STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155819	A. BUILDING 00 B. WING	03/18/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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 Complaint IN00449701. Complaint IN00449701- No deficiencies related to the allegations are cited. Survey dates: March 11, 12, 13, 14, 17 and 18, 2025 Facility number: 013153 Provider number: 155819 AIM number: 201254360 Census Bed Type: SNF/NF: 11 SNF: 45 Residential: 25 Total: 81 Census Payor Type: Medicare: 19 Medicaid: 9 Other: 28 Total: 56 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review was completed on March 21, 2025.	F 0000	The submission of this plan of correction does not indicate any admission by Wellbrooke of Kokomo that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and the living environment provided to the residents of Wellbrooke of Kokomo. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests from the department a desk review for substantial compliance.	
F 0623 SS=E Bldg. 00	483.15(c)(3)-(6)(8) Notice Requirements Before Transfer/Discharge Based on interview and record review, the facility failed to ensure residents and resident's	F 0623	1 1. Resident 36, 28, 30, 18, 74, were affected. No adverse	03/21/2025

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

Amorette Dunkle | Executive Director | 04/01/2025

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

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	representatives were given notification in writing of the reason for the resident's transfer and discharge to the hospital for 5 of 5 residents reviewed for hospitalization or discharge. (Resident 36, 28, 30, 18 and 74) Findings include: 1. The clinical record for Resident 36 was reviewed on 3/12/25 at 2:49 p.m. The diagnoses included, but were not limited to, hypertensive chronic kidney disease, chronic obstructive pulmonary disease, acute respiratory failure with hypoxia, acute respiratory failure with hypercapnia, influenza with other respiratory manifestations, pneumonia, and sepsis. A nursing progress note, dated 10/30/24 at 7:23 p.m., indicated the resident was sent to the emergency room for evaluation following a fall. A nursing progress note, dated 10/31/24 at 3:01 p.m., indicated the resident had been admitted to the hospital for a hip fracture. During the clinical record review, there was no documentation found to indicate the resident and resident's representative were given information in writing regarding the reason for the resident's transfer to the hospital. 2. The clinical record for Resident 28 was reviewed on 3/12/25 at 2:55 p.m. The diagnoses included, but were not limited to, hypertensive heart disease, acute on chronic diastolic (congestive) heart failure, left bundle branch block, arteriosclerotic heart disease without angina pectoris, severe protein calorie malnutrition, polyneuropathy, gout, pleural effusion, edema, and osteoarthritis.		effects noted. 2 2. All residents have the potential to be affected. Staff educated on proper documentation of paperwork sent on transfer/discharge. 3 3. As a measure of ongoing compliance, the Director of Social Services (DSS) or designee will audit transfers and discharges to ensure documentation is in place related to transfer/discharge paperwork. Audit to consist of five transfer/discharges, if available, weekly x4 weeks, then twice monthly x2 months, then monthly x3 months. 4 4. As a quality measure, the 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 revised and updated as warranted.	

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	A nursing progress note, dated 1/23/25 at 4:30 p.m., indicated the resident was transferred to the hospital for evaluation following a fall. A nursing progress note, dated 1/23/25 at 5:11 a.m., indicated the resident had been admitted to the hospital for a right hip fracture. During the clinical record review, there was no documentation found to indicate the resident and resident's representative were given information in writing regarding the reason for the resident's transfer to the hospital.3. The clinical record for Resident 30 was reviewed on 3/17/25 at 10:02 a.m. The diagnoses included, but were not limited to, chronic obstructive pulmonary disease, pulmonary embolism, hypertension, congestive heart failure, obesity, cerebrovascular accident, hemiplegia, hemiparesis, transient ischemic attack, and muscle weakness. A nursing progress note, dated 1/18/25 at 12:25 p.m., indicated the resident was sent to the emergency room for evaluation. A nursing progress note, dated 1/19/25 at 4:08 a.m., indicated the resident had been admitted to the hospital for pulmonary embolism and right heart strain. During the clinical record review, there was no documentation found to indicate the resident and resident's representative were given information in writing regarding the reason for the resident's transfer to the hospital.4. The clinical record for Resident 18 was reviewed on 3/12/25 at 12:07 a.m. The diagnoses included, but were not limited to, acute respiratory failure, hypertension, congestive heart failure, chronic obstructive pulmonary			

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	disease, chronic kidney disease, and diabetes mellitus. A nursing progress note, dated 1/12/25 at 11:49 a.m., indicated the resident was transferred to the hospital for a decline in condition and increased confusion. During the clinical record review, there was no documentation found to indicate the resident and resident's representative were given information in writing regarding the reason for the resident's transfer to the hospital. 5. The clinical record for Resident 74 was reviewed on 3/14/25 at 11:11 a.m. The diagnoses included, but were not limited to, malignant neoplasm of cecum, chronic obstructive pulmonary disease, diabetes mellitus, anxiety disorder, acute pulmonary edema, and depression. A nursing progress note, dated 1/12/25 at 11:49 a.m., indicated the resident was transferred to the hospital. The Nurse Practitioner was notified and gave a verbal order to send Resident 74 to the emergency room for evaluation and treatment. During the clinical record review, there was no documentation found to indicate the resident and resident's representative were given information in writing regarding the reason for the resident's transfer to the hospital. During an interview, on 3/14/25 at 9:38 a.m., the Clinical Support Nurse indicated they did not find documentation to indicate the residents or resident's representatives were given information in writing regarding the reason for the resident's hospitalization.			

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	During an interview, on 3/14/25 at 11:22 a.m., the Executive Director (ED) indicated she did not have any documentation to indicate the residents or resident's representatives were given information in writing regarding the reason for the resident's hospitalization. A current facility policy, titled "Guidelines for Transfer and Discharge (including AMA)," dated as reviewed on 11/18/16 and received from the ED on 3/19/25 at 1:39 p.m., indicated "...Notify the resident in writing, and if known, a family member or legal representative, 30 days in advance, of the transfer or discharge, the effective date of transfer or discharge, the location to which the resident is transferred or discharged, and the reasons for the transfer of discharge, according to the criteria for transfer or discharge...Record the reasons for, the effective date of transfer or discharge, and the location to which the resident is being transferred or discharged in the medical record and on a discharge form or a letter. Give a copy of the discharge notice to the resident and his/her family legal representative...The physician should document medical reasons for transfer or discharge in the medical record when the reason for transfer and discharge is for any reason other than nonpayment of the stay or the facility ceasing to operate...." 3.1-12(a)(6)(A)(i) 3.1-12(a)(6)(A)(ii) 3.1-12(a)(6)(A)(iii)			
F 0625 SS=E Bldg. 00	483.15(d)(1)(2) Notice of Bed Hold Policy Before/Upon Trnsfr Based on interview and record review, the facility failed to ensure residents and resident representatives were given notification in writing	F 0625	1 1. Resident 36, 28, 30, 18, 74 were affected. No adverse effects noted.	03/21/2025

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	of the facility's policy for bed hold and cost at the time of transfer to the hospital for 5 of 5 residents reviewed for hospitalization or discharge. (Resident 36, 28, 30, 18 and 74) Findings include: 1. The clinical record for Resident 36 was reviewed on 3/12/25 at 2:49 p.m. The diagnoses included, but were not limited to, hypertensive chronic kidney disease, chronic obstructive pulmonary disease, acute respiratory failure with hypoxia, acute respiratory failure with hypercapnia, influenza with other respiratory manifestations, pneumonia, and sepsis. A nursing progress note, dated 10/30/24 at 7:23 p.m., indicated the resident was sent to the emergency room for evaluation following a fall. A nursing progress note, dated 10/31/24 at 3:01 p.m., indicated the resident had been admitted to the hospital for a hip fracture. During the clinical record review, there was no documentation found to indicate the resident and resident's representative were given information in writing regarding the facility's bed hold policy, including the facility's charge to hold a bed. 2. The clinical record for Resident 28 was reviewed on 3/12/25 at 2:55 p.m. The diagnoses included, but were not limited to, hypertensive heart disease, acute chronic diastolic (congestive) heart failure, left bundle branch block, arteriosclerotic heart disease without angina pectoris, severe protein calorie malnutrition, polyneuropathy, gout, pleural effusion, edema, and osteoarthritis. A nursing progress note, dated 1/23/25 at 4:30		2 2.All residents have the potential to be affected. Staff educated on proper documentation of paperwork sent on discharge. 3 3. As a measure of ongoing compliance, the Director of Social Services (DSS) or designee will audit discharges to ensure documentation is in place related to discharge paperwork including bed hold policy. Audit to consist of five discharges, if available, weekly x4 weeks, then twice monthly x2 months, then monthly x3 months. 4 4. As a quality measure, the 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 revised and updated as warranted.	

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	p.m., indicated the resident was transferred to the hospital for evaluation following a fall. A nursing progress note, dated 1/23/25 at 5:11 a.m., indicated the resident had been admitted to the hospital for a right hip fracture. During the clinical record review, there was no documentation found to indicate the resident and resident's representative were given information in writing regarding the facility's bed hold policy, including the facility's charge to hold a bed.3. The clinical record for Resident 30 was reviewed on 3/17/25 at 10:02 a.m. The diagnoses included, but were not limited to, chronic obstructive pulmonary disease, pulmonary embolism, hypertension, congestive heart failure, obesity, cerebrovascular accident, hemiplegia, hemiparesis, transient ischemic attack, and muscle weakness. A nursing progress note, dated 1/18/25 at 12:25 p.m., indicated the resident was sent to the emergency room for evaluation. A nursing progress note, dated 1/19/25 at 4:08 a.m., indicated the resident had been admitted to the hospital for pulmonary embolism and right heart strain. During the clinical record review, there was no documentation found to indicate the resident and resident's representative were given information in writing regarding the facility's bed hold policy, including the facility's charge to hold a bed.4. The clinical record for Resident 18 was reviewed on 3/12/25 at 12:07 a.m. The diagnoses included, but were not limited to, acute respiratory failure, hypertension, congestive heart failure, chronic obstructive pulmonary disease, chronic kidney disease, and diabetes mellitus.			

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	A nursing progress note, dated 1/12/25 at 11:49 a.m., indicated the resident was transferred to the hospital for a decline in condition and increased confusion. During the clinical record review, there was no documentation found to indicate the resident and resident's representative were given information in writing regarding the facility's bed hold policy, including the facility's charge to hold a bed. 5. The clinical record for Resident 74 was reviewed on 3/14/25 at 11:11 a.m. The diagnoses included, but were not limited to, malignant neoplasm of cecum, chronic obstructive pulmonary disease, diabetes mellitus, anxiety disorder, acute pulmonary edema, and depression. A nursing progress note, dated 1/12/25 at 11:49 a.m., indicated the resident was transferred to the hospital. The Nurse Practitioner was notified and gave a verbal order to send Resident 74 to the emergency room for evaluation and treatment. During the clinical record review, there was no documentation found to indicate the resident and resident's representative were given information in writing regarding the facility's bed hold policy, including the facility's charge to hold a bed. During an interview, on 3/14/25 at 9:38 a.m., the Clinical Support Nurse indicated they did not find documentation to indicate the resident or resident representatives were given information in writing regarding the facility's bed hold policy at the time of the resident's hospitalization. During an interview, on 3/14/25 at 11:22 a.m., the Executive Director (ED) indicated she did not have			

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	any documentation to indicate the resident or resident representatives were given information in writing regarding the facility's bed hold policy at the time of the resident's hospitalization. A current facility policy, titled "Bed Hold Policy," dated as revised on 11/18/16 and received from the ED on 3/17/25 at 2:15 p.m., indicated "...The campus will properly inform residents in advance of their option to make bed-hold payments as well as the amount of the facility's charge to hold a bed. For this optional payment, the campus must make clear that the resident/responsible party must affirmatively elect to make them prior to being billed...If the resident leaves the campus for hospitalization, therapeutic leave, or any other reason (other than the resident's death)...The campus will continue to hold the resident's bed until notified by resident of the responsible party/agent that the bed is no longer desired...It is the policy of the Company that every campus will properly inform residents in advance of their option to make a bed-hold and the amount of the facility charge...." A current facility policy, titled "Guidelines for Transfer and Discharge (including AMA)," dated as reviewed on 11/18/16 and received from the ED on 3/19/25 at 1:39 p.m., indicated "...Notice of Bed-Hold Policy and Readmission...Before the facility transfers a resident to a hospital or allows a resident to go on therapeutic leave, Nursing staff or other designated staff member should provide written information to the resident and a family member of legal representative of the bed-hold and admission policies...." 3.1-12(a)(25)(A) 3.1-12(a)(25)(B)			

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F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning Based on observation, interview and record review, the facility failed to ensure oxygen was administered at the correct physician ordered flow rate for 2 of 4 residents reviewed for respiratory care. (Resident 34 and 37) Findings include: 1. During an observation, on 3/11/25 at 3:49 p.m., the resident was sitting in his room with oxygen administered at 3 liters per minute (L) via nasal cannula. During an observation, on 3/12/25 at 3:22 p.m., the resident was resting in his bed with oxygen administered at 3 L via nasal cannula. The clinical record for Resident 34 was reviewed on 3/13/25 at 9:17 a.m. The diagnoses included, but were not limited to, chronic obstructive pulmonary disease with acute exacerbation, acute respiratory failure with hypoxia, acute respiratory infection, and respiratory syncytial virus. A physician's order, dated 2/1/25, indicated to administer oxygen at 2 L per nasal cannula continuously. During an interview, on 3/13/25 at 8:05 a.m., the Director of Nursing (DON) indicated the staff were supposed to verify how much oxygen the resident was on with the physician's order. 2. During an observation, on 3/11/25 at 12:06 p.m., the resident was lying in bed with 3 L of oxygen administered via nasal cannula.	F 0695	1. Residents 34 and 37 were affected. Residents immediately assessed with no adverse effects noted. Resident oxygen in place per order and orders reviewed in eMAR. 2. All residents that have orders for oxygen have the potential to be affected. All nurses have been educated on following physician orders and documenting liter flow in EHR. A house wide audit to ensure that all residents that require oxygen have oxygen in place and documented appropriately will be completed by 3/21/25. 3. As a measure of ongoing compliance, the Director of Health Services (DHS), or designee, will complete audits of 3 resident to ensure oxygen orders are being followed and documented accurately in EHR 3x weekly x4 weeks, then weekly x 4 weeks, then every other week x 4 weeks, then monthly x3 months 4. As a quality measure, the 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 revised and updated as warranted.	03/21/2025

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	During an observation, on 3/12/25 at 3:33 p.m., the resident was lying in bed with 3 L of oxygen administered via nasal cannula. The clinical record for Resident 37 was reviewed on 3/12/25 at 3:42 p.m. The diagnoses included, but were not limited to, hypertensive heart disease with heart failure, acute on chronic diastolic congestive heart failure, chronic respiratory failure with hypoxia, emphysema, pulmonary fibrosis, and shortness of breath. A physician's order, dated 9/19/24, indicated to administer oxygen at 2 L per nasal cannula continuously. During an interview, on 3/13/25 at 10:28 a.m., LPN 1 indicated oxygen should be administered according to the physician's order. A current facility policy, titled "Administration of Oxygen," dated 12/13/24 and received from the Clinical Support Nurse on 3/14/25 at 9:40 a.m., indicated "...Verify physician's order...Adjust the oxygen delivery device so that...the proper flow of oxygen is administered...." 3.1-47(a)(6)			
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 Complaint IN00449701. Complaint IN00449701- No deficiencies related to the allegations are cited.	R 0000	The submission of this plan of correction does not indicate any admission by Wellbrooke of Kokomo that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and the living environment provided to	

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	Survey dates: March 11, 12, 13, 14, 17 and 18, 2025 Facility number: 013153 Residential Census: 25 Wellbrooke of Kokomo was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey. Quality review was completed on March 21, 2025.		the residents of Wellbrooke of Kokomo. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests from the department a desk review for substantial compliance.	