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	03/18/2021

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

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00344382, IN00346596 and IN00347809. Complaint IN00344382 - Substantiated. Federal/State deficiencies related to the allegations are cited at F689. Complaint IN00346596 - Unsubstantiated due to lack of evidence. Complaint IN00347809 - Substantiated. No deficiencies related to the allegations were cited. Survey dates: March 16, 17 and 18, 2021 Facility number: 000127 Provider number: 155222 AIM number: 100291430 Census bed type: SNF/NF: 63 Total: 63 Census payor type: Medicare: 4 Medicaid: 48 Other: 11 Total: 63 This deficiency reflects state findings cited in accordance with 410 IAC 16.2-3.1. Quality review was completed on March 25, 2021.	F 0000	**Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during a complaint survey on March 18, 2021. Please accept this plan of correction as the provider's credible allegation of compliance.** **The provider respectfully requests a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.**	
F 0689 SS=D	483.25(d)(1)(2) Free of Accident			

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

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Bldg. 00	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 prevent a resident with a known cognitive impairment and recent wandering behaviors from eloping from the facility for 1 of 3 residents being reviewed for elopement (Resident B). Finding includes: The record for Resident B was reviewed on 3/17/21 at 12:12 p.m. Diagnoses included, but were not limited to, acute respiratory failure with hypoxia, unspecified symptoms and signs involving cognitive functions and awareness, Wernicke's Encephalopathy (brain damage caused by a lack of Vitamin B1 (Thiamine deficiency), which causes brain damage in the lower parts of the brain called the thalamus and the hypothalamus) Korsakoff's psychosis (brain damage caused by a lack of Vitamin B1, which develops as Wernicke Encephalopathy symptoms go away resulting from permanent damage to areas of the brain involved with memory), altered mental status, delirium due to known physiological condition, acidosis and anemia. The progress notes for Resident B indicated the following: On 10/6/2020 at 4:20 p.m., the resident was	F 0689	F 689 – Free of Accident Hazards/Supervision/Devices 1. The residents found to have been affected by the alleged deficient practice was Resident B who has been discharged from the facility.2. All residents in the facility have the potential to be affected by the same alleged deficient practice. The Social Services Director and Clinical Management Team completed elopement risk assessments on all residents and initiated interventions if needed. 3. The Director of Nursing or Designee will conduct all staff education on the following policies: “Elopement Prevention and Management Overview” 4. Director of Nursing or Designee will review the 24/72 hour report daily, Monday-Friday, to determine any resident’s exhibiting symptoms of cognitive decline and/or wandering elopement behavior. Those residents identified will have a new elopement assessment documented and new	04/12/2021

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	admitted to the facility. His level of cognitive impairment was severely impaired and affected all areas of judgement. He did not obey commands. On 10/10/2020 at 1:39 p.m., the resident was disorganized in his thinking. His level of cognitive impairment was severely impaired and affected all areas of his judgement. There were safety concerns related to the resident was not aware of his own limitations and he attempted to stand and walk without assistance. On 10/28/2020 at 7:26 p.m., the resident was readmitted back to the facility after a brief stay in the hospital. He was disoriented and his level of cognitive impairment was severely impaired and affected all areas of judgement. He was comfort care only and Hospice was to evaluate him for admission to Hospice services. His Elopement Evaluation was a score of 0. He had no history of elopement and he had not attempted to leave the facility without informing the staff. He had not verbally expressed the desire to go home, packed his belongings or stayed near an exit door. He did not wander or have a wandering behavior. On 11/3/2020 at 4:45 p.m., the resident's BIMS (Brief Interview Mental Score) was 12 (indicated moderately cognitively impaired). On 11/10/2020 at 2:22 p.m., the SSD (Social Service Director) completed a significant change assessment for Resident B. During a staff interview, the staff indicated he had memory loss and a decline in cognition. On 12/21/2020 at 2:37 p.m., the SSD documented the nursing staff informed her the		interventions updated and added to care plan. This will occur 5 times weekly x4 weeks, twice weekly x4 weeks, and monthly x4 months. The results of the audit observations will be reported, reviewed, and trended for compliance thru the facility Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendations. 5. Date of Compliance: April 12, 2021	

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	resident had been wandering. The resident's family and the facility staff "believe" the resident required a secured unit related to the level of confusion and wandering. The SSD sent a referral to two other secured facilities in town. On 12/29/2020 at 3:20 p.m., a resident notified the ED she thought Resident B was in the parking lot behind the facility. Resident B was found outside the facility by the ED. He left the facility without notifying the staff. He was returned to the facility by the ED without any problems. He was found to be having delusions related to aliens coming after him. He was placed on 1:1 supervision. On 12/29/2020 at 3:55 p.m., an Elopement evaluation was completed, and Resident B's elopement score was 1.0. He had a history of or attempted to leave the facility without informing the staff and he wandered. The staff was notified the resident was an elopement and wandering risk. On 12/29/2020 at 4:53 p.m., the SSD referred Resident B out to psychiatric services due to his elopement and delusions. The resident indicated he left the facility because the Martians were leaving, and he needed to go with the Aliens. The resident then called the SSD an alien and pointed at another resident in the hallway indicating the resident was also an alien. The SSD indicated she was unable to send the resident out for a psychiatric stay. He was denied because he did not have a payor source which would cover a psychiatric stay. There was no documentation to indicate the resident was having delusions prior to this episode.			

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On 12/29/2020 at 5:51 p.m., Resident B was found up and ambulating unsteadily in the hallway. He used his wheelchair for mobility, which was located down the hallway and was unlocked. The SSD assisted the resident to his wheelchair in the hallway.

On 12/29/2020 at 5:56 p.m., the ED spoke with the resident's brother and he gave permission for Resident B to be transferred to another sister facility which had a secured unit. He was transferred due to the risk of elopement.

There was no further documentation found in his record to indicate the SSD followed up on the secured unit referrals, which was sent to the two facilities regarding the resident's wandering prior 12/29/2020 at 3:15 p.m., when he was found to have eloped from the facility.

A document, titled "Kokomo IN. Monthly Weather/AccuWeather," dated 3/17/2021 and provided by ED 4 on 3/18/2021 at 12:45 p.m., indicated on 12/29/2020, the high for the day was 49 F (Fahrenheit) and the low for the night was 30 F.

An investigation packet which included the investigation information regarding Resident B's elopement was provided by the DON on 3/17/21 at 11:30 a.m. The following documents were included in the investigation packet, but were not limited to:

A document, titled "Indiana State Department of Health Survey Report System," dated 3/16/21, indicated Resident B left the facility without notifying the staff and was found in a parking lot next to the facility on 12/29/2020 at 3:20 p.m.

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	He had no injuries and was placed on 1:1 supervision until he could be discharged to an alternate facility with a secured unit later that evening. A signed handwritten statement, dated 12/29/2020, from Hospitality Aide (HA) 5 indicated around 2:30 p.m., she heard the door alarm sounding on the patio/smoker's door. When she went to turn it off, she did not see anyone by the door on the inside or outside of the facility. She did observe one resident outside (Resident D), who denied setting the door alarm off and she did not witness anyone setting it off. HA 5 observed the wooden gate open, which led to the sidewalk. Resident D denied witnessing anyone using the wooden gate, so HA 5 went back into the facility. A signed typed statement, dated 12/29/2020, from ED 6 indicated she was in her office around 3:15 p.m., when Resident D came in and informed her, she thought one of the resident's from the facility was in the driveway behind the facility with an ambulance. She went out behind the facility and was informed by a police officer, who was with the ambulance, they had Resident B in the ambulance and was checking him out. The resident was released back to ED 6 and he was taken back into the facility. Once he was back into the facility, ED 6 asked him why he left the facility without informing staff and he indicated he was trying to get away from the Martians. He was placed on 1 on 1 supervision until a secure placement could be set up. His brother was notified, who agreed with the transfer to a sister facility, transportation was set up and ED 6 followed the Cab and assisted with getting Resident B into the facility.			

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	Staff interviews indicated the last time a staff member observed Resident B, on 12/29/2020, was at 2:30 p.m., at the kitchen door. During an interview, on 3/16/21 at 2:35 p.m., with the Director of Nursing (DON), Administer in Training (AIT) and the Unit Coordinator (UC) in attendance, the DON indicated she was not employed at the facility when Resident B eloped from the facility. The AIT indicated she was not employed at the facility when Resident B eloped from the facility. The UC indicated she was only working weekends at that time, so she was not at the facility when he eloped. She could not say for sure what happened, and she did not start into this position until 2/1/21. The UC indicated the resident was able to propel himself in his wheelchair and he was often confused and disoriented, but as far as she knew he was not an elopement risk prior to him eloping from the facility on 12/29/2020. During an interview, on 3/18/2021 at 12:12 p.m., the SSD indicated she contacted a sister facility to get Resident B a bed in their secured unit after he eloped from their facility on 12/29/2020. ED 6 came to her office and told her Resident B needed to be transferred out of the facility because he left the facility without informing staff first. She indicated on 12/21/2020, she had talked with the nursing staff about Resident B's wandering behavior and she told the resident's brother, a secured unit was needed because he was wandering around aimlessly and there was a chance, even though he was not an elopement risk, he could elope from the facility. The brother did not have guardianship of the resident, so she had talked with him about obtaining guardianship over the resident. He wanted the resident in a facility close to him. She checked			

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	with two facilities here in town, but neither one had a bed available for him. During an interview, on 3/18/2021 at 2:50 p.m., Resident D indicated she could not remember the date or time Resident B eloped from the facility, but she did remember the incident. That day, she went outside to smoke, and the alarm was already sounding. She did not think much about it because the door alarm sounded all the time. When she got outside to smoke, a police car and an ambulance was parked in the driveway between the facility and the apartments. There was a man, who she recognized as "one of us". He was sitting, in a wheelchair, with a mask on talking to the police. She went back into the facility to tell ED 6 she thought there was a resident from the facility out back with the police and ambulance. On 3/18/21 at 2:55 p.m., while interviewing Resident D in a small area on the other side of the main dining room, in front of the patio alarmed door, which was Resident D's choice of areas to be interviewed, an unidentified resident propelled herself to the patio alarmed door and asked Resident D what the code for the patio door was. Resident D yelled over to the unidentified resident the alarm code numbers, then she continued talking. When asked if she knew who the resident was, she answered she did not know her name, but she knew she was a new resident and she was an independent smoker. The unidentified female resident was observed after being given the code to the alarmed door, placing the code into the keypad on the right side of the wall. The unidentified female resident was observed having difficulty pulling her wheelchair over the metal threshold while keeping the heavy			

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	metal door pushed open. During this time, the door alarm began to sound. An unidentified male resident who was already outside smoking, took a hold of her wheelchair armrest and pulled her wheelchair across the threshold. The alarm continued to sound. At 3:01 p.m., another unidentified male resident came up to the sounding alarmed door and put the door alarm code into the keypad. The door alarm stopped sounding. During the interview time frame, there was no staff member observed coming to the door to check the status of the alarm. Resident D then opened the right patio metal door, holding it open and asked the unidentified resident what her name was. The door alarm was sounding, so Resident D placed the code into the keypad to stop the alarm from sounding. As the residents went in and out to smoke, there was no staff member observed to check the status of the patio door alarm when it sounded. During an interview, on 3/18/21 at 3:29 p.m., CNA 8 indicated the staff member responsible for checking the patio alarm when it went off was the receptionist because she was sitting right there, and she could hear it go off. The rest of the staff on the units could not hear it sound. She indicated the alarm did light up on the call light box on the wall. The staff was not able to hear the alarm sounding on the units because they were too far away from the dining room. A current policy, titled "Resident Wander Search Procedure," dated 6/17/2014, with a revised date 4/20/2016 and provided by the DON on 3/17/2021 at 11:30 a.m., indicated "...Definitions: Wander: a symptom of residents with dementia and other memory deficits that			

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	may appear to be aimless walking...Policy: 1. It is the policy of this facility to maintain a safe environment for residents with cognitive disabilities and to provide areas for safe wandering activities. 2. The facility will identify the at-risk resident for unsafe wandering practices and have interventions in place for prevention of harm...4. The facility understands that residents with memory deficits may wander and that... b. Wandering is not unsafe and does not require interventions when in a controlled, supervised environment. c. Some residents may wander into unsafe, unsupervised areas and those residents are the subject of this policy. 5. Residents most 'at risk' for unsafe wandering include but not limited to... c. Is unable to verbally make their wishes known d. Does not recognize familiar faces. 6. Unsafe wandering/those 'at risk' will be identified on the IDT Care plan...." A current policy, titled "Elopement Prevention and Management Overview," dated 7/1/2016 and provided by the DON on 3/17/21 at 11:30 a.m., indicated "...Definition: Elopement is defined as when a resident/patient leaves the premises or a safe area without authorization and/or any necessary supervision and places the resident/patient at harm or injury. Unsafe wandering is defined as when a resident/patient enters an area that is physically hazardous or contains potential safety hazards...Procedure: 1. Identify resident/patients who are at risk for elopement. 2. Determine elopement risk factors which may include, but are not limited to: a. Acute or chronic confusion/disorientation b. Anxiety c. Dementia, or dementia related disease d. History of purposeful wandering and/or elopement e. New admission with adjustment difficulties, or a desire to return to previous			

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	living situation. Restless, irritable 3. Document risk factors. 4. Develop and document individualized interventions to manage risk factors. 5. Discuss interventions and goals with resident/patient and/or family responsible party. 6. Communicate risk factors and interventions to the caregiving staff. 7. Monitor and document resident/patient response to elopement risk reduction interventions. 8. Evaluate effectiveness of interventions during clinical meetings. 9. Modify goals and interventions as indicated and communicate changes to the caregiving team, resident patient and/or family responsible party." A current policy, titled "Elopement Prevention," dated 7/1/2016 and provided by the DON on 3/17/21 at 11:30 a.m., indicated "...Definition: Elopement is defined as when a resident/patient leaves the premises or a safe area without authorization and/or any necessary supervision and places the resident/patient at harm or injury...Procedure: 1. Identify resident/patients who are at risk for elopement...c. Any resident/patient that has a change in condition that places them at risk for elopement...5. Develop the care plan with input for the interdisciplinary team and the resident/patient and family/responsible party. 6. Initiate individualized interventions to address elopement risk factors. Interventions may include, but are not limited to, an Environmental modification to prevent undetected exit such as; door alarms or wander alerts. b. Structured activities scheduled at times of increased elopement risk. c. Increased frequency of resident observation rounds. d. Divisional tasks. e. Redirection of ambulation pattern f. Utilization of safe wandering areas. 7. Communicate individualized interventions to the caregiving staff, resident/patient and/or			

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	family/responsible party. 8. Evaluate and document effectiveness of interventions during the clinical meeting. Modify goals and intervention as indicated. Communicate modifications to the caregiving staff, resident/patient and/or responsible party." This Federal tag related to Complaint IN00344382. 3.1-45(a)(2)			