STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		î ´	li i		(X3) DATE		
ANDILAN	OI CORRECTION	155819	A. BUILDING <u>00</u> COMPLI B. WING 03/18/2				
			ST.	DEET A	DDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIE	R			OUTH DIXON ROAD		
WELLBR	OOKE OF KOKOM	10		KOKOMO, IN 46902			
(X4) ID		STATEMENT OF DEFICIENCIE	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TA	AG	DEFICIENCY)		DATE
F 0000							
Bldg. 00	This visit was for a	Recertification and State	F 0000		The submission of this plan of		
		This visit included a State	F 0000		The submission of this plan of correction does not indicate ar		
	-	ure Survey. This visit also			admission by Wellbrooke of	ıy	
		igation of Complaint			Kokomo that the findings and		
	IN00449701.	.gamen or companie			allegations contained herein a	re	
					accurate, true representation of		
	Complaint IN0044	9701- No deficiencies related to			the quality of care provided, a		
	the allegations are				the living environment provide	d to	
	Survey dates: Marc	ch 11, 12, 13, 14, 17 and 18, 2025			the residents of Wellbrooke of Kokomo. The facility recognizes its obligation to provide legally and		
	Facility number: 013153				medically necessary care and		
	Provider number: 1				services to its residents in an		
	AIM number: 2012	254360			economic and efficient manne		
	Census Bed Type:				The facility hereby maintains in substantial compliance with		
	SNF/NF: 11				state and federal requirements		
	SNF: 45				governing the management of		
	Residential: 25				facility. It is thus submitted as		
	Total: 81				matter of statute only. The fac		
	Census Payor Type	e:			respectfully requests from the department a desk review for		
	Medicare: 19				substantial compliance.		
	Medicaid: 9			1	•		
	Other: 28						
	Total: 56						
	These deficiencies accordance with 41	reflect State Findings cited in 0 IAC 16.2-3.1.					
	Quality review was	s completed on March 21, 2025.					
F 0623 SS=E	483.15(c)(3)-(6)(8 Notice Requirement	ents Before					
Bldg. 00	Transfer/Discharo				4 4 B 11 100 00 :	•	00/04/5555
		and record review, the facility idents and resident's	F 0623		1 1. Resident 36, 28, 30, 1 74, were affected. No adverse		03/21/2025
LABORATOR	Y DIRECTOR'S OR PRO	VIDER/SUPPLIER REPRESENTATIVE'S SIG	NATURE		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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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155819	B. W	ING		03/18/	/2025
		l .		CTDEET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	₹			OUTH DIXON ROAD		
WELLED	OOKE OF KOKOM	10		KOKOMO, IN 46902			
WELLDIN	OOKE OF KOKOW			KOROWO, IN 40902			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	•	e given notification in writing			effects noted.		
		e resident's transfer and			2 2. All residents have the		
	_	spital for 5 of 5 residents			potential to be affected. Staff		
	_	alization or discharge.			educated on proper document	ation	
	(Resident 36, 28, 30	0, 18 and 74)			of paperwork sent on		
					transfer/discharge.		
	Findings include:				3 3. As a measure of ongo	•	
					compliance, the Director of Sc		
		rd for Resident 36 was reviewed			Services (DSS) or designee w		
		p.m. The diagnoses included,			audit transfers and discharges		
		d to, hypertensive chronic			ensure documentation is in pla	асе	
	-	onic obstructive pulmonary			related to transfer/discharge		
	_	ratory failure with hypoxia,			paperwork. Audit to consist of		
		ilure with hypercapnia,			transfer/discharges, if availabl	e,	
		r respiratory manifestations,			weekly x4 weeks, then twice		
	pneumonia, and sep	osis.			monthly x2 months, then mon	thly	
					x3 months.		
		note, dated 10/30/24 at 7:23			4 4. As a quality measure,		
	_	resident was sent to the			ED or designee will review an	-	
	emergency room fo	or evaluation following a fall.			findings and corrective action	at	
					least quarterly in the campus		
		note, dated 10/31/24 at 3:01			Quality Assurance Performan		
	_	resident had been admitted to			Improvement meetings. The p		
	the hospital for a hi	p fracture.			will be revised and updated as	;	
	D	1			warranted.		
		record review, there was no					
		nd to indicate the resident and					
		ative were given information in					
		ne reason for the resident's					
	transfer to the hosp	Itai.					
	2 The alimination	rd for Resident 28 was reviewed					
		p.m. The diagnoses included,					
		d to, hypertensive heart nronic diastolic (congestive)					
	heart failure, left bu						
	· ·						
		rt disease without angina					
	-	tein calorie malnutrition,					
	and osteoarthritis	ut, pleural effusion, edema,					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPL	
		155819	B. W	ING		03/18	/2025
NAME OF P	PROVIDER OR SUPPLIEF				ADDRESS, CITY, STATE, ZIP COD		
				2200 SOUTH DIXON ROAD			
WELLBR	OOKE OF KOKOM	IU		KOKON	MO, IN 46902		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY)		DATE
	A nursing progress	note dated 1/23/25 at 4:30					
A nursing progress note, dated 1/23/25 at 4:30 p.m., indicated the resident was transferred to the							
	-	ion following a fall.					
	nospital for evaluation following a fair.						
	A nursing progress	note, dated 1/23/25 at 5:11					
	a.m., indicated the	resident had been admitted to					
	the hospital for a rig	ght hip fracture.					
	D : 4 ** * *	1 1 4					
	_	record review, there was no					
		ative were given information in					
	-	ne reason for the resident's					
		ital.3. The clinical record for					
	•	viewed on 3/17/25 at 10:02 a.m.					
		ided, but were not limited to,					
	-	pulmonary disease,					
	pulmonary embolis	m, hypertension, congestive					
		y, cerebrovascular accident,					
		aresis, transient ischemic attack,					
	and muscle weakne	ess.					
	A	note, dated 1/18/25 at 12:25					
	0.7	resident was sent to the					
	emergency room fo						
	A nursing progress	note, dated 1/19/25 at 4:08					
		resident had been admitted to					
	the hospital for puli	monary embolism and right					
	heart strain.						
		1					
	-	record review, there was no					
		nd to indicate the resident and					
	_	ative were given information in ne reason for the resident's					
		ital.4. The clinical record for					
	_	viewed on 3/12/25 at 12:07 a.m.					
		uded, but were not limited to,					
	-	ilure, hypertension, congestive					
		ic obstructive nulmonary	1				1

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		l í	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPL	
		155819	B. WI	NG		03/18/	2025
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 2200 SOUTH DIXON ROAD KOKOMO, IN 46902			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	T	ID			(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE
	disease, chronic kid mellitus.	ney disease, and diabetes					
	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.						
	documentation four resident's representa	record review, there was no ad to indicate the resident and ative were given information in the reason for the resident's tal.					
	Clinical Support Nu documentation to in resident's representa	y, on 3/14/25 at 9:38 a.m., the arse indicated they did not find dicate the residents or atives were given information the reason for the resident's					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155819		X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 00 COMPLETED B. WING 03/18/2025						
	PROVIDER OR SUPPLIER		2200 S	STREET ADDRESS, CITY, STATE, ZIP COD 2200 SOUTH DIXON ROAD KOKOMO, IN 46902				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
	Executive Director any documentation resident's representation writing regarding hospitalization.	(ED) indicated she did not have to indicate the residents or atives were given information g the reason for the resident's						
	as reviewed on 11/1 on 3/19/25 at 1:39 president in writing, or legal representation transfer or discharge or discharge, the location of discharge transfer of discharge transfer or discharge effective date of trallocation to which the	arge (including AMA)," dated 18/16 and received from the ED 5.m., indicated "Notify the and if known, a family member ive, 30 days in advance, of the e, the effective date of transfer cation to which the resident is arged, and the reasons for the e, according to the criteria for eRecord the reasons for, the nsfer or discharge, and the resident is being transferred e medical record and on a						
	discharge form or a discharge notice to legal representative document medical a discharge in the me for transfer and disc	letter. Give a copy of the the resident and his/her familyThe physician should reasons for transfer or dical record when the reason charge is for any reason other f the stay or the facility						
	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		d Policy Before/Upon Trnsfr	P.0625		0.00/24/2025			
	failed to ensure resi	and record review, the facility dents and resident e given notification in writing	F 0625	1 1. Resident 36, 28, 30, 1 74 were affected. No adverse effects noted.	8, 03/21/2025			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155819	B. W	ING		03/18/	2025
			<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	L			OUTH DIXON ROAD		
WELLBR	OOKE OF KOKOM	0	KOKOMO, IN 46902				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG			DATE
		cy for bed hold and cost at the			2 2.All residents have the		
		he hospital for 5 of 5 residents			potential to be affected. Staff		
	-	alization or discharge.			educated on proper document		
	(Resident 36, 28, 30), 18 and 74)			of paperwork sent on discharg		
	Tr' 1' ' 1 1				3 3. As a measure of ongo	-	
	Findings include:				compliance, the Director of Sc		
	1 The eliminal mass.	ed for Docidant 26 was reviews 1			Services (DSS) or designee w	/III	
		rd for Resident 36 was reviewed o.m. The diagnoses included,			audit discharges to ensure	tod	
	-	I to, hypertensive chronic			documentation is in place rela to discharge paperwork includ		
		onic obstructive pulmonary			bed hold policy. Audit to consi	-	
	-	ratory failure with hypoxia,			five discharges, if available, w		
		ilure with hypercapnia,			x4 weeks, then twice monthly	•	
	influenza with other respiratory manifestations,				months, then monthly x3 mon		
	pneumonia, and sep				4 4. As a quality measure,		
					ED or designee will review an		
	A nursing progress	note, dated 10/30/24 at 7:23			findings and corrective action	-	
		resident was sent to the			least quarterly in the campus		
	emergency room for	r evaluation following a fall.			Quality Assurance Performan	ce	
					Improvement meetings. The p	lan	
	A nursing progress	note, dated 10/31/24 at 3:01			will be revised and updated as	3	
	_	resident had been admitted to			warranted.		
	the hospital for a hij	p fracture.					
	During the clinical i	record review, there was no					
	_	nd to indicate the resident and					
		ative were given information in					
	_	ne facility's bed hold policy,					
		y's charge to hold a bed.					
	2. The clinical reco	rd for Resident 28 was reviewed					
		o.m. The diagnoses included,					
	-	l to, hypertensive heart					
		nic diastolic (congestive) heart					
		oranch block, arteriosclerotic					
		at angina pectoris, severe					
		nutrition, polyneuropathy,					
	gout, pleural effusion	on, edema, and osteoarthritis.					
	A nursing progress	note, dated 1/23/25 at 4:30					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDIN	G	00	COMPL	ETED
		155819	B. WING			03/18	/2025
			CTD	EET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	2			OUTH DIXON ROAD		
WELLED		0					
WELLDR	OOKE OF KOKOM	0	KO	KUIV	1O, IN 46902		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFI	X	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	E COMPLETIO	
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION	TAG	ì	DEFICIENCY)		DATE
	p.m., indicated the i	resident was transferred to the					
	hospital for evaluati	ion following a fall.					
	A nursing progress	note, dated 1/23/25 at 5:11					
	a.m., indicated the r	resident had been admitted to					
	the hospital for a rig	ght hip fracture.					
	~	record review, there was no					
		nd to indicate the resident and					
	-	ative were given information in					
		ne facility's bed hold policy,					
	-	y's charge to hold a bed.3. The					
		Resident 30 was reviewed on					
		n. The diagnoses included, but					
		chronic obstructive pulmonary					
		embolism, hypertension,					
	-	lure, obesity, cerebrovascular					
		a, hemiparesis, transient					
	ischemic attack, and	d muscle weakness.					
		note, dated 1/18/25 at 12:25					
	-	resident was sent to the					
	emergency room fo	r evaluation.					
	l	1 1 1 1 1 1 1 1 1 2 2 2 2 2 2 2 2 2 2 2					
		note, dated 1/19/25 at 4:08					
		resident had been admitted to					
	• •	nonary embolism and right					
	heart strain.						
	Dunin a the1!! 1	managed marriages theory					
	-	record review, there was no					
	-	ative were given information in					
		ne facility's bed hold policy, y's charge to hold a bed.4. The					
	_	Resident 18 was reviewed on					
		n. The diagnoses included, but					
	· ·	acute respiratory failure,					
		estive heart failure, chronic					
	-	ary disease, chronic kidney					
	disease, and diabete	es meilitus.	1				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155819		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 00 COMPLETED B. WING 03/18/2025			
	PROVIDER OR SUPPLIEF		2200 S	ADDRESS, CITY, STATE, ZIP COD OUTH DIXON ROAD MO, IN 46902	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION
	a.m., indicated the	note, dated 1/12/25 at 11:49 resident was transferred to the ae in condition and increased			
	documentation four resident's representa writing regarding th	record review, there was no and to indicate the resident and ative were given information in the facility's bed hold policy, y's charge to hold a bed.			
	on 3/14/25 at 11:11 but were not limited cecum, chronic obs	rd for Resident 74 was reviewed a.m. The diagnoses included, d to, malignant neoplasm of tructive pulmonary disease, nxiety disorder, acute			
	A nursing progress a.m., indicated the hospital. The Nurse gave a verbal order	note, dated 1/12/25 at 11:49 resident was transferred to the Practitioner was notified and to send Resident 74 to the r evaluation and treatment.			
	documentation four resident's representa writing regarding th	record review, there was no and to indicate the resident and ative were given information in the facility's bed hold policy, y's charge to hold a bed.			
	Clinical Support No documentation to in representatives wer	y, on 3/14/25 at 9:38 a.m., the arse indicated they did not find adicate the resident or resident e given information in writing sy's bed hold policy at the time epitalization.			
		v, on 3/14/25 at 11:22 a.m., the (ED) indicated she did not have			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155819		r í	JILDING	NSTRUCTION 00	(X3) DATE COMPL 03/18/	ETED			
	PROVIDER OR SUPPLIE OOKE OF KOKOM			STREET ADDRESS, CITY, STATE, ZIP COD 2200 SOUTH DIXON ROAD KOKOMO, IN 46902					
	SUMMARY (EACH DEFICIENT REGULATORY OF any documentation resident representate writing regarding the time of the resident as revised on the ED on 3/17/25 campus will proper of their option to mas the amount of the bed. For this option make clear that the must affirmatively being billedIf the hospitalization, the reason (other than to campus will continuntil notified by resparty/agent that the the policy of the Coproperly inform resoption to make a befacility charge" A current facility p Transfer and Dischas reviewed on 11/2 on 3/19/25 at 1:39 Bed-Hold Policy are facility transfers and a resident to go on staff or other design provide written information of the summarise	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL RESC IDENTIFYING INFORMATION to indicate the resident or ives were given information in the facility's bed hold policy at dent's hospitalization. Dlicy, titled "Bed Hold Policy," 11/18/16 and received from the 2:15 p.m., indicated "The lay inform residents in advance aske bed-hold payments as well the facility's charge to hold a mal payment, the campus must resident/responsible party the leet to make them prior to resident leaves the campus for responsible to hold the resident's bed dident of the responsible bed is no longer desiredIt is company that every campus will idents in advance of their the dehold and the amount of the Dolicy, titled "Guidelines for targe (including AMA)," dated 18/16 and received from the ED to.m., indicated "Notice of the ReadmissionBefore the the tesident to a hospital or allows the rapeutic leave, Nursing mated staff member should formation to the resident and a tegal representative of the				ATE	(X5) COMPLETION DATE		
	3.1-12(a)(25)(A) 3.1-12(a)(25)(B)								

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 03/18/2025 155819 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 2200 SOUTH DIXON ROAD WELLBROOKE OF KOKOMO KOKOMO. IN 46902 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE F 0695 SS=D Respiratory/Tracheostomy Care and Bldg. 00 Suctioning Based on observation, interview and record F 0695 1. Residents 34 and 37 were 03/21/2025 review, the facility failed to ensure oxygen was affected. Residents immediately administered at the correct physician ordered flow assessed with no adverse effects rate for 2 of 4 residents reviewed for respiratory noted. Resident oxygen in place care. (Resident 34 and 37) per order and orders reviewed in eMAR. Findings include: 2. All residents that have orders for oxygen have the potential to be 1. During an observation, on 3/11/25 at 3:49 p.m., affected. All nurses have been the resident was sitting in his room with oxygen educated on following physician administered at 3 liters per minute (L) via nasal orders and documenting liter flow cannula. in EHR. A house wide audit to ensure that all residents that During an observation, on 3/12/25 at 3:22 p.m., the require oxygen have oxygen in resident was resting in his bed with oxygen place and documented administered at 3 L via nasal cannula. appropriately will be completed by 3/21/25. The clinical record for Resident 34 was reviewed 3. As a measure of ongoing on 3/13/25 at 9:17 a.m. The diagnoses included, compliance, the Director of Health but were not limited to, chronic obstructive Services (DHS), or designee, will pulmonary disease with acute exacerbation, acute complete audits of 3 resident to respiratory failure with hypoxia, acute respiratory ensure oxygen orders are being infection, and respiratory syncytial virus. followed and documented accurately in EHR 3x weekly x4 A physician's order, dated 2/1/25, indicated to weeks, then weekly x 4 weeks, administer oxygen at 2 L per nasal cannula then every other week x 4 weeks, continuously. then monthly x3 months 4. As a quality measure, the During an interview, on 3/13/25 at 8:05 a.m., the Executive Director (ED) or Director of Nursing (DON) indicated the staff were designee will review any findings supposed to verify how much oxygen the resident and corrective action at least was on with the physician's order. quarterly in the campus Quality Assurance Performance 2. During an observation, on 3/11/25 at 12:06 p.m., Improvement meetings. The plan the resident was lying in bed with 3 L of oxygen will be revised and updated as administered via nasal cannula. warranted.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/03/2025 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155819		A. BUILDING B. WING	COMPLETED 03/18/2025		
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD OUTH DIXON ROAD	
WELLBR	OOKE OF KOKOM	0		10, IN 46902	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
	-	on, on 3/12/25 at 3:33 p.m., the n bed with 3 L of oxygen sal cannula.			
	on 3/12/25 at 3:42 p but were not limited with heart failure, ac congestive heart fail	for Resident 37 was reviewed o.m. The diagnoses included, to, hypertensive heart disease cute on chronic diastolic dure, chronic respiratory failure ysema, pulmonary fibrosis, ath.			
		dated 9/19/24, indicated to at 2 L per nasal cannula			
	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.				
	Oxygen," dated 12/2 Clinical Support Nu indicated "Verify	olicy, titled "Administration of 13/24 and received from the arse on 3/14/25 at 9:40 a.m., physician's orderAdjust the vice so thatthe proper flow of red"			
	3.1-47(a)(6)				
R 0000					
Bldg. 00	Survey. This visit in State Licensure Sur the Investigation of	State Residential Licensure acluded a Recertification and vey. This visit also included Complaint IN00449701. 701- No deficiencies related to ited.	R 0000	The submission of this plan of correction does not indicate ar admission by Wellbrooke of Kokomo that the findings and allegations contained herein a accurate, true representation of the quality of care provided, ar the living environment provided.	re of nd

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155819	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE COMPL 03/18 /	ETED
NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF KOKOMO		STREET ADDRESS, CITY, STATE, ZIP COD 2200 SOUTH DIXON ROAD KOKOMO, IN 46902					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	I	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
	Facility number: 01 Residential Census: Wellbrooke of Kok compliance with 41 State Residential Li	25 omo was found to be in 0 IAC 16.2-5 in regard to the			the residents of Wellbrooke of Kokomo. The facility recognize its obligation to provide legally medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it in substantial compliance with state and federal requirements governing the management of facility. It is thus submitted as a matter of statute only. The facil respectfully requests from the department a desk review for substantial compliance.	es and r. t is all s this	

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