on the resident's bed. The resident's heels were directly on the mattress. Resident 23 indicated she had a wound on her buttocks which she acquired while in the facility and it caused her pain when she sat to long in one position. She needed help from the staff to reposition due to weakness. During an observation, on 11/14/22 at 2:43 p.m., Resident 23 was observed lying on her back, in bed, with the head of the bed elevated and her heels flat on the mattress. During an observation, on 11/15/22 at 9:16 a.m., Resident 23 was observed lying on her back, in bed, with the head of the bed elevated and her heels flat on the mattress. During a wound observation, on 11/15/22 at 10:30 a.m., the foam dressing for Resident 23's pressure	F 0686	F686- Treatment/Svcs to prevent/heal pressure ulcer 1. Resident 23 pressure ulcer was assessed with no adverse effects noted. 2. All residents have the potential to be affected. All clinical staff educated on pressure ulcer prevention. 3. As a measure of ongoing compliance, DHS or designee to round on all residents with wounds to ensure all wound healing interventions are in place 3 times weekly x 4 weeks, then 2 x weekly 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.	12/20/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155678	A. BUILDING 00 B. WING	11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERFORD PLACE HEALTH CAMPUS	800 ST JOSEPH DR KOKOMO, IN 46901

(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
	wound on the left buttocks was removed. The wound appeared unstageable with tan colored slough on more than 50 percent of the wound bed. The foam dressing had a scant amount of light red colored discharge. Resident 23 reported pain when she was lying in certain positions or for long periods of time. During an observation, on 11/16/22 at 10:30 a.m., Resident 23 was observed lying on her back, in bed, with the head of the bed elevated to a 30-degree angle with her legs slightly elevated. No pillows were observed under her legs or heels to float. At 10:56 a.m., a nurse walked into the room and changed the television channel for Resident 23. No staff asked or assisted her to reposition or float her heels. During an observation, on 11/16/22 at 1:47 p.m., Resident 23 was observed seated, in her wheelchair, with a pressure reducing cushion in place. Her head was down to the right side, and her arms were resting on her inner thighs. Her left ankle was positioned on the inside corner of the left footrest. During an observation, on 11/17/22 at 10:58 a.m., to 11:08 a.m., Resident 23 was observed seated, in her wheelchair, with a pressure reducing cushion in place. She was watching television. She indicated she had not been up to the toilet or repositioned by staff for a while. Her buttock on the left side was very achy. The record for Resident 23 was reviewed on 11/17/22 at 3:15 p.m. Diagnosis included, but were not limited to, diabetes, chronic kidney disease, muscle weakness, respiratory failure, hypertension, coronary artery disease, and unsteadiness on her feet.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155678	A. BUILDING 00 B. WING	11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERFORD PLACE HEALTH CAMPUS	800 ST JOSEPH DR KOKOMO, IN 46901

(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
	An Occupational Therapy Evaluation and Treatment, dated 9/21/22, indicated Resident 23 had impairment in both her right and left arms. A Care Area Assessment (CAA), dated 9/27/22, indicated Resident 23 required extensive assistance for bed mobility, transfers, dressing, toileting, and grooming. She was completely dependent on staff for locomotion, balance during transition, and did not have a pressure ulcer or injury upon admission. The CAA indicated Resident 23 had risk factors related to immobility, incontinence, and poor nutrition. She required a special mattress or seat cushion. A nurse progress note, dated 9/20/22 at 10:44 p.m., indicated Resident 23 had admitted to the facility and had preventative dressings to the resident's coccyx. The progress note lacked indication she had skin breakdown or pressure wounds upon admission to the facility. A physician's progress note, dated 9/21/22 at 9:24 a.m., indicated Resident 23 had thrush in the groin area but no skin break down on the buttocks. A nurse practitioner's progress note, dated 9/29/22 at 7:27 p.m., indicated Resident 23's skin was normal. A nurse practitioner's progress note, dated 10/6/22 at 8:27 p.m., indicated Resident 23 was uncomfortable when she was in bed for a long period of time and increased discomfort when she was in bed at night. Her skin was normal, and she was comfortable in her wheelchair. A nurse progress note, dated 10/14/22 at 4:59 p.m., indicated Resident 23 had an open pressure			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155678	A. BUILDING 00 B. WING	11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERFORD PLACE HEALTH CAMPUS	800 ST JOSEPH DR KOKOMO, IN 46901

(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
	wound to her left upper buttocks which measured 4.5 centimeters (cm) by 4.0 cm in size. Her surrounding skin was reddened and blanchable. She complained of pain and discomfort in the area. The wound was cleansed with wound cleanser, patted dry, and a foam dressing was applied. She was repositioned and given Tylenol for discomfort. The progress note lacked indication the provider was notified. The progress note did not indicate what stage the presssure wound was. A wound care assessment, dated 10/16/22 at 11:05 a.m., indicated treatment orders of wound gel and a foam dressing every three days and as needed. A low air loss alternating mattress was ordered. A nurse practitioner's progress note, dated 10/18/22 at 7:59 p.m., indicated Resident 23's was seen for osteoarthritis, pressure ulcer, and chronic obstructive pulmonary disease. Her pressure ulcer dressing was clean, dry, and intact but lacked indication the provider visualized the pressure wound. A Physical Therapy Discharge Summary, dated 10/7/22, indicated Resident 23 was dependent on staff for transfers, and to sit to stand. She required substantial/maximal assistance to roll left and right. A Care Plan, dated 10/17/22, indicated Resident 23 had a pressure ulcer to the left buttock and indicated the following: a. Administer analgesics per physician's order. b. Assess and record the condition of the skin surrounding the pressure ulcer. c. Encourage fluids. d. Observe and report signs of infection, localized pain, redness, swelling, tenderness, drainage, odor, and fever.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155678	A. BUILDING 00 B. WING	11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERFORD PLACE HEALTH CAMPUS	800 ST JOSEPH DR KOKOMO, IN 46901

(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
	e. Observe for and report signs of pain related to pressure ulcer. f. Obtain a dietary consult. g. Pressure reducing cushion to chair. h. Pressure reducing mattress. i. Provide diet, supplements, vitamins, and minerals as ordered. j. Treatment per physician orders and notify if treatment is not effective. k. Weekly skin assessment, measurement, and observation of the pressure ulcer and record. A Wound Management Report, dated 10/16/22 at 10:55 a.m., indicated Resident 23 had an unstageable deep tissue pressure wound which measured five (5) centimeters (cm) by 5 cm with a depth of 0.1 cm located on her left buttock. The wound had a light amount of serosanguinous drainage with well-defined edges. The surrounding wound was described as erythema (redness) and blanchable. The wound was not present upon entry or admission to the facility. A Wound Management Report, dated 10/17/22 at 10:43 a.m., indicated Resident 23 had a stage two pressure wound which measured 0.6 cm by 0.6 cm with no depth located on her right buttock. The wound had a light amount of serosanguinous drainage with well-defined edges. The surrounding wound was described as erythema (redness) and blanchable. The wound was not present upon entry or admission to the facility. A Wound Management Report, dated 10/17/22 at 11:05 a.m., indicated Resident 23 had an unstageable deep tissue pressure wound and measured six (6) cm by 6 cm with a depth of 0.1 cm. The wound had a light amount of serous (clear, amber, thin, and watery) drainage with irregular wound edges. The surrounding wound			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155678	A. BUILDING 00 B. WING	11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERFORD PLACE HEALTH CAMPUS	800 ST JOSEPH DR KOKOMO, IN 46901

(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
	was described as dark purple or rusty discoloration, erythema and blanchable. She had 75 percent of her wound covered with slough (necrotic tissue which needs to be removed from the wound for healing). No documentation was found in the Wound Management report for weekly wound assessments for the left deep tissue/unstageable pressure wound on the dates of 10/24/22, or 10/31/22. A Wound Management Report, dated 11/2/22 at 12:27 p.m., indicated Resident 23 had a stage two pressure wound which closed. The report indicated staff would continue to monitor for one week. A Wound Management Report, dated 11/2/22 at 12:28 p.m., indicated Resident 23 had an unstageable deep tissue pressure wound which measured four (4) cm by 3.5 cm with a depth of 0.1 cm. The wound had light amount of serous drainage with irregular wound edges. The surrounding wound was described as erythema, blanchable, and edges were well defined. She had 100 percent of her wound covered with slough. A Wound Management Report, dated 11/6/22 at 11:20 a.m., indicated Resident 23 had a unstageable deep tissue pressure wound which measured 3.6 cm by 3.6 cm with a depth of 0.2 cm. The wound had a light amount of serosanguineous drainage with well-defined wound edges. The surrounding wound was described as erythema, blanchable, and edges were well defined. She had 98 percent of her wound covered with slough. A Wound Management Report, dated 11/14/22 at			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155678	A. BUILDING 00 B. WING	11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERFORD PLACE HEALTH CAMPUS	800 ST JOSEPH DR KOKOMO, IN 46901

(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
	10:55 a.m., indicated Resident 23 had an unstageable deep tissue pressure wound which measured 3 cm by 3.7 cm with a depth of 1 cm. The wound had a light amount of serosanguineous drainage with well-defined wound edges. The surrounding wound was described as erythema, blanchable, and edges were well defined. She had 50 percent of her wound covered with slough. A Care Profile indicated to: a. Encourage Resident 23 to float heels while in bed. b. Encourage to turn and reposition while in bed. c. Pressure reducing cushion to wheelchair. d. Pressure reducing mattress. The Care Profile lacked indication for staff to assist with turning and repositioning. Physician orders included, but were not limited to, 1. The right gluteus pressure wound: a. On 10/16/22, wound care directed staff to observe right gluteus dressing to open area(s) every shift for draining on dressing and dislodgement. b. On 10/17/22, wound care directed staff once every five days to cleanse with wound cleanser and gauze, apply skin prep to periwound, place 1-2 mm of wound gel to wound bed and cover with foam dressing to the right gluteus. 2. The left gluteus pressure wound: a. On 9/20/22, complete weekly skin assessments on Monday. b. On 9/21/22, encourage resident to float heels while in bed. c. On 9/21/22, apply pressure reducing cushion to wheelchair. d. On 10/14/22, encourage resident to reposition			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155678	A. BUILDING 00 B. WING	11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERFORD PLACE HEALTH CAMPUS	800 ST JOSEPH DR KOKOMO, IN 46901

(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
	every 2 hours due to worsening open area to left upper buttocks. e. On 10/16/22, wound care directed staff to observe left gluteus dressing to open area(s) every shift for draining on dressing and dislodgement. f. On 10/16/22 to 11/2/22, wound care to left gluteus to cleanse with wound cleanser and gauze, apply NO-Sting skin prep to periwound, place 1-2 mm of wound gel to wound bed and cover with foam dressing. g. On 10/17/22, apply a specialty low air loss alternating pressure mattress. h. On 11/2/22, wound care to left gluteus to cleanse with 0.125% Dakin's Solution and gauze, apply skin prep to periwound, place 2 mm layer of Santyl to wound bed and cover with foam dressing. During an interview, on 10/15/22 at 3:13 p.m., RN 5 indicated Resident 23 had a facility acquired pressure wound on her left buttocks and recently had a facility acquired pressure wound healed on her right buttock. During an interview, on 11/21/22 at 10:44 a.m., the Corporate Support Nurse indicated the pressure wounds on Resident 23 were facility acquired and were unavoidable because of the resident needing the head of the bed up at a 30-degree angle. A current policy, titled "Notification of Change in Condition," not dated and received from the Director of Nursing on 11/17/22 at 2:30 p.m., indicated "...To ensure appropriate individuals are notified of change in condition. The facility must inform the resident, consult with the resident's physician and if known notify the resident's legal representative when: A significant change in the resident's physical, mental or psychosocial status.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155678	A. BUILDING 00 B. WING	11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERFORD PLACE HEALTH CAMPUS	800 ST JOSEPH DR KOKOMO, IN 46901

(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
	A need to alter treatment significantly...Documentation of notification attempts should be recorded in the resident electronic health record...." A current policy, titled "Pressure/Stasis/Diabetic Wound Guidelines," dated as revised 12/01/2021, indicated "...Purpose: To provide weekly documentation of wound measurements and condition...Re-assessment/measurement weekly or with significant change in wound noting the current treatment, medical interventions provided, and comments as needed...." 3.1-40(a)(1)			
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 identify the unique characteristics and abilities, provide supervision, monitor the effectiveness of interventions, and modify the care plan with fall prevention interventions for 1 of 1 resident reviewed for falls. (Resident 15) Finding includes: During an observation, on 11/15/22 at 9:13 a.m., Resident 15 was observed in her room, lying in	F 0689	F689-Free of Accidents/Hazards/Supervision/Devices 1. Resident 15 remains in the campus and has had no adverse effects related to alleged deficient practice. 2. All residents have the potential to be affected. Clinical staff educated on the falls management program. 3. As a measure of ongoing	12/20/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155678	A. BUILDING 00 B. WING	11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERFORD PLACE HEALTH CAMPUS	800 ST JOSEPH DR KOKOMO, IN 46901

(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
	bed, as she kicked her legs over the edge of the bed. She begun to yell for help as she reached up in the air. During an observation, on 11/15/22 at 2:12 p.m., Resident 15 was observed in her room, lying in bed, she yelled out "help me." The fall mat was lying up next to the wall, on the right side of the room, near the door. Resident 15 had attempted to get out of bed, her right leg was over the top of the bed rail. During an observation, on 11/15/22 at 2:45 p.m., Resident 15 was observed in the lounge near the nurse's station, with five other residents, and no staff within sight. She was seated in her Broda chair in a slightly reclined position, holding a white stuffed animal. At 2:47 p.m., Resident 15 begun to yell out, "hey, help me, help me." Resident 15 was leaning forward, trying to rock forward with her back off the backrest of the chair. Staff were observed to walk past the lounge and had no interactions with the residents. The record for Resident 15 was reviewed on 10/4/22 at 8:30 a.m. Diagnoses included, but were not limited to, Alzheimer's disease, dementia, Parkinson's disease, and falls. A Significant Change Minimum Data Set (MDS) assessment, dated 11/15/22, indicated the resident had a severe cognitive impairment, was totally dependent on staff for transfers, bed mobility, dressing, eating, oral hygiene, toilet hygiene, and bathing. A care area assessment (CAA), dated 11/15/22, indicated the resident had triggered for falls and dementia. She was non-ambulatory and used a Broda chair for her mobility. Resident 15 had		compliance, DHS or designee to round on 5 residents to ensure all fall interventions are in place 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 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.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155678	A. BUILDING 00 B. WING	11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERFORD PLACE HEALTH CAMPUS	800 ST JOSEPH DR KOKOMO, IN 46901

(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
	multiple falls since her last assessment with minor injury and required assistance with all the activities of daily living. A Fall Event report indicated, on 10/6/22, Resident 15 had an unwitnessed fall in her room. She was transferring herself, had mild pain in her back, and an abrasion. The risk factors were indicated as cognitive impairment, required assistance with transfers, had difficulties understanding and following directions. Staff initiated an immediate intervention for Resident 15 and placed a mat next to her bed. Additional intervention added was to place Dycem (Non-Slip product) in her Broda chair. A Fall Event report indicated, on 10/12/22, Resident 15 had an unwitnessed fall in her room and was found between her bed and the wall. Resident 15 had complained of mild pain in her right flank area and redness was observed. The risk factors were indicated as cognitive impairment, required assistance with transfers, had difficulties understanding and following directions, and refused to comply with safety measures. Immediate intervention initiated was having the bed in the lowest position. The safety measures in place at the time of the fall was Resident 15 had nonslip socks on. A Fall Event report indicated, on 10/15/22, Resident 15 had an unwitnessed fall in her room when she was self-transferring. The safety equipment in place at the time of the fall included a Broda chair and the bed in lowest position. She had complained of mild pain in her heel. The risk factors were indicated as cognitive impairment, required assistance with transfers and ambulation, had difficulties understanding and following directions, refused to comply with safety			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155678	A. BUILDING 00 B. WING	11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERFORD PLACE HEALTH CAMPUS	800 ST JOSEPH DR KOKOMO, IN 46901

(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
	measures, and she had restlessness present. New interventions initiated immediately were bed in lowest position and repositioned to the opposite side of bed. A nurse progress note, dated 10/15/22, indicated Resident 15 had been attempting to climb out of bed and was yelling. A nurse progress note, dated 10/16/22, indicated the resident was found on the floor when the nurse brought in Resident 15's morphine and Ativan for pain and restlessness. She had blood in her mouth where she had bit her tongue. A Fall Event report indicated, on 10/24/22 at 5:21 p.m., Resident 15 had an unwitnessed fall when self-transferring in her room. She had no safety equipment ordered. Interdisciplinary Team (IDT) reviewed and added no new interventions. A Fall Event report indicated, on 10/24/22 at 10:03 p.m., Resident 15 had an unwitnessed fall when self-transferring and was found on the floor by a family member, lying on her side, in front of the Broda chair. The report indicated she had a fall mat next to her bed as a new intervention. IDT reviewed and indicated to put the bed in a low position as a new intervention. A physician progress note, dated 10/27/22, indicated Resident 15 had multiple falls. A Fall Event report indicated, on 10/28/22, Resident 15 had an unwitnessed fall in her room and was found on the floor against the dresser next to bed. She was self-transferring and toileting just prior to fall. She was agitated and had restlessness. A fall mat was in place for safety equipment. The risk factors were indicated as			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155678	A. BUILDING 00 B. WING	11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERFORD PLACE HEALTH CAMPUS	800 ST JOSEPH DR KOKOMO, IN 46901

(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
	cognitive impairment, required assistance with transfers and ambulation, had difficulties understanding and following directions, refused to comply with safety measures, and required the use of assistive device and forgot to use them. New interventions initiated immediately after the fall were to put her bed in the lowest position. IDT reviewed and added a specialty mattress with bolsters. A Fall Event report indicated, on 11/8/22, Resident 15 had an unwitnessed fall in her room when transferring herself and had no safety equipment in place. She was found in front of her Broda chair. New interventions initiated immediately after the fall were to put her bed in the lowest position. IDT reviewed and added to encourage resident after meals for a new intervention. A Care Plan, dated 9/20/22, indicated Resident 15 was at risk for falling related to diagnoses, medication use, and mobility and indicated the following interventions: a. On 9/20/22, to encourage her to assume standing position slowly. b. On 9/22/22, ensure the floor is free of liquids and foreign objects. c. On 9/20/22, to keep call light within reach. d. On 9/20/22, to keep her personal items and frequently used items within reach. e. On 9/20/22, to provide non-skid footwear. f. On 9/20/22, to staff to assist resident with transfers. g. On 9/20/22, therapy evaluation and treatment as needed. h. On 10/7/22, to use Dycem to Broda chair. i. On 10/17/22, to encourage her to sit in common area while up. j. On 10/17/22, use touch pad call light. k. On 10/25/22, to put the bed down low.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155678	A. BUILDING 00 B. WING	11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERFORD PLACE HEALTH CAMPUS	800 ST JOSEPH DR KOKOMO, IN 46901

(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
	l. On 10/25/22, to administer medication. m. On 10/31/22, to use specialty mattress with bolsters. n. On 11/9/22, to encourage resident to lay down after meals. The Care Plan lacked indications for staff to provide supervision or frequent supervisions. During an interview, on 11/15/22 at 3:10 p.m., Licensed Practical Nurse (LPN) 4 indicated staff would bring Resident 15 out to the lounge and let her sit in her Broda chair. The nursing staff are busy with medications to pass and treatments to provide. Supervision of the lounge occurs when she attempted to get out of her chair or yell out. She did well when she had one on one interactions or when she was in a quiet, calm environment. Resident 15 needed supervision while she was in her room or in the lounge to reduce the number of falls. During an interview, on 11/21/22 at 9:30 a.m., the Clinical Support nurse indicated fall preventions were put into place for Resident 15 and each fall was reviewed. During an interview, on 11/21/22 at 5:20 p.m., the Executive Director indicated a root cause analysis was completed for Resident 15. A request for a copy of the Root Cause Analysis for each fall was requested and was not provided. The Fall Event Reports indicated a root cause was found but lacked the information of the findings. A review of a facility document, titled "Recorded Falls Report," dated from 5/2/22 to 11/13/22, indicated the facility had a total of 134 falls.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155678	A. BUILDING 00 B. WING	11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERFORD PLACE HEALTH CAMPUS	800 ST JOSEPH DR KOKOMO, IN 46901

(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
	A current facility policy, titled "Fall Management Program Guidelines," with a revision date of 5/31/17, indicated the "Fall Event," included an investigation of circumstances surrounding the fall to determine the cause, reassessment to identify possible contributing factors, interventions to reduce risk of repeat episodes and a review by the interdisciplinary team (IDT) to evaluate the thoroughness of the investigation. 3.1-45(a)(2)			
F 0693 SS=D Bldg. 00	483.25(g)(4)(5) Tube Feeding Mgmt/Restore Eating Skills §483.25(g)(4)-(5) Enteral Nutrition (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)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. Based on record review and interview, the facility failed to ensure a resident with a Gastrostomy tube (GT) feeding received care and services for	F 0693	F693- Tube feeding mgmt./restore eating skills 1. Residents 61 and 121 remain	12/20/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155678	A. BUILDING 00 B. WING	11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERFORD PLACE HEALTH CAMPUS	800 ST JOSEPH DR KOKOMO, IN 46901

(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
	the feeding tube to meet the resident's needs, related to not checking for residual volume prior to administration of tube feeding, ensure the catheter syringe and graduated cylinder were labeled, dated, and stored appropriately for 2 of 2 residents reviewed for tube feeding. (Resident 61 and 115) Findings include: 1. During an observation, on 11/14/22 at 12:45 p.m., Resident 61 was observed in his room, lying in bed, on a low air loss mattress. The head of the bed was elevated to a 30-degree angle. His upper body was positioned to the right side of the bed with his right temple area resting on the bed rail. During an observation, on 11/16/22 at 9:36 a.m., to 9:45 a.m., Resident 61 was observed in his room, lying in bed, with the head of bed at a 50-degree angle. Two small black fruit flies flew around the bedside table and landed on the tube feeding equipment. A catheter syringe for the tube feeding was not dated and was laid on top of the bed side table which was more than 50 percent dirty. Another catheter syringe and graduated cylinder was open and undated on the bed side table. An intravenous (IV) pole with a tube feeding pump was unplugged. The IV pole had a tan colored dried formula on the upper part of the IV pole and on the touch screen of the pump. During an observation, on 11/16/22 at 2:09 p.m., Resident 61 was leaning to the right side of the bed with his head resting on the side rail. The head of the bed was elevated to 30 degrees. During an observation and interview, on 11/17/22 11:35 a.m., Resident 61 was observed lying to the right side of the bed with his head over to the		in the campus with no adverse effects from alleged deficient practice. 2. All residents requiring tube feedings have the potential to be affected. Licensed staff educated on tube feeding policy and procedure. 3. As a measure of ongoing compliance, DHS or designee to round on all residents requiring tube feedings to ensure proper storage of equipment 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 observe licensed staff perform bolus tube feeding 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	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155678	A. BUILDING 00 B. WING	11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERFORD PLACE HEALTH CAMPUS	800 ST JOSEPH DR KOKOMO, IN 46901

(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
	edge of the bed and near the bed rail. A Qualified Medication Aide (QMA) and Registered Nurse (RN) 6 repositioned Resident 61 and removed the abdomen compression band which had covered his G-tube. RN 6 had reviewed the orders and gathered the supplies for Resident 61's tube feeding. He connected a 60 ml catheter syringe to the opening of the G-tube and aspirated gastric contents. The 60 ml syringe was filled slightly above the 60 ml line and the G tube was filled with tan colored formula. RN-6 pushed the formula back into the G-tube, and then flushed with water. He administered a water flush before and after he gave Resident 61's his medication. After the medication administration, RN-6 administered 300 ml of Jevity formula and 120 ml of water. Resident 61 had facial grimacing, moaning out, a distended stomach, and audible expiratory wheezes (relatively high-pitched whistling noise produced by movement of air through narrowed or compressed small airways). RN 6 indicated the physician's order lacked indication of how many times he needed to pull back for the residual volume or when to notify the physician. The record for Resident 49 was reviewed. Diagnoses included, but were not limited to, cerebral infraction (stroke), non-st elevation myocardial infarction (heart attack), dementia, chronic kidney disease (kidney failure), dysphagia (swallowing difficulties), and chronic obstructive pulmonary disease (diseases which cause airflow blockage). A Care Area Assessment (CAA), dated 9/22/22, indicated Resident 61 received tube feedings and water flushes. Resident 61 required assistance from staff for all activities of daily living. Resident 61's Physician Order Report, dated			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155678	A. BUILDING 00 B. WING	11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERFORD PLACE HEALTH CAMPUS	800 ST JOSEPH DR KOKOMO, IN 46901

(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
	9/17/22 to 11/18/22, included, but were not limited to, a. On 10/20/22 to 11/12/22, staff were to change irrigation set every day. b. On 10/20/22 to current, check tube placement by air bolus and aspirating stomach contents before medication delivery. c. On 10/20/22 to 11/15/22, staff were to check residual every shift and document the amount of residual. d. On 11/17/22 to current, check residual every shift and document amount of residual. A Care Plan, dated 10/12/22, indicated Resident 61 required tube feeding, related to a stroke. Interventions included, but were not limited to, a. Assess for complications. b. Administer enteral feeding per doctor's order. c. Assess for hydration. d. Check for gastric residuals per doctor's order. Hold enteral feedings as ordered. Resume feedings as ordered. e. Check placement and patency of feeding tube before each feeding or medication administration. A Care Profile, dated 10/12/22, directed staff to keep the head of the bed elevated to 30 to 45 degrees. A Registered Dietitian progress note, dated 11/14/22 at 2:40 p.m., indicated Resident 61 was recently hospitalized and remained nothing by mouth. Resident 61's feeding was clarified to Jevity 1.5 300 milliliters (ml) four times a day as the current rate did not provide enough calories and had too much protein for the diagnosis of chronic kidney disease stage 4. The new rate and formula will provide 1200 mL total volume, 1800 calories, 76 grams protein, and 911 mL water. Resident 61 would receive water flushes after each feeding			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155678	A. BUILDING 00 B. WING	11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERFORD PLACE HEALTH CAMPUS	800 ST JOSEPH DR KOKOMO, IN 46901

(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
	four times a day and 160 mL with med passes three times a day to meet fluid needs. A nurse progress note, dated 11/16/22 at 4:17 p.m., indicated Resident 61's tube feeding was clarified to Jevity 1.5 300 ml four times a day as the current formula and rate did not provide enough calories and was too high in protein for chronic kidney disease. This would provide 1200 ml total volume. Water flushes of 120 ml after each feeding four times a day and 160 ml with med passes three times a day to meet fluid needs. A review of Resident 61's weights indicated: a. On 9/21/22 at 11:46 a.m., his weight was 172 pounds. b. On 9/28/22 at 10:56 a.m., his weight was 170 pounds. c. On 10/5/22 at 1:38 p.m., his weight was 166.2 pounds. d. On 10/14/22 at 11:57 a.m., his weight was 164.1 pounds. e. On 11/14/22 at 6:44 a.m., his weight was 162.7 pounds. f. On 11/21/22 at 10:33 a.m., his weight was 157.2 pounds. A nurse progress note, dated 11/20/22 at 6:23 a.m., indicated Resident 61 had a emesis of mucous feeding like material, he was placed on his side. Resident 61's record lacked indication staff should hold feeding if residual volume was over a certain amount. During an interview, on 11/16/22 at 9:45 a.m., Corporate Support Nurse (CNS) indicated the tube feeding supplies were not labeled and were undated, lying on the dirty table. She indicated the staff were responsible for storing the tube			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155678	A. BUILDING 00 B. WING	11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERFORD PLACE HEALTH CAMPUS	800 ST JOSEPH DR KOKOMO, IN 46901

(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
	feeding equipment and to ensure the supplies were labeled and dated. During an interview, on 11/17/22 at 12:20 p.m., the CNS indicated she did not expect staff to pour the contents of the syringe into a cylinder and continue to aspirate. Staff should follow the policy and procedure. During an interview, on 11/17/22 at 12:36 p.m., the Corporate Registered Dietitian indicated the nursing staff should follow the physician's order of when to hold a feeding with a certain residual volume. Staff should assess the total stomach content to get the residual volume. When the nurse pulled back and filled the syringe with formula, he should empty the contents into a graduate cylinder and continue to pull back until all stomach contents are emptied. Resident 61 would be at risk for aspiration. During an interview, on 11/18/22 at 12:25 p.m., the CNS indicated staff should follow the policy and procedures. During an interview, on 11/21/22 11:15 a.m., the CNS indicated staff should follow the procedure for residual volume and the policy and procedure were the most recent the staff should follow. During an interview, on 11/21/22 at 12:15 p.m., the Director of Health Services (DHS) indicated staff should pull back for full stomach contents to check for residual. The nurse should dump the contents of the syringe in a container, and aspirate until no further tube feeding.2. During an observation, on 11/17/22 at 3:17 p.m., Nurse 9 entered the resident's room and washed her hands. She then donned gloves. Resident 121 was sitting in an upright position in her bed. The nurse			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155678	A. BUILDING 00 B. WING	11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERFORD PLACE HEALTH CAMPUS	800 ST JOSEPH DR KOKOMO, IN 46901

(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
	placed an air bolus with 30 ml air in the feeding tube and listened in the upper abdominal region for placement with stethoscope. While the nurse was retrieving water, the Assistant Director of Nursing was holding the syringe and separating the plunger from the syringe. No aspiration was performed. The record for Resident 121 was reviewed on 11/16/22 at 09:59 a.m. Diagnoses included, but were not limited to, hemiplegia with hemiparesis following cerebral infarction effecting left non dominant side, facial weakness, speech and language deficits. A care plan, dated 11/14/22, indicated the resident required tube feedings and an oral diet to meet her nutrition and hydration needs. Interventions included, but were not limited to, check for proper placement of the feeding tube prior to the feeding and check the residual per physician order. A physician's order, dated 11/7/22, indicated check the feeding tube for residual every shift and record. A physician's order, dated 11/10/22, indicated Glucerna (liquid nutrition) 1.2 calorie 350 milliliter bolus 3 times daily with 60 milliliter bolus water flush. A progress note, dated 11/10/22 at 12:08 p.m., indicated the resident had a 60-milliliter residual. The feeding was held, and the nurse practitioner was called for new orders. During an interview, on 11/17/22 at 3:17 p.m., the Assistant Director of Health Services indicated aspiration for stomach contents should be			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155678	A. BUILDING 00 B. WING	11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERFORD PLACE HEALTH CAMPUS	800 ST JOSEPH DR KOKOMO, IN 46901

(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
	completed. A current policy, titled "Tube Feedings-CNS," dated 11/11/21 and received from the Dietitian indicated "...residual practices are based on resident tolerance or nursing protocol...tube feeding tolerance should be monitored and charted by nursing and followed by registered dietitian...." A procedure, titled "Feeding Tube: Enteral Nutrition via Nasoenteric, Gastrostomy, or Jejunostomy Competency," dated 9/7/16, indicated Step 4. For intermittent or bolus feeding, have a clean, enteral, large catheter tip syringe ready. Step 5. Place the resident in high fowler position or elevate the head of bed 30 to 45 degrees. Step 6. Verify tube placement. Attach a catheter tip 60 ml syringe to the proximal end of the feeding tube and attempt to aspirate a sufficient amount of secretions for evaluation. Observe the appearance of the aspirate. Step 7. Check residual volume before each intermittent feeding. a. Draw 30 ml of air into a catheter tip 60 ml syringe, attach the syringe to the proximal end of the feeding tube, and inject air. b. Pull back and aspirate the total amount of gastric contents. c. Return aspirate contents to stomach unless the volume exceeds 500 ml or an amount determined by the organization's practice, or physician's order. d. Flush the tube with 15 to 30 ml of water. Step 8. Initiate the feeding as ordered volume. Step 9. Keep the head of bed at 30 to 45 degrees during intermittent feeding administration. 3.1-44(a)(2)			
F 0694 SS=D Bldg. 00	483.25(h) Parenteral/IV Fluids § 483.25(h) Parenteral Fluids.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155678	A. BUILDING 00 B. WING	11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERFORD PLACE HEALTH CAMPUS	800 ST JOSEPH DR KOKOMO, IN 46901

(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
	Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences. Based on interview and record review, the facility failed to provide Peripherally Inserted Central Catheter (PICC) care for 1 of 2 residents reviewed for PICC line care. (Resident 323) Finding includes: During an observation, on 11/14/22 at 1:16 p.m., Resident 323 was seated in his chair with a short-sleeved button on shirt. His left arm was exposed to reveal a PICC line dressing on the upper left forearm. The PICC line dressing had been peeling up on the left corner, with a date of 11/4/22. No date was found on the IV tubing hung on the IV pole. The record for Resident 323 was reviewed on 11/14/22 at 1:30 p.m. Diagnoses included, but were not limited to, neurosyphilis, Alzheimer's disease, and dementia. An admission assessment, dated 11/4/22, indicated Resident 323 had a midline with a dressing which was clean, dry, and intact. A care plan, dated 11/8/22, indicated Resident 323 required intravenous medication related to neurosyphilis. Interventions included, but were not limited to, notify the physician of any complications, assess for complications from the IV (localized infection, systemic infection, electrolyte imbalance, air embolus dislodgement, infiltration, phlebitis, fluid overload and dehydration ever shift and as needed), IV as	F 0694	F694- Parental/IV fluids 1. Resident 323 was immediately assessed with no adverse effects related to alleged deficient practice. 2. All residents requiring infusions are at risk. Licensed staff educated on central catheter insertion and care. 3. As a measure of ongoing compliance, DHS or designee to round on all residents with PICC lines to ensure timely dressing changes weekly x 6 months or until 100% compliance is maintained. As a measure of ongoing compliance, DHS or designee to complete a chart review on all residents requiring infusions to ensure all appropriate physician orders are in place weekly 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	12/20/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155678	A. BUILDING 00 B. WING	11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERFORD PLACE HEALTH CAMPUS	800 ST JOSEPH DR KOKOMO, IN 46901

(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
	ordered, and observe IV site for swelling, redness, tenderness, and warmth. A physician's order, dated 11/4/22, indicated to give "Penicillin G potassium (antibiotic) 3,000,000 units per 50 milliliters by intravenous route every 4 hours until 11/15/22. Documentation indicated Resident 323 had not received his antibiotic on 11/4/22 and 11/5/22 until 9:00 p.m. Resident 323 missed five doses. A physician's order, dated 11/14/22, indicated to flush the PICC line with 5 ml of normal saline before and after medications. There was no documentation staff had flushed the PICC line from 11/4/22 to 11/13/22. A physician's order, dated 11/14/22, indicated to monitor the IV site for signs and symptoms of infiltration. There was no documentation staff had monitored the PICC line from 11/4/22 to 11/13/22. A physician's order, dated 11/14/22, indicated to change the end cap every 96 hours. There was no documentation staff changed the end cap from 11/4/22 to 11/13/22. A physician's order, dated 11/14/22, indicated to change the dressing every five days, measure external catheter length, and enter the measurements in the notes. There was no documentation staff completed the dressing changes from 11/4/22 to 11/13/22. A physician's order, dated 11/14/22, indicated to change the IV tubing primary and secondary sets every 24 hours. There was no documentation staff changed the IV tubing from 11/4/22 to 11/13/22. A review of the nursing progress notes indicated			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155678	A. BUILDING 00 B. WING	11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERFORD PLACE HEALTH CAMPUS	800 ST JOSEPH DR KOKOMO, IN 46901

(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
	the following: On 11/4/22 at 9:22 p.m., the pharmacy was called for the IV Penicillin, and it was currently not available. On 11/5/22 at 9:45 p.m., the resident received his IV antibiotic. During an interview, on 11/14/22 at 2:01 p.m., Registered Nurse (RN) 3 indicated Resident 323's PICC line dressing had not been changed since it was placed on 11/4/22, when he was discharged from the hospital. The PICC line dressing was to be changed every five days. A current policy, titled "Catheter Insertion and Care," dated 12/15 and provided by the Corporate Nurse Support (CNS) on 11/18/22 at 3:34 p.m., indicated "...Guidance: a. Apply and maintain sterile dressing on intravenous access devices. Dressings must stay clean, dry, and intact. Explain to the resident that the dressing should not get wet. b. Change dressings if any suspicion of contamination is suspected. c. Catheter site care and dressing changes will include removal of the old dressing, observation and evaluation of catheter skin junction and surrounding tissue, cleansing with an approved antiseptic solution, replacement of any stabilization device and application of a sterling dressing. d. Change transparent semi-permeable membrane dressing every five to seven days and as needed when wet, soiled, or not intact...." 3.1-47(a)(2)			
F 0695 SS=E Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155678	A. BUILDING 00 B. WING	11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERFORD PLACE HEALTH CAMPUS	800 ST JOSEPH DR KOKOMO, IN 46901

(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
	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 an oxygen nasal cannula was dated, failed to ensure a physician's order was followed, failed to ensure a nebulizer mask and tubing were dated, and failed to ensure a resident had an order with BIPAP (machine used to treat sleep apnea) settings for 4 of 4 residents reviewed for respiratory care. (Resident 23, 38, 61 and 18) Findings include: 1. During an observation, on 11/14/22 at 12:51 p.m., Resident 23 was seated in her bed with the head of bed elevated to 50-degrees. Her oxygen tubing was positioned to her right cheek. Her door lacked indication she was on oxygen. No date or label was found on her tubing. She indicated it felt too big and it kept falling off. During an observation, on 11/16/22 at 1:40 p.m., Resident 23 was seated in her wheelchair. Her nasal cannula was observed to be hung over her left leg. Her door lacked indication she was on oxygen. No date or label was found on her tubing. During an observation, on 11/17/22 at 10:29 a.m., Resident 23 was seated in her wheelchair drinking water. Her nasal cannula was hanging under chin. She indicated it kept falling off. Her door lacked indication she was on oxygen. No date or label was found on her tubing.	F 0695	F695- Respiratory/Tracheostomy care and suctioning 1. Residents 23, 38, 61, and 18 did not have any adverse effects from alleged deficient practice. 2. All residents requiring the use of respiratory equipment have the potential to be affected. Clinical staff educated on Respiratory equipment, oxygen administration, and respiratory inhaled treatments. 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 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	12/20/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155678	A. BUILDING 00 B. WING	11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERFORD PLACE HEALTH CAMPUS	800 ST JOSEPH DR KOKOMO, IN 46901

(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
	During an observation, on 11/17/22 at 10:58 a.m., to 11/17/22 at 11:08 a.m., Resident 23 was seated in her wheelchair with her oxygen nasal canula under chin. Her door lacked indication she was on oxygen. No date or label was found on her tubing. During an observation, on 11/17/22 at 1:34 p.m., a housekeeper walked into Resident 23's room. Her nasal cannula was lying on her lap. Resident 23 indicated it kept falling off. Her door lacked indication she was on oxygen. No date or label was found on her tubing. Resident 23's physician orders included, but were not limited to, clean external concentrator filters every two weeks, change oxygen tubing monthly, oxygen at two liters per minute by nasal cannula continuous. A care plan, dated 10/4/22, indicated Resident 23 had a functional and cognitive decline related to respiratory disease related to the diagnosis of respiratory failure, shortness of breath, and chronic obstructive pulmonary disease. Interventions included, but were not limited to, monitor oxygen saturations by pulse oximetry as ordered, and administer oxygen per orders. 2. During an observation, on 11/14/22 at 1:01 p.m., Resident 38's oxygen concentrator and portable oxygen tank were observed in the hallway, to the right side, of the resident's door. Resident 38 was seated in his recliner, curled with his knees up, and wrapped in a blanket. His oxygen tubing was unlabeled or dated. The oxygen concentrator was set to three liters per minute. A sign hung on the door frame and indicated "no smoking" oxygen in use.		100% compliance is maintained	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155678	A. BUILDING 00 B. WING	11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERFORD PLACE HEALTH CAMPUS	800 ST JOSEPH DR KOKOMO, IN 46901

(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
	During an observation, on 11/15/22 at 9:15 a.m., Resident 38's oxygen concentrator and portable oxygen were observed in the hallway, to the right side, of the resident's door. The oxygen tubing was unlabeled or dated and was running under the door. Resident 38 had received oxygen at three liters per minute by his nasal cannula. A sign hung on the door frame and indicated "no smoking" oxygen in use. During an observation, on 11/16/22 at 9:34 a.m., Resident 38's oxygen concentrator and portable oxygen were observed in the hallway, to the right side, of the resident's door. The oxygen tubing was unlabeled and was running under the door. A sign hung on the door frame and indicated "no smoking" oxygen in use. Resident 38's oxygen via nasal cannula was turned to 3 liters. The record for Resident 38 was reviewed on 11/16/22 at 9:21 a.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease with exacerbation, hypertensive heart and chronic kidney disease with heart failure, cardiomegaly, and pulmonary hypertension. Resident 38's physician orders included, but were not limited to, change oxygen tubing monthly, clean external concentrator filter every two weeks on Sunday, use oxygen at four liters per minute by nasal cannula continuously. Resident 38's care profile indicated Resident 38's oxygen concentrator was supposed to be in the hallway, and oxygen set at three liters. During an interview, on 11/16/22 at 12:18 p.m., the Director of Health Services (DHS) indicated the oxygen concentrator was set at three liters per minute and he had orders for four liters per			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155678	A. BUILDING 00 B. WING	11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERFORD PLACE HEALTH CAMPUS	800 ST JOSEPH DR KOKOMO, IN 46901

(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
	minute. The oxygen tubing was not labeled, and it should have been. 3. During an observation, on 11/14/22 at 9:05 a.m., on Resident 61's nightstand was a nebulizer machine with clear tubing and nebulizer mask connected. The chamber of the nebulizer had a dry white residue and was uncovered and undated. During an observation, on 11/15/22 at 10:30 a.m., on Resident 61's nightstand was a nebulizer machine with clear tubing and nebulizer mask connected. The chamber of the nebulizer had a dry white residue and was uncovered and undated. During observation, on 11/16/22 at 9:45 a.m., on Resident 61's nightstand was a nebulizer machine with clear tubing and nebulizer mask connected. The chamber of the nebulizer had a dry white residue and was uncovered and undated. The record for Resident 61 was reviewed on 11/16/22 at 11:00 a.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease (diseases which causes airflow blockage and breathing-related problems), hypoxemia (below-normal level of oxygen in your blood), and COVID-19. During an interview, on 11/16/22 at 9:45 a.m., the Corporate Nurse Support (CNS) indicated the nebulizer supplies were not covered or dated and were lying on the nightstand. The nebulizer equipment should be cleaned after each use and labeled with a date. This was an infection control issue. During an interview, on 11/18/22 at 9:09 a.m., the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155678	A. BUILDING 00 B. WING	11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERFORD PLACE HEALTH CAMPUS	800 ST JOSEPH DR KOKOMO, IN 46901

(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
	CNS indicated if staff noticed a resident did not have the oxygen on, they should replace it or notify the nursing staff. Staff should ensure all respiratory equipment was labeled and dated. 4. The record for Resident 18 was reviewed on 11/16/22 at 11:39 a.m. Diagnoses included, but were not limited to, acute respiratory failure with hypoxia, history of pneumonia with covid, obstructive sleep apnea, and chronic lung disease. A physician's order, dated 1/19/2022, indicated to use the BiPap (a machine to help breathing) at night. No BiPap settings were indicated in the order. A care plan, dated 1/31/22, indicated a potential for complications due to respiratory disease related to obstructive sleep apnea and respiratory failure. Interventions included, but not were not limited to, oxygen per order, monitor lung sounds, and oxygen saturations. There was no intervention for the BiPap at night. A care plan, dated 1/31/22, indicated a potential for shortness of breath while lying flat related to obstructive sleep apnea and respiratory failure. Interventions included, but were not limited to, oxygen per physician's order, and elevate the head of the bed. There was no intervention for the BiPap at night. During an interview, on 11/16/22 at 04:57 p.m., the Corporate Nurse Consultant indicated the BiPap settings would follow the manufacturers guidelines.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155678	A. BUILDING 00 B. WING	11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERFORD PLACE HEALTH CAMPUS	800 ST JOSEPH DR KOKOMO, IN 46901

(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
	During an interview, on 11/17/22 at 10:50 a.m., Nurse 6 indicated the BiPap was preset, and the order did not necessarily need to include settings. The resident took the BiPap mask off and did not use it anyway. He would look in the chart to locate settings if he needed to verify them. During an interview, on 11/21/22 at 12:08 p.m., the Clinical Support Nurse indicated the policy for respiratory and medication treatment orders would cover the BiPap settings. The BiPap order was set by the respiratory therapy company. She and the new Director of Health Services indicated the order should include settings for the BiPap. There were no directions for the BiPap order in the medication or respiratory policy. No manufacturer's guidelines were received at the time of exit. A current policy, titled "Respiratory Equipment," dated 12/1/21, indicated "...mark water bottle with date and initials upon opening and discard after 24 hours...change oxygen cannula and tubing monthly and as necessary...." A facility policy, titled "Administration of Oxygen," dated as revised 5/18, indicated to verify physician's orders, place the nasal cannula around the resident's ears and in the nose, place an "Oxygen in Use" sign outside the room entrance door, date the tubing for the date it was initiated. Tubing should be changed monthly and as needed and place the nasal cannula into the nostrils and adjust the plastic slide to position to hold in place. A facility policy, titled "Respiratory Inhalation Treatments," dated as revised 5/11/16, indicated			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155678	A. BUILDING 00 B. WING	11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERFORD PLACE HEALTH CAMPUS	800 ST JOSEPH DR KOKOMO, IN 46901

(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 clean the equipment and leave to air dry. 3.1-47(a)(6)			
F 0700 SS=D Bldg. 00	483.25(n)(1)-(4) Bedrails §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. Based on observation, interview and record review, the facility failed to obtain a physician's order, develop a care plan, obtain a consent, ensure the bed rails were installed correctly, and perform scheduled maintenance for the use of side rails for 2 of 2 residents reviewed for accident hazards. (Resident 15 and 61) Findings include: 1. During an observation, on 11/15/22 at 9:13 a.m.,	F 0700	F700- Bed rails 1. Resident 15 and 61 had no adverse effects from alleged deficient practice. 2. All residents have the potential to be affected. IDT team and clinical staff educated on the guidelines for the use of bed rails. 3. As a measure of ongoing compliance, DHS or designee to complete audits on 5 rooms 3	12/20/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155678	A. BUILDING 00 B. WING	11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERFORD PLACE HEALTH CAMPUS	800 ST JOSEPH DR KOKOMO, IN 46901

(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 15 was observed in her room, lying in bed, with bed rail up on the left side, and she had begun to yell for help. During an observation, on 11/15/22 at 2:12 p.m., Resident 15 was observed in her room, lying in bed, the left side bed rail was up, she was yelling out "help me." Resident 15 put her right leg over the top of the bed rail. The record for Resident 15 was reviewed on 11/21/22 at 9:32 a.m. Diagnoses included, but were not limited to, Alzheimer's disease, dementia, Parkinson's disease, and falls. A Significant Change Minimum Data Set (MDS) assessment, dated 11/15/22, indicated Resident 15 required an extensive assistance of two staff for bed mobility and transfers. She was dependent on staff for activities of daily living (ADL). She had an unsteady balance. A Bed Rail Assessment, dated 10/25/22 at 6:23 p.m., had been completed. The assessment indicated she had one half bilateral grab bars and used the bed rails for an enabler. The risk indicated for implementing the bed rails included accidental hazards such as climbing over, around or through the rails. The risk was also included over the foot board or could be caught between the mattresses. A Bed Rail Consent, dated 10/25/22 at 6:23 p.m., lacked indication it was signed. The record lacked indication a physician's order, a care plan, or a signed consent for the use of the side rails was obtained. A nurse progress note, dated 10/25/22 at 6:23 p.m.,		times a week for 4 weeks, then 2 times a week x 4 weeks, then weekly x 4 weeks, then monthly x 3 months or until 100% compliance is maintained to assess mobility bar use, review of consents, orders, and care plan, if mobility rails. 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	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155678	A. BUILDING 00 B. WING	11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERFORD PLACE HEALTH CAMPUS	800 ST JOSEPH DR KOKOMO, IN 46901

(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
	indicated Resident 15 had a bed rail assessment completed. One-half bilateral bed rails were used for an enabler. The risk for implementing the bed rails were accidental hazards such as climbing over, around, between, or through the rails, or over the foot board. The resident could be caught between the mattresses. During an interview, on 11/21/22 at 10:30 a.m., the Maintenance Director indicated he had not performed an inspection of the bed rails for Resident 15 because the bed rails were provided by hospice. He would only inspect the bed rails incase an incident would occur. During an interview, on 11/20/22 at 11:00 a.m., the Clinical Nurse Consultant (CNS) indicated Resident 15 did not have an order, a care plan, consent, or an assessment for the use of side rails and she should have had them documented in her medical record. 2. During an observation, on 11/15/22 at 9:18 a.m., Resident 61 was lying with the head of bed up to a 30-degree angle. He was slumped over to the right side with his right temple resting on the side rail and calling out with a moaning tone. During an observation, on 11/17/22 at 10:06 a.m., Resident 61 was observed in his room, lying in bed, with both bed rails up. A MDS assessment, dated 11/7/22, indicated he was totally dependent on staff for transfers, required extensive assistance with bed mobility, and had a severe cognitive impairment. An Admission Care Area Assessment (CAA), dated 10/18/22, indicated he was readmitted to the facility after a hospitalization for gastrointestinal			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155678	A. BUILDING 00 B. WING	11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERFORD PLACE HEALTH CAMPUS	800 ST JOSEPH DR KOKOMO, IN 46901

(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
	hemorrhage, hemiplegia (muscle weakness on one side) and hemiparesis following cerebral infarction affecting left non-dominant side, dysphagia (swallowing difficulties) following cerebral infarction (stroke). A physician's order, entered after the start of survey on 11/16/22, indicated Resident 61 had an order for bed rails to be assessed as an enabler for safe transfers or increased mobility. A review the facility document, titled "Bed System Measurement Devices Test Result Worksheet," on 11/17/22 at 3:27 p.m., lacked indication Resident 61 had a bed rail maintenance assessment was completed. During an interview, on 11/17/22 at 10:51 a.m., the Corporate Support Nurse (CSN) indicated Resident 15 would not be able to manually use the bed rails and put them down on her own. Resident 15 did not have an order or care plan to use or monitor bed rails. During an interview, on 11/18/22 at 9:00 a.m., the CSN indicated she felt Resident 15 was appropriate for bed rails because she was able to push herself up. Maintenance did inspect the bed rails when Resident 15 was in a different room before she moved into a new room. Resident 61 was not appropriate for bed rails. A current facility policy, titled "Semi Annual Bed Rail Inspections Life Safety," with a revision date of 5/8/19, indicated to inspect bed rails every six months. A current facility policy, titled "Guidelines for the Use of Bed Rails," dated 10/9/17, indicated must ensure correct installation, use, and maintenance.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155678	A. BUILDING 00 B. WING	11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERFORD PLACE HEALTH CAMPUS	800 ST JOSEPH DR KOKOMO, IN 46901

(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
	Staff should assess for the potential risk for climbing over, around, between, or through the bedrails. The policy indicated to complete a resident assessment which should include, but was not limited to, medical diagnosis, conditions, symptoms, and behavior symptoms, size and weight, sleep habits, medications, acute medical/surgical conditions, underlying medical conditions, existence of delirium, ability to safely toilet self, cognition, communication, mobility in and out of bed, and the risk for falling. 3.1-45(a)(2)			
F 0758 SS=E 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,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155678	A. BUILDING 00 B. WING	11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERFORD PLACE HEALTH CAMPUS	800 ST JOSEPH DR KOKOMO, IN 46901

(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
	unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order 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 the use of multiple antipsychotics was avoided for 7 of 7 residents reviewed for psychotropic medication use. (Resident 46, 47, 55, 5, 12, 18 and 106) Findings include: 1. The record for Resident 46 was reviewed on 11/16/22 at 11:32 a.m. Diagnoses included, but were not limited to, Alzheimer's disease, dementia with behavioral disturbance, mood disorder, personality change due to known physiological condition, anxiety disorder and depressive	F 0758	F758- Free from unnecessary Psychotropic meds/PRN use 1. Residents 46, 47, 55, 5, 12, 18, and 106 had no adverse effects related to alleged deficient practice. 2. All residents receiving psychotropic medications are at risk. SSD educated on Psychotropic medication usage and gradual dose reductions. 3. As a measure of ongoing compliance, SSD to review all residents receiving psychotropic medications to ensure gradual dose reduction has been	12/20/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155678	A. BUILDING 00 B. WING	11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERFORD PLACE HEALTH CAMPUS	800 ST JOSEPH DR KOKOMO, IN 46901

(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
	disorder. A physician's order, dated 12/3/21, indicated valproic acid solution (an anticonvulsant) 250 mg (milligram)/5 ml (milliliter) give 5 ml by mouth twice a day for a diagnosis of a mood disorder. A care plan, dated 4/14/22, indicated the resident received an anticonvulsant medication. The medication was for the diagnosis of a mood disorder. The approaches included, but were not limited to, administer medications per the physician's order, monitor for adverse side effects of the medication, observe mood, affect, and behaviors with all hands-on care and contacts, and to titrate the medication to the lowest effective dose. A PASARR (preadmission screening and resident review), dated 12/17/21, indicated the resident had no known or suspected bipolar disorder and had a dementia diagnosis. The mental health medication listed was Lexapro (a Selective Serotonin Reuptake Inhibitor) for depression and generalized anxiety, lorazepam (benzodiazepine) for anxiety and valproic acid (an anticonvulsant medication) for seizures. There were no other mental health medications listed on the PASARR A pharmacy recommendation, dated 7/28/22, indicated the resident had been on valproic acid 250 mg twice a day since 12/2021. The resident's chart was reviewed, and the chart reflected no signs of depression and no behavioral disturbances have been documented in the progress notes in the last 30 days. To reach the minimal effective dose, consider a dose reduction to valproic acid 250 mg at bedtime.		completed or contraindication containing risk vs benefit analysis has been documented 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	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155678	A. BUILDING 00 B. WING	11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERFORD PLACE HEALTH CAMPUS	800 ST JOSEPH DR KOKOMO, IN 46901

(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

A progress note, dated 10/31/22 at 10:50 a.m., the Social Service Director (SSD) indicated the resident's mood had remained stable and continued to be social with staff and peers. There were no current psychosocial concerns.

During an interview, on 11/21/22 at 11:01 a.m., the SSD indicated the facility physician normally would put the resident on valproic acid when they had a diagnosis of dementia.

2. The record for Resident 47 was reviewed on 11/16/22 at 10:22 a.m. Diagnoses included, but were not limited to, bipolar disorder, schizoaffective disorder (a disorder which affects a person's ability to think, feel and behave clearly), pseudobulbar affect (inappropriate involuntary laughing and crying due to a nervous system disorder), anxiety disorder, cognitive communication deficit, vascular dementia without behavioral disturbance, psychotic disturbance, and mood disturbance.

A PASARR level I, dated 6/11/21, indicated the resident had diagnoses of major depressive disorder, bipolar disorder, anxiety disorder, and dementia.

A physician's order, dated 7/24/22, indicated Seroquel (an antipsychotic medication) 75 mg (milligram) at bedtime for hallucinations.

A diagnosis of schizoaffective disorder with hallucinations was added 7/18/2022.

During an interview, on 11/21/22 at 10:51 a.m., the Social Service Director indicated Resident 47 had a diagnosis of dementia and was on Seroquel for hallucinations.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155678	A. BUILDING 00 B. WING	11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERFORD PLACE HEALTH CAMPUS	800 ST JOSEPH DR KOKOMO, IN 46901

(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
	3. The record for Resident 55 was reviewed on 11/16/22 at 11:06 a.m. Diagnoses included, but were not limited to, Alzheimer's disease, dementia with behavioral disturbance, anxiety disorder, and hallucinations. A PASARR level I, indicated the resident was not on an antipsychotic medication. A diagnosis of hallucinations was added 8/2/22. A physician's order, dated 11/1/22, indicated Risperdal (an antipsychotic) 1 mg tablet at bedtime for hallucinations. During an interview, on 11/21/22 at 10:51 a.m., the Social Services Director (SSD) indicated the resident had a diagnosis of dementia.4. The record for Resident 5 was reviewed on 11/16/22 at 3:02 p.m. Diagnoses included, but were not limited to, Parkinson's disease, unspecified dementia without behavioral disturbance, psychotic disturbance, mood disturbance, anxiety, depressive episodes, and generalized anxiety disorder. A physician's order, dated 4/1/22, indicated Seroquel (an antipsychotic) 50 mg at bedtime. A physician's order, dated 12/31/22, indicated Nuplazid (an antipsychotic) 34 mg once a day. A progress note, dated 10/31/22 at 11:09 a.m., indicated the resident utilized Seroquel and Nuplazid for a diagnosis of Parkinson's with delusions. The resident continued to have distressing hallucinations on occasion. The Nursing Drug Handbook indicated Nuplazid increased the QT interval (a heart arrhythmia			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155678	A. BUILDING 00 B. WING	11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERFORD PLACE HEALTH CAMPUS	800 ST JOSEPH DR KOKOMO, IN 46901

(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
	which causes fast, chaotic heartbeats and can cause sudden death) and use with other drugs which increased the QT interval should be avoided. The Nursing Drug Handbook indicated Seroquel can increase the QT interval and use with other medications which increase the QT interval should be avoided. The black box warning indicated the medication was not indicated for use in elderly patients with dementia related psychosis because of the risk of sudden death from cardiovascular disease. 5. The record for Resident 12 was reviewed on 11/15/22 at 4:46 p.m. Diagnoses included, but were not limited to, generalized anxiety disorder, depressive episodes, unspecified dementia with behavioral disturbance, and age-related physical debility. A physician's order, dated 9/1/2022, indicated Seroquel 50 mg once a day for unspecified dementia with behavioral disturbance. A care plan, dated 9/20/22, indicated the resident had a diagnosis of dementia with behaviors such as physical aggression with care which was treated with an antipsychotic medication. The approaches included, but were not limited to, give medications per orders, and monitor for the side effects of the medication. A social services progress note, dated 10/31/22, indicated the resident used Seroquel for a diagnosis of dementia with behaviors such as physical and verbal aggression. The resident's mood and behaviors had been stable since admission.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155678	A. BUILDING 00 B. WING	11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERFORD PLACE HEALTH CAMPUS	800 ST JOSEPH DR KOKOMO, IN 46901

(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
	During an interview, on 11/16/22 at 10:49 a.m., the SSD indicated the use of Seroquel with dementia for behaviors was a "gray" area with the diagnosis dementia. 6. During an observation, on 11/14/22 at 3:39 p.m., Resident 18 was sitting, in his Broda chair, and snoring during lunch. During an observation, on 11/16/22 at 3:09 p.m., the resident was lying flat, in bed, and was snoring. During an observation, on 11/16/22 at 4:14 p.m., the resident was resting in bed, lying flat, with his eyes closed. The record for Resident 18 was reviewed on 11/16/22 at 11:39 a.m. Diagnoses included, but were not limited to, encephalopathy, urinary tract infection, Parkinson's disease, dementia in other diseases without behavioral disturbances, schizophrenia, anxiety, and depression. A care plan, dated 3/14/22, indicated the resident demonstrated physically abusive and resistive behavior toward staff during hands-on care. Interventions included, but were not limited to, approach resident in a calm manner, and explain the care process. A care plan, dated 3/14/22, indicated the resident demonstrated inappropriate behaviors by putting self on the floor mat. Interventions included, but were not limited to, assess for unmet needs, and determine cause of inappropriate behaviors. A care plan, dated 4/5/22, indicated the resident was at risk for consequences related to receiving antipsychotic medication for Parkinson with psychosis. Interventions included, but were not limited to, administer medication as ordered by			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155678	A. BUILDING 00 B. WING	11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERFORD PLACE HEALTH CAMPUS	800 ST JOSEPH DR KOKOMO, IN 46901

(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
	physician, observe and report signs of sedation, anticholinergic and/or extrapyramidal symptoms. Current physician's orders included, but were not limited to, Ativan (antianxiety) 1 milligram, Benadryl (antihistamine) 25 milligram, Haldol (antipsychotic) 1 milligram and Reglan (nausea and gastric medication) 10 milligram cream (ABHR cream) 1 packet topical every 4 hours. A psychiatry progress note, dated 4/17/22, indicated the resident was showing increased sexual behavior, by making sexual comments to staff. The resident had episodes of restlessness and anxiety and the primary care doctor ordered Ativan. His wife had indicated he was more tired recently and it could be the Paxil (an antidepressant). The patient was being treated for psychosis with Parkinson's disease with Seroquel 75 milligrams. No psychosis was present the day of visit. A physician's order, dated 7/18/22, indicated to add to the diagnosis of schizoaffective disorder. A psych CAR (clinically at risk) note, dated 7/30/22 at 11:24 a.m., indicated the resident had a diagnosis of schizoaffective disorder as well as psychotic disorder, however, all behaviors related to these diagnoses have resolved. No current issues with mood or behaviors. A psych CAR progress note, dated 8/24/22 at 12:19 p.m., indicated the resident received Seroquel for a diagnosis of schizoaffective disorder. Behaviors have stabilized over the last few months with fewer and fewer episodes. A progress note, dated 10/6/22, indicated new orders were received to discontinue Seroquel and			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155678	A. BUILDING 00 B. WING	11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERFORD PLACE HEALTH CAMPUS	800 ST JOSEPH DR KOKOMO, IN 46901

(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
	lorazepam and add ABHR cream TID. During an interview, on 11/21/22 at 11:13 a.m., the Social Service Director indicated she was unable to find any documentation as to why a diagnosis of schizophrenia was added. 7. During an observation, on 11/16/22 at 11:00 a.m., Resident 106 was sitting in a recliner, in her room, with her feet elevated. She was smiling and friendly. Her daughter was in the room styling her hair. During an observation, on 11/16/22 at 4:16 p.m., the resident was resting, in the recliner, with her feet elevated and her eyes were closed. The record for Resident 106 was reviewed on 11/16/22 at 11:34 a.m. Diagnoses included, but were not limited to, encephalopathy, delusional disorders, altered mental status, and dementia with behavioral disturbances. A psych CAR note, dated 7/30/22, indicated medications, behaviors, diagnosis, and care plans were reviewed. The resident received Seroquel for delusional disorder. She had a history of delusions. She would become combative with care and would refuse hygiene and medications at times. No psychosocial concerns. A physician's order, dated 9/30/22, indicated Seroquel 50 milligrams twice daily. A diagnosis was not included with the physician's order. A behavioral progress note, dated 10/17/22, indicated the facility had requested an evaluation due to a history of delusions and hallucinations.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155678	A. BUILDING 00 B. WING	11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERFORD PLACE HEALTH CAMPUS	800 ST JOSEPH DR KOKOMO, IN 46901

(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
	The resident was taking Seroquel 50 milligrams twice daily. The resident was observed to be calm, cooperative, and pleasant. The resident had a Seroquel increase due to an increase in hallucinations and delusions. No delusions noted during the visit. No hallucinations had been documented or noted by patient recently. A psych CAR note, dated 10/31/22 at 10:25 a.m.., indicated Seroquel was continued for the diagnosis of delusional disorder and dementia with behaviors. During an interview, on 11/16/22 at 4:23 p.m., Nurse 6 indicated the resident did not have behaviors. The use of the medication was due to dementia with behavioral disturbances. During an interview, on 11/17/22 at 10:24 a.m., the Social Service Director indicated the resident was admitted with Seroquel due to aggressive behavior and believed the resident had a gradual dose reduction. The resident had hallucinations. The diagnosis of dementia with behaviors was for the use of Seroquel. The resident may have had a urinary tract infection but was not sure if she did. During an interview, on 11/21/22 at 3:01 p.m., the Pharmacist indicated Seroquel was an antipsychotic used for psychosis, hallucinations and delusions related to dementia and agreed this was an off-label use. She would not recommend the use of antipsychotics for the diagnosis of dementia alone. The labeled use for Seroquel was schizophrenia. 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			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155678	A. BUILDING 00 B. WING	11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERFORD PLACE HEALTH CAMPUS	800 ST JOSEPH DR KOKOMO, IN 46901

(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
	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 recent publication of "PDR.net" indicated "...Risperdal was indicated for the treatment of schizophrenia...the black box warning indicated antipsychotics are not approved for the treatment of dementia-related psychosis in geriatric patients and the use of Risperdal in this population should be avoided if possible due to an increase in morbidity and mortality...." A recent publication of "PDR.net" indicated "...Haldol (haloperidol) was indicated for the treatment of schizophrenia...the black box warning indicated antipsychotics are not approved for the treatment of dementia-related psychosis in geriatric patients and the use of Haldol in this population should be avoided if possible due to an increase in morbidity and mortality...." A current policy, titled "Psychotropic Medication Usage and Gradual Dose Reduction," dated 11/15/21 and received from the Clinical Support Nurse on 11/21/22 at 2:30 p.m., indicated "...residents shall receive psychotropic medications only if designated medically necessary...with appropriate diagnosis, or documentation to support usage...regular monthly review of antipsychotics in CAR (clinically at risk meetings) for continued need, appropriate diagnosis, side effects, risks and/or benefits will be conducted, to ensure the use of psychopharmacologic medications are therapeutic and remain beneficial to the resident...." 3.1-48(a)(1)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155678	A. BUILDING 00 B. WING	11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERFORD PLACE HEALTH CAMPUS	800 ST JOSEPH DR KOKOMO, IN 46901

(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
	3.1-48(a)(4)			
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 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 drugs and biologicals used in the facility were stored in accordance with professional standards for 2 of 2 residents (Resident 61, 323) and failed to dispose of loose pills in 4 of 7 carts reviewed for medication storage. (Dementia cart, 200 hall cart, 300 hall cart and 600 hall cart)	F 0761	F761- label/store biologicals 1. No residents were affected by alleged deficient practice. 2. All residents have the potential to be affected. Licensed staff education on medication storage policy. 3. As a measure of ongoing compliance, DHS or designee to	12/20/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155678	A. BUILDING 00 B. WING	11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERFORD PLACE HEALTH CAMPUS	800 ST JOSEPH DR KOKOMO, IN 46901

(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
	Findings include: 1. During a random continuous observation of a medication cart, on 11/15/22 at 9:20 a.m., located in the 600 hall, an intravenous (IV) bag filled with Penicillin G (a medication used to treat infections) was found lying on top of the cart visible to staff and residents who walked by. No staff were observed next to the medication cart, down the hallway was two housekeeping staff entering a resident's room. At 9:25 a.m., Registered Nurse (RN) 2 walked out of a resident's room about 12 feet from the medication cart. The record for Resident 323 was reviewed on 11/14/22 at 1:30 p.m. Diagnoses included, but were not limited to, neurosyphilis, Alzheimer's disease, and dementia. A physician's order, dated 11/4/22, indicated to give "Penicillin G potassium (antibiotic) 3,000,000 units per 50 milliliters by intravenous route every 4 hours until 11/15/22. During an interview, on 11/15/22 at 9:25 a.m., RN 2 indicated the IV Penicillin was left on top of the medication cart unsecured. She left the Penicillin on top of the cart to warm up to room temperature before administering the medication to Resident 323. She was not sure of where she should put the IV bag to warm up to room temperature. 2. During an observation and interview, on 11/16/22 at 9:45 a.m., Resident 61 was observed, in his room, lying in bed. Sitting to the right of his television was a bottle of polymyxin B sulf-trimethoprim (antibiotic for the eyes) and ammonium lactate (medication used to treat dry, scaly skin conditions). The Corporate Support Nurse (CSN) indicated the medication in his room		audit 3 medication carts to ensure medications are dated, separated by route, and no loose pills in cart 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	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155678	A. BUILDING 00 B. WING	11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERFORD PLACE HEALTH CAMPUS	800 ST JOSEPH DR KOKOMO, IN 46901

(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
	and all medications should be locked and secured in the medication cart or storage room. The record for Resident 61 was reviewed. Diagnoses included, but were not limited to, gastrointestinal hemorrhage, hemiplegia (muscle weakness on one side) and hemiparesis following cerebral infarction affecting left non-dominant side, and dysphagia (swallowing difficulties). A MDS assessment, dated 11/7/22, indicated he was totally dependent on staff for transfers, required extensive assistance with bed mobility, and had a severe cognitive impairment. During an interview, on 11/16/22 at 10:05 a.m., the Corporate Support Nurse (CSN) indicated no medications should be left in resident's room or on the medication cart. All medications be locked up in the medication cart.3. During an observation, on 11/19/22 at 12:16 p.m., the medication cart on the skilled dementia unit had two unidentified loose pills in the bottom of the second drawer. The fourth drawer had four unidentified loose pills. During an interview, on 11/19/22 at 12:18 p.m., Certified Resident Medication Aide (CRMA) 10 indicated having loose pills in the bottom of the medication cart was not a good thing. The pills were to be destroyed using the drug buster in the medication room. During an interview, on 11/17/22 at 12:25 p.m., the Dementia Care Director indicated she would investigate the loose pills. During an interview, on 11/21/22 at 9:03 a.m., the Director of Nursing indicated there should not be loose pills in the medication carts. The pills were			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155678	A. BUILDING 00 B. WING	11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERFORD PLACE HEALTH CAMPUS	800 ST JOSEPH DR KOKOMO, IN 46901

(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 be disposed of in the sharps container or drug buster. 4. During a medication storage observation, on 11/17/22 at 1:52 p.m., the 300/200 hall medication cart had a bottle of polymyxin eye drops with no label, and five vials of eyes drops were found opened in the cart without an open date. The 600-hall medication cart had 5 vials of opened eye drops without an open date on them. During an interview, on 11/17/22 at 1:55 p.m., the Certified Resident Medication Aide indicated the eye drops should be dated when opened and there should not be loose medications in the cart. A current policy, titled "Medication Storage in the Facility," dated 11/18 and received from the Clinical Support Nurse on 11/15/22 at 3:30 p.m., indicated "...Medications and biologicals are stored safely, securely and properly...medication storage areas are kept clean, free of clutter...certain medications such as...ophthalmics...once open required an expiration date shorter then the manufacturer's expiration date to insure medication purity and potency...." 3.1-25(j) 3.1-25(m) 3.1-25(o)			
F 0806 SS=D Bldg. 00	483.60(d)(4)(5) Resident Allergies, Preferences, Substitutes §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences;			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155678	A. BUILDING 00 B. WING	11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERFORD PLACE HEALTH CAMPUS	800 ST JOSEPH DR KOKOMO, IN 46901

(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
	§483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; Based on observation, interview and record review, the facility failed to ensure a resident's food preferences were accommodated by the facility for 1 of 1 resident reviewed for food preferences. (Resident 323) Finding includes: During an observation and interview, on 11/14/22 at 1:17 p.m., Resident 323 was seated in his chair picking at his teeth with a toothpick. His lunch plate appeared untouched and consisted of one-half inch cut up sausage, cabbage, carrots, and potatoes. The resident indicated he did not like the food because it got caught in his teeth and he would spend an hour digging it out. He had reminded the staff multiple times, when he had not eaten his lunch on other occasions, he had requested a hotdog or bologna which were not provided. It was upsetting he could not receive a hotdog which was something he enjoyed. A physician's order, dated 11/4/22, indicated Resident 323 had an order for a regular diet and thin liquids. A nurse progress note, dated 11/6/22 at 5:55 p.m., indicated a family member reported Resident 323 practiced fasting on Tuesday, Friday, and Sunday until 3:00 p.m. Resident 323 had declined breakfast and lunch but did accept a nutritional drink in the early afternoon. A Dining and Nutrition Preference note, dated 11/6/22 at 9:29 a.m., indicated the resident's	F 0806	F806- Resident allergies, preferences, substitutes 1. Resident 323 was discharged from campus during the survey. Resident did not experience any adverse effects related to alleged deficient practice 2. All residents have the potential to be affected by alleged deficient practice. Food service staff were educated on securing and following resident preference. 3. As a measure of ongoing compliance, DFS or designee to review staff compliance with following resident preference by reviewing 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	12/20/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155678	A. BUILDING 00 B. WING	11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERFORD PLACE HEALTH CAMPUS	800 ST JOSEPH DR KOKOMO, IN 46901

(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
	favorite foods were chicken and favorite snacks were chips and crackers. A physician's order, dated 11/16/22 at 1:21 p.m., indicated Resident 323 had a regular diet and thin liquids. His order indicated for every meal to serve a hot dog sliced down the middle and cut up into small pieces and Vienna sausages cut up with bell peppers cooked per resident's request. A Dining and Nutrition Preference note, dated 11/17/22 at 7:49 a.m., indicated Resident 323's favorite foods were hot dogs and bologna sandwiches. During an interview, on 11/16/22 at 11:00 a.m., the Kitchen Manager indicated he was not notified Resident 323 had requested and had a preference to have a hotdog or bologna. He could accommodate Resident's 323 food preferences if he was notified. A facility policy, titled "Resident Dining and Nutrition Preferences," dated 11/22/17, indicated the resident's preference information will be obtained and be a part of the resident medical record. 3.1-21(a)(4)			
F 0812 SS=D Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155678	A. BUILDING 00 B. WING	11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERFORD PLACE HEALTH CAMPUS	800 ST JOSEPH DR KOKOMO, IN 46901

(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
	directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, interview and record review, the facility failed to serve food in accordance with professional standards for food service safety when four kitchen and dietary staff failed to wear a hair restraint which completely covered the hair while preparing and serving food for 4 of 4 randomly observed kitchen staff. (Cook 1, Cook 2, DSA 1 and DSA 2) and failed to store food in a safe and sanitary manner. Findings include: 1. During an initial tour, on 11/14/22 at 12:00 p.m., to 12:24 p.m., with the Dining Service Manager (DSM), two female cooks were walking throughout the kitchen through the food prep area with a black hat on and a ponytail longer than 10 inches sticking out the back unsecured and not covered with a hair net. Dining Service Assistant (DSA) 1 had walked into the kitchen through the dining room door, between the dish room area and the food prep area. An unidentified DSA 2 with black colored hair, pulled on top of her head into a three-inch ponytail had no hat or hairnet on and walked in the kitchen area. The hairnets were	F 0812	F812-Food Procurement, Store/Prepare/Serve-sanitary 1. No residents were affected by alleged deficient practice. 2. All residents have the potential to be affected. All food service staff educated on hair restraint and labeling and dating of food. 3. As a measure of ongoing compliance, DFS or designee will review food service staff on various shifts to ensure hair is restrained per policy 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, DFS or designee to round on food storage to ensure proper labeling and dating of items 3 times weekly x 4 weeks, then 2 times weekly x 4 weeks, then weekly x 4 weeks, then monthly x	12/20/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155678	A. BUILDING 00 B. WING	11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERFORD PLACE HEALTH CAMPUS	800 ST JOSEPH DR KOKOMO, IN 46901

(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
	located at the back of the kitchen more than 12 feet away near the employee entrance. During an interview, at that time, the Dietary Manager indicated all staff should be wearing a hairnet or wearing a ball cap to secure their hair. He would need to review the facility's policy to whether the long ponytail needed to be secured or covered. 2. During an initial tour, on 11/14/22 at 12:00 p.m., the following one-gallon containers of salad dressing were observed opened, and in a reach-in cooler: a. Buttermilk Ranch dressing with a received date of 10/26/22. b. Thousand Island dressing. c. Caesar dressing. d. Two containers of California French dressing e. Honey Mustard dressing quarter full and had a date received of 7/27/22. During an interview, on 11/14/22 at 12:24 p.m., the DSM indicated the salad dressing containers were opened and lacked indications of when the salad dressing was opened. Staff were expected to remove the received label and replace the label with a new label which would indicate the use by date. During an interview, on 11/16/22 at 11:00 a.m., the Corporate Certified Dietary Manager (CDM) and DSM indicated all staff should be wearing hairnets in the kitchen when food was being prepped. The CDM indicated all containers should be labeled with a received date when the shipment was brought in, and a new label would be placed with an open date to ensure the product was used within the appropriate time frame.		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	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155678	A. BUILDING 00 B. WING	11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERFORD PLACE HEALTH CAMPUS	800 ST JOSEPH DR KOKOMO, IN 46901

(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
	A facility policy, titled "Hair Restraint," undated, indicated a hat would be worn to effectively keep hair from contacting exposed food. Employees with hair extruded out of the cap will be required to have the hair wrapped into a bun style or tucked under a hat. A food service employee will wear hair restraints while in all food preparations area. A facility policy, titled "Food Labeling and Dating Policy," indicated foods were in production when the seal had been broken. The policy lacked indication the staff should document an open date on containers. 3.1-21(i)(1) 3.1-21(i)(3)			
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 Residential Complaint IN00391896 and Nursing Home Complaint IN00388949. Complaint IN00391896 - Substantiated. State deficiencies related to the allegations are cited at R217. Complaint IN00388949 - Substantiated. Federal/State deficiencies related to the allegations are cited at F561. Survey dates: November 14, 15, 16, 17, 18 and 21, 2022. Facility number: 002667	R 0000	Waterford Place Health Campus POC due: 12-15-22 Date of Compliance: 12-15-22 The submission of this plan of correction does not indicate and admission by Waterford Place Health Campus 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 Waterford Place Health Campus. 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	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155678	A. BUILDING 00 B. WING	11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERFORD PLACE HEALTH CAMPUS	800 ST JOSEPH DR KOKOMO, IN 46901

(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
	Residential Census: 65 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review was completed on November 30, 2022.		compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests from the department a desk review for substantial compliance.	
R 0090 Bldg. 00	410 IAC 16.2-5-1.3(g)(1-6) Administration and Management - Deficiency (g) The administrator is responsible for the overall management of the facility. The responsibilities of the administrator shall include, but are not limited to, the following: (1) Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour time period. Unusual occurrences include, but are not limited to: (A) epidemic outbreaks; (B)poisonings; (C) fires; or (D) major accidents. If the division cannot be reached, a call shall be made to the emergency telephone number published by the division. (2) Promptly arranging for or assisting with the provision of medical, dental, podiatry, or nursing care or other health care services as requested by the resident or resident's legal representative. (3) Obtaining director approval prior to the admission of an individual under eighteen (18) years of age to an adult facility.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155678	A. BUILDING 00 B. WING	11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERFORD PLACE HEALTH CAMPUS	800 ST JOSEPH DR KOKOMO, IN 46901

(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
	(4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that indicates the: (A) employee's full name; and (B) dates and hours worked during the past twelve (12) months. (5) Posting the results of the most recent annual survey of the facility conducted by state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. The results must be available for examination in the facility in a place readily accessible to residents and a notice posted of their availability. (6) Maintaining reports of surveys conducted by the division in each facility for a period of two (2) years and making the reports available for inspection to any member of the public upon request			
	Based on observation and interview, the facility failed to post the most recent survey results or a notice to indicate where the survey results could be located, in 1 of 2 buildings reviewed for survey results. (The Legacy building) Finding includes: During the general observation tour of the facility, on 11/18/2022 at 10:13 a.m., with the Director of Plant Operations (DPO) the results of the most recent survey or a notice to indicate where the survey results could be located was not observed to be available. During an interview, at this time, the Legacy Director indicated the survey was posted in the main building, adding she was unaware of the need to post the survey in the Legacy building. A policy was not provided before the exit date of	R 0090	R 090- 1. No residents were affected by this. The legacy neighborhood director (LND) immediately posted a copy of the most recent survey and a sign placed where it could easily be seen identifying the location of the document. 2. All residents residing at The Legacy are potentially affected by alleged deficient practice. LND was educated on ensuring the presence of survey documents. 3. As a measure of ongoing compliance, LND or designee will conduct weekly audits to ensure the survey binder is in designated location x 6 months or until 100% compliance is maintained. 4. As a quality measure, the Executive Director (ED) or	12/20/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155678	A. BUILDING 00 B. WING	11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERFORD PLACE HEALTH CAMPUS	800 ST JOSEPH DR KOKOMO, IN 46901

(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
	the survey.		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	
R 0092 Bldg. 00	410 IAC 16.2-5-1.3(i)(1-2) Administration and Management - Noncompliance (i) The facility must maintain a written fire and disaster preparedness plan to assure continuity of care of residents in cases of emergency as follows: (1) Fire exit drills in facilities shall include the transmission of a fire alarm signal and simulation of emergency fire conditions, except that the movement of nonambulatory residents to safe areas or to the exterior of the building is not required. Drills shall be conducted quarterly on each shift to familiarize all facility personnel with signals and emergency action required under varied conditions. At least twelve (12) drills shall be held every year. When drills are conducted between 9 p.m. and 6 a.m., a coded announcement may be used instead of audible alarms. (2) At least every six (6) months, a facility shall attempt to hold the fire and disaster drill in conjunction with the local fire department. A record of all training and drills shall be documented with the names and signatures of the personnel present. Based on interview and record review, the facility failed to conduct a quarterly fire drill on each shift, for the period of the last quarter of 2021 through the last quarter of 2022.	R 0092	R092- 1. No residents were affected by alleged deficient practice. 2. All residents at The Legacy	12/20/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155678	A. BUILDING 00 B. WING	11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERFORD PLACE HEALTH CAMPUS	800 ST JOSEPH DR KOKOMO, IN 46901

(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
	Finding includes: The fire drills, for the period of the fourth quarter of 2021 through the third quarter of 2022, were reviewed on 11/18/2022 at 10:31 a.m., with the Director of Plant Operations (DPO). Documentation was lacking a fire drill for the first shift had been conducted in the first quarter of 2022. During an interview, at this time, the DPO indicated there was a lack of documentation the fire drill had taken place. A current facility policy, titled "Fire Drills," dated as last revised 09/13/2018, indicated "Fire drills are conducted once per shift, per quarter"		are potentially affected by alleged deficient practice. The Director of Plant Operations reviewed all fire drill records for timely completion and was educated on the schedule for conducting fire drills. 3. As a measure of ongoing compliance, LND or designee will conduct monthly audits to ensure timely completion of fire drills 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	
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			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155678	A. BUILDING 00 B. WING	11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERFORD PLACE HEALTH CAMPUS	800 ST JOSEPH DR KOKOMO, IN 46901

(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 1, 2, 3, 4, 5, 6 and 7) Findings include: During the initial tour, on 11/16/2022 beginning at 11:16 a.m., three residents interviewed indicated they were unaware of their service plan and denied having signed a service plan. During an interview, on 11/16/2022 at 11:26 a.m., the Director indicated she completed resident service plans. The residents did not participate in the service plan, and she was unaware the resident needed to sign and date the plan. On 11/17/2022 12:20 p.m., five current and two discharged resident's service plans were reviewed. All records lacked documentation of signature and date on the resident service plan by the resident or the resident's representative.	R 0217	R217- 1. Residents 1,2, 3, 4, 5, 6, and 7 remain in the campus. Service plans have since been completed and signed by the resident or representative. 2. All residents have the potential to be affected by alleged deficient practice. Clinical staff educated on AL 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	12/20/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155678	A. BUILDING 00 B. WING	11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERFORD PLACE HEALTH CAMPUS	800 ST JOSEPH DR KOKOMO, IN 46901

(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
	A current facility policy, titled "AL-Evaluation and Service Plan Guidelines," with an effective date of 12/11/2017 and received on 11/18/2022 at 10:16 a.m., indicated "...Upon admission, semi-annually and with significant change in health status or functioning, the licensed nurse shall evaluate the resident's physical, mental, psychosocial functioning, and care needs...A Service plan shall be identified and implemented in response to the resident's reevaluation and in collaboration with the resident and/or responsible party. The Assisted Living Director or designee will discuss the services he/she requires...The resident and/or responsible party should be notified and documented in the EHR (Electronic Health Record) for any changes to the Service Plan...." This State tag relates to Complaint IN00391896.		Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted and will continue until 100% compliance is maintained	