STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155222	A. BUILDING 00 B. WING	05/17/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00430125, IN00431349, IN00431786, IN00432671, IN00433433, IN00433437, IN00433490 and IN00433713. Complaint IN00430125-No deficiencies related to the allegations are cited. Complaint IN00431349-No deficiencies related to the allegations are cited. Complaint IN00431786- No deficiencies related to the allegations are cited. Complaint IN00432671-No deficiencies related to the allegations are cited. Complaint IN00433433-No deficiencies related to the allegations are cited. Complaint IN00433437-No deficiencies related to the allegations are cited. Complaint IN00433490-No deficiencies related to the allegations are cited. Complaint IN00433713-No deficiencies related to the allegations are cited. Survey dates: May 13, 14, 15, 16 and 17, 2024. Facility number: 000127 Provider number: 155222 AIM number: 100291430 Census Bed Type:	F 0000	Please accept this plan of correction as the provider's credible allegation of compliance. The provider respectfully requests a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Sydnie Reed	Executive Director	06/04/2024

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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	SNF/NF: 67 Total: 67 Census Payor Type: Medicare: 3 Medicaid: 61 Other: 3 Total: 67 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review was completed on May 23, 2024.			
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. 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 there was an accurate physician's order for the use of oxygen, oxygen was set at the correct liter flow rate, the compressor was set at the correct rate and oxygen tubing was labeled and dated for 4 of 4 residents reviewed for oxygen. (Resident 118, 20, 23 and 43) Findings include: 1. During an observation, on 5/14/24 at 11:16 a.m., Resident 118's Easy Air compressor was set at 20 and the oxygen concentrator was set at 2 liters per	F 0695	**Corrective actions accomplished for those residents found to be affected by the alleged deficit practice:** There were no residents harmed by the alleged deficit practice. Facility immediately corrected the physician order, liter flow rate, and compressor flow rate for Resident 118. Facility immediately changed and dated oxygen tubing for residents 20, 23, and 43.	06/12/2024

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	minute for the trach stoma (opening). During an observation, on 5/16/24 at 11:07 a.m., the resident was sitting up in a chair in his room and the oxygen concentrator was set at 2 liters per minute. The resident did not have oxygen on his trach stoma. The clinical record for Resident 118 was reviewed on 5/15/24 at 12:22 p.m. The diagnoses included, but were not limited to, congestive heart failure, chronic obstructive pulmonary disease, and dependence on supplemental oxygen. A care plan, dated 5/8/24, indicated the resident had chronic obstructive pulmonary disease with shortness of breath while lying flat. The interventions included, but were not limited to, oxygen therapy as ordered. A physician's order, dated 5/14/24, indicated oxygen at 3 liters per minute by the stoma mask continuous with compression at 50%. During an interview, on 5/15/24 at 11:15 a.m., the outside oxygen company representative who set up the resident's oxygen to his trach stoma indicated the Easy air setting should be at 20 for pressure, 80 for humidity and the oxygen concentrator at 2 liters per minute. During an interview, on 5/16/24 at 11:09 a.m., LPN 2 indicated the resident's oxygen concentration should be set at 3 liters per minute for continuous use. She would need to look at the physician's order to see what the Easy air compressor should be set on. She was going to call the Director of Nursing (DON) because she did not know what the Easy air should be set at.		**Identification of other residents having the potential to be affected by the same alleged practice and corrective actions taken:** All residents who utilize oxygen have the potential to be affected. There were no residents harmed by the alleged practice. Facility completed a whole house audit of oxygen tubing to ensure all were dated. There are no other residents residing in facility that utilize Easy Air flow compressors. **Measures put in place and systemic changes made to ensure the alleged deficit practice does not recur:** Facility completed education on supplemental oxygen using nasal cannula and oxygen-medical gas use policies with emphasis ensuring flow rate matches physician orders and ensuring tubing is dated within the last 7 days. **How the corrective measures will be monitored to ensure the alleged deficit practice does not recur:** The DON/designee will conduct audits of 5 residents with oxygen use per week for 4 weeks, then 3 residents with oxygen use per week for 4 weeks, and then 1 resident with oxygen use per week for 4 months to ensure oxygen tubing is dated and that oxygen tanks are set according to the oxygen order. Any discrepancies	

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	During an observation and interview, on 5/16/24 at 11:12 a.m., the DON indicated the respiratory therapist from the oxygen supply company should have set up the Easy air compressor at the correct rate and it should not be changed. The DON set the Easy air on 50 and the concentrator at 3 liters per minute. During an interview, on 5/16/24 at 3:28 p.m., the Clinical Support Nurse indicated the physician's order for the Easy air compressor should have been written to set the machine at 20 and it would equal the 50%. The staff working should have known how to set the Easy air compressor by following the physician's order. The physician's order was not clear.2. During an observation, on 5/13/24 at 1:30 p.m., Resident 20 was wearing oxygen with an unlabeled nasal cannula tubing. During an observation, on 5/14/24 at 11:00 a.m., Resident 20 was wearing oxygen with an unlabeled nasal cannula tubing. The clinical record for Resident 20 was reviewed on 5/14/24 at 4:08 p.m. The diagnoses included, but were not limited to, multiple sclerosis, edema, chronic obstructive pulmonary disease, anemia, dependence on supplemental oxygen, anxiety, and other seasonal allergic rhinitis. A physician's order, dated 3/8/24, indicated to administer oxygen at 2 liters per minute via nasal cannula (NC) continuously every shift for chronic respiratory failure. A physician's order, dated 3/25/24, indicated to change oxygen tubing and humidifier every 7 days and as needed (prn) every night shift on Monday.		will be corrected immediately and education will be provided. The results of audit observations will be reported, reviewed, and trended for compliance through the facility Quality Assurance Committee for a minimum of six months and then randomly thereafter for further recommendation.	

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	During an interview, on 5/16/24 at 11:10 a.m., LPN 1 indicated the nurses would verify the flow rate with the physician's order and set the oxygen flow according to the order. She indicated the tubing was ordered to be changed every Monday on nightshift. 3. During an observation, on 5/13/24 at 12:30 p.m., Resident 23 was wearing oxygen at a flow rate of 3 liters per minute with unlabeled nasal cannula tubing. During an observation, on 5/14/24 at 10:46 a.m., Resident 23 was wearing oxygen at 2.5 liters per minute with unlabeled nasal cannula tubing. During an observation, on 5/15/24 at 10:50 a.m., the resident was wearing oxygen at 2.5 liters per minute with unlabeled nasal cannula tubing. The clinical record for Resident 23 was reviewed on 5/15/24 at 09:38 a.m. The diagnoses included, but were not limited to, moderate persistent asthma, aneurysm of carotid artery, nonrheumatic aortic valve stenosis, chronic obstructive pulmonary disease, hypothyroidism, and anemia. A physician's order, dated 9/27/23, indicated to administer oxygen at 2 liters per minute via nasal cannula continuously every shift. A physician's order, dated 3/25/24, indicated to change, initial, and date the cannula tubing every night shift on Monday. 4. During an observation, on 5/13/24 at 12:55 p.m., Resident 43 was wearing oxygen at 3 liters per minute with unlabeled nasal cannula tubing. During an observation, on 5/14/24 at 10:15 a.m.,			

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	Resident 43 was wearing oxygen at 3 liters per minute with unlabeled nasal cannula tubing. The clinical record for Resident 43 was reviewed on 5/16/24 at 2:41p.m. The diagnoses included, but were not limited to, chronic obstructive pulmonary disease, type 2 diabetes mellitus with diabetic autonomic polyneuropathy, tobacco use, difficulty in walking, weakness, anxiety disorder, anemia, bipolar disorder, and recurrent major depressive disorder. A physician's order, dated 4/29/24, indicated to administer oxygen at 2 liters per minute via nasal cannula continuously every shift. A physician's order, dated 3/25/24, indicated to change cannula tubing every night shift on Monday. During an interview, on 5/16/24 at 11:10 a.m., LPN 1 indicated the nurses verify the flow rate with the physician's order and set the oxygen flow according to the order. She indicated the tubing was ordered to be changed every Monday on nightshift. A current policy, titled "Continuous Aerosol Therapy," no date and received from the Clinical Support Nurse on 5/16/24 at 2:19 p.m., indicated "...A physician order/provider's order is required for aerosol therapy with or without oxygen...The order should include the mode of administration (mask, collar, face tent) ...The frequency and the duration of the therapy...The percentage of oxygen." A current policy, titled "Supplemental Oxygen using Nasal Cannula," no date and received from the Clinical Support Nurse on 5/15/24 at 11:45 a.m.,			

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	indicated "...The nurse or RT (respiratory therapist) will verify the oxygen order for route an LPM (liters per minute) delivery rate...The nurse of RT will set the delivery rate on the tank or concentrator as ordered by the physician...Nasal cannulas and tubing are changed weekly or when soiled and labeled with date opened...." A current policy, titled "Oxygen-Medical Gas Use," no date and received from the Clinical Support Nurse on 5/15/24 at 11:45 a.m., indicated "...Residents Receiving Oxygen...Will have a physician/provider's order for the oxygen including route of administration, liters per minute and frequency of use...." 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.			

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	§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 ensure assessments were completed and physician's orders and consents were obtained prior to the use of side rails for 2 of 2 residents reviewed for accident hazards. (Resident 117 and 118) Findings include: 1. During an observation, on 5/13/24 at 1:07 p.m., Resident 117 had two upper side rails on her bed which were in the raised position. The clinical record for Resident 117 was reviewed on 5/14/24 at 4:06 p.m. The diagnoses included, but were not limited to, wedge compression fracture of the thoracic (T) spine at T 11 and T 12, generalized muscle weakness, and restless leg syndrome. A progress note, dated 5/3/24 at 1:49 p.m., indicated the resident was at the facility for rehabilitation services due to a spinal fixation at level T 12 due to a fall. The electronic record did not have a side rail assessment or consent. A physician's order, dated 5/15/24, indicated 1/4 side rails to the bed to promote independence with activities of daily living. The physician's order for the side rails was completed after the side rails were utilized. A care plan, dated 5/3/24 and revised on 5/16/24, indicated the resident had an activities of daily	F 0700	**Corrective actions accomplished for those residents found to be affected by the alleged deficit practice:** There were no residents harmed by the alleged deficit practice. Facility immediately completely assessments, obtained consents, and updated orders for residents 117 and 118. **Identification of other residents having the potential to be affected by the same alleged practice and corrective actions taken:** All residents have the potential to be affected. There were no residents harmed by the alleged practice. Facility completed a whole house audit of residents utilizing bed rails and corrected any assessments, obtained consents, and updated orders as necessary. **Measures put in place and systemic changes made to ensure the alleged deficit practice does not recur:** Facility completed education with direct care employees on the safe use of bed rails policy with emphasis on completing bed rail assessment, obtaining consent and physician's orders prior to placing bed rails. The facility room readiness plan has been updated to ensure bed	06/12/2024

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	living self-care performance deficit related to the wedge compression fracture of the T 11 and T 12 vertebra. The interventions included, but were not limited to, 1/4 side rails which was added to the care plan on 5/16/24. During an interview, on 5/16/24 at 10:29 a.m., the Clinical Support Nurse indicated the side rail assessment was not completed until 5/15/24. The side rail informed consent was signed by the resident on 5/8/24 however there was no date by the resident's signature to show when the consent was signed. 2. During an observation, on 5/14/24 at 11:10 a.m., Resident 118 had two upper side rails on his bed with the left side rail in the raised position. The clinical record for Resident 118 was reviewed on 5/15/24 at 12:22 p.m. The diagnoses included, but were not limited to, a fracture of the shaft of the humerus of the right arm, congestive heart failure, and weakness. The electronic record did not include a side rail consent or assessment. A physician's order, dated 5/15/24, indicated 1/4 side rails to the bed to promote independence with activities of daily living. The physician order was obtained after the side rails were on the resident's bed. During an interview, on 5/16/24 at 10:30 p.m., the Clinical Support Nurse indicated the resident did not have a side rail assessment or consent completed until 5/15/24. The consent and assessment should have been completed when the side rails were applied.		rails are not in place prior to assessment being completed. **How the corrective measures will be monitored to ensure the alleged deficit practice does not recur:** The DON/designee will conduct weekly audits of all new admissions per week for 12 weeks, then monthly for 3 months to ensure residents have an active physician's order, a signed consent, and assessments completed as necessary. Any discrepancies will be corrected immediately and education will be provided. The results of audit observations will be reported, reviewed, and trended for compliance through the facility Quality Assurance Committee for a minimum of six months and then randomly thereafter for further recommendation.	

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	A current policy, titled "Safe Use of Bed Rails," not dated and received from the Executive Director on 5/15/24 at 3:30 p.m., indicated "...It is the policy of this facility to provide resident centered care that meets the safety, psychosocial, physical and emotional needs and concerns of the residents. The facility will assess the residents' cognition and therapeutic need of the bed rail to assist the resident in reaching their highest potential of independence. A physician order is required to implement the use of bed rails...Assessment of residents with bed rails include...Review of prior interventions and outcomes prior to the initiation of the bed rails...Consent...Disclosure of the needs, risk and benefits of use...Education provided to the resident or resident representative...Signed by the resident or, if applicable, the resident representative...Monitoring...Documentation...Physician order is required...Completion of Bed Safety Evaluation...Consent obtained for bed rail use...Education provided to the resident...Care Plan for the use/need for bed rails...." 3.1-45(a)(1)			
F 0758 SS=D Bldg. 00	483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic			

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	Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §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 a prn (as needed) psychotropic medication was renewed after 14 days for 1 of 5	F 0758	**Corrective actions accomplished for those residents found to be affected**	06/12/2024

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	residents reviewed for unnecessary medications. (Residents 38) Finding includes: The clinical record for Resident 38 was reviewed on 5/15/24 at 3:45 p.m. The diagnoses included, but were not limited to, fracture of the second cervical vertebra, adjustment disorder with mixed anxiety and depressed mood, vascular dementia, and cognitive communication deficit. A care plan, dated 1/15/24, indicated the resident had a mood problem potential related to anxiety and depressed mood. The interventions included, but were not limited to, monitoring and recording mood to determine if problems seem to be related to external causes, medications, treatments, concern over diagnosis, and change in sleep patterns. A physician's order, dated 5/1/24, indicated to give lorazepam (an anxiety medication) concentrate 2 milligram(mg)/milliliter(ml) 0.5 ml by mouth every 4 hours prn (as needed). A Medication Administration Record (MAR) indicated the resident received the following: a. On 5/14/24 at 3:00 p.m., the resident received a prn lorazepam concentrate 2mg/ml b. On 5/15/24 at 8:00 p.m., the resident received a prn lorazepam concentrate 2mg/ml c. On 5/16/24 at 2:52 p.m., the resident received a prn lorazepam concentrate 2mg/ml During an interview, on 5/16/24 at 11:43 a.m., the Director of Nursing (DON) indicated a prn lorazepam order needed to have a 14 day stop date. The physician would need to reevaluate the resident's need for the antianxiety medication after		**by the alleged deficit practice:** There were no residents harmed by the alleged deficit practice. Facility immediately corrected the physician order to show 14 day stop date. **Identification of other residents having the potential to be affected by the same alleged practice and corrective actions taken:** All residents with a PRN psychotropic medication order have the potential to be affected. There were no residents harmed by the alleged practice. Facility completed whole house audit on PRN psychotropic medication orders to ensure all have a 14 day stop date. **Measures put in place and systemic changes made to ensure the alleged deficit practice does not recur:** Facility completed education with direct care employees and providers on the psychotropic policy with emphasis on stop dates for any prn psychotropic medications. Clinical IDT will review each new psychotropic medication in the daily clinical meeting to ensure stop dates are ordered when medication schedule is prn. **How the corrective measures will be monitored to ensure the alleged deficit practice does not recur:** The DON/designee will	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	14 days. During an interview, on 5/17/24 at 9:07 a.m., the Clinical Support Nurse indicated if the resident had an order for prn lorazepam, the medication would need to have a stop date after 14 days. A current policy, titled "Antipsychotic Second Clinical Review," no date and received by the Clinical Support Nurse on 5/17/24 at 9:28 a.m., indicated "...Antipsychotic Medication Orders will...Require a clinical review by a supervisory level nurse...PRN or "as needed" use of antipsychotic medications is: Not to be used routinely due to increased risk for adverse events...Supported by documentation within the medical record...Limited to 14 days use and may not be continued/renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication...A face-to face assessment of the resident is required by the practitioner ...Telephonic or verbal orders may not be provided...Documentation by the practitioner is required in the progress notes...If on-going a new order for the PRN antipsychotic is required to be written every 14 days with the prescriber assessment and documentation...The physician/provider makes the final determination regarding the use of the medication...." 3.1-48(b)(2)		conduct audits of 5 residents with the use of PRN antipsychotics per week for 4 weeks, then 3 residents with PRN antipsychotic use per week for 4 weeks, and then 1 resident with PRN antipsychotic use per week for 4 months to ensure all PRN orders have a stop date of 14 days. Any discrepancies will be corrected immediately and education will be provided. The results of audit observations will be reported, reviewed, and trended for compliance through the facility Quality Assurance Committee for a minimum of six months and then randomly thereafter for further recommendation.	