STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155139	A. Building B. Wing	03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
North Woods Village	2233 W Jefferson St Kokomo, IN 46901

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 49891 Based on interview and record review, the facility failed to ensure a medication for blood pressure was held according to the physician's ordered parameters for 1 of 1 resident reviewed for quality of care. (Resident 100) Findings include: The clinical record for Resident 100 was reviewed on 3/4/25 at 10:41 a.m. The diagnoses included, but were not limited to, paraplegia, neuromuscular dysfunction of the bladder, familial dysautonomia, and chronic systolic congestive heart failure. An Emergency Department After Visit Summary, dated 1/11/25, indicated the resident was seen for a headache and his blood pressure was higher than the normal range during the visit. A physician's order, dated 1/13/25, indicated to give midodrine (a medication used to increase blood pressure) 10 milligrams (mg) three times per day with special instructions to hold the medication if the systolic blood pressure was greater than 120. The Medication Administration Record (MAR), dated January 1 through 31, 2025, indicated a midodrine dose was not held: a. On 1/14/25 at 1:00 p.m., with a systolic blood pressure of 128 and 8:00 p.m., with a systolic blood pressure of 126. b. On 1/16/25 at 1:00 p.m., with a systolic blood pressure of 122. c. On 1/18/25 at 8:00 p.m., with a systolic blood pressure of 136. d. On 1/21/25 at 8:00 p.m., with a systolic blood pressure of 126. e. On 1/31/25 at 1:00 a.m., with a systolic blood pressure of 126. The MAR, dated February 1 through 28, 2025, indicated a midodrine dose was not held: a. On 2/4/25 at 1:00 a.m., with a systolic blood pressure of 126. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. On 2/6/25 at 8:00 p.m., with a systolic blood pressure of 125. c. On 2/8/25 at 1:00 a.m., with a systolic blood pressure of 128 and 1:00 p.m., with a systolic blood pressure of 122. d. On 2/10/25 at 1:00 p.m., with a systolic blood pressure of 127. e. On 2/12/25 at 8:00 p.m., with a systolic blood pressure of 125. f. On 2/14/25 at 8:00 p.m., with a systolic blood pressure of 129. g. On 2/16/25 at 1:00 a.m., with a systolic blood pressure of 122. h. On 2/18/25 at 1:00 a.m., with a systolic blood pressure of 122. i. On 2/19/25 at 1:00 a.m., with a systolic blood pressure of 126 and 1:00 p.m., with a systolic blood pressure of 122. j. On 2/20/25 at 1:00 p.m., with a systolic blood pressure of 132. k. On 2/21/25 at 8:00 p.m., with a systolic blood pressure of 139. l. On 2/22/25 at 1:00 a.m., with a systolic blood pressure of 126 and 1:00 p.m., with a systolic blood pressure of 132. m. On 2/24/25 at 8:00 p.m., with a systolic blood pressure of 124. n. On 2/25/25 at 8:00 p.m., with a systolic blood pressure of 129. o. On 2/26/25 at 8:00 p.m., with a systolic blood pressure of 127. p. On 2/27/25 at 1:00 p.m., with a systolic blood pressure of 126. The MAR, dated March 1 through 6, 2025, indicated a midodrine dose was not held: a. On 3/1/25 at 8:00 p.m., with a systolic blood pressure of 128. b. On 3/3/25 at 1:00 p.m., with a systolic blood pressure of 122 and 8:00 p.m., with a systolic blood pressure of 125. c. On 3/4/25 at 8:00 p.m., with a systolic blood pressure of 127. During an interview, on 3/6/25 at 10:05 a.m., LPN 8 indicated the vital signs, and the medication orders should be reviewed before giving medication. If the systolic blood pressure was above the hold parameter, then the medicine should not be given and charted it was not given. The staff initials would then be in parenthesis on the MAR and there would be a note to indicate why the medication was not given. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A current facility policy, titled General Dose Preparation and Medication Administration, dated 11/15/24 and received from the Executive Director on 3/5/25 at 8:40 a.m., indicated . Prior to administration of medication . if necessary, obtain vital signs 3.1 -37(a)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 49891 Based on observation, interview, and record review, the facility failed to ensure a portable oxygen tank was turned on to administer the correct flow rate for 1 of 1 resident reviewed for respiratory care. (Resident 4) Findings include: During an observation, on 3/2/25 at 10:25 a.m., Resident 4 was in the hallway in her wheelchair at the nurse's medication cart with QMA 2 receiving her medications. The resident had a nasal cannula in her nose with a portable oxygen tank hanging on the back of her wheelchair. The flow rate on the portable tank was set at zero (0) liters/minute. QMA 2 administered medications to Resident 4 and signed the medication administration record (MAR). QMA 2 did not look at the portable oxygen tank to verify the amount of oxygen the resident was receiving. During an observation, on 3/2/25 at 12:15 p.m., the resident wheeled herself past 2 nurses and a certified nursing assistant (CNA) and greeted them as she entered the dining room for lunch. The nasal cannula was in her nose, and the portable oxygen tank on the back of her wheelchair was still set at zero (0) liters/minute. The clinical record for Resident 4 was reviewed on 3/4/25 at 9:59 a.m. The diagnoses included, but were not limited to, chronic obstructive pulmonary disease, chronic respiratory failure with hypoxia, and asthma. A physician's order, dated 10/15/24, indicated to give continuous oxygen at 4 liters per nasal cannula. A Nurse Practitioner (NP) progress note, dated 2/27/25 at 9:51 a.m., indicated to continue administering supplemental oxygen for the resident's respiratory diagnosis. During an interview, on 3/2/25 at 12:26 p.m., LPN 6 indicated Resident 4 needed 4 liters of oxygen per the physician's order, but the portable oxygen tank was turned off. During an interview, on 3/5/25 at 10:46 a.m., LPN 7 indicated the resident did not transfer herself. A CNA would transfer the resident into her wheelchair and the nurse would turn the portable oxygen tank on to the correct liter flow based on the order. During an interview, on 3/6/25 at 10:09 a.m., LPN 8 indicated the nurse was supposed to make sure the portable oxygen tank was set on the correct liter flow. If the resident had gotten herself up, then the nurse would check the oxygen flow rate as they gave the resident her medications. A current facility policy, titled Oxygen Therapy, dated 4/23 and received from the Executive Director on 3/5/25 at 8:40 a.m., indicated .The nurse will coordinate the oxygen therapy services as ordered by the resident's physician 3.1-47(a)(6)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 44598 Based on observation, interview and record review, the facility failed to ensure staff wore gloves when touching a resident's medication for 1 of 9 residents observed for medication administration. (Resident 3) Findings include: During an observation, on 3/2/25 at 10:12 a.m., QMA 2 removed the resident's medication from the medication cart. She placed the card of multivitamin 7.5 milligrams (mg) iron with 400 micrograms (mcg) of folic acid in her right hand. QMA 2 used her right hand and popped the pill from the card into her left bare hand. She took the pill with her fingers and placed the pill into the medication cup. During an interview, on 3/2/25 at 10:14 a.m., QMA 2 indicated she should have used gloves and not touched the pill with her bare hands. The clinical record for Resident 3 was reviewed on 3/2/25 at 10:12 a.m. The diagnoses included, but were not limited to, diabetes mellitus, atrial fibrillation, and anxiety disorder. A physician's order indicated to give a multivitamin 7.5 milligrams (mg) iron and 400 micrograms (mcg) folic acid tablet daily. A current facility policy, titled General Dose Preparation and Medication Administration, dated as revised 1/3/25 and received from the Director of Nursing on 3/2/25 at 12:07 p.m., indicated .Appropriate hand hygiene should be performed before and after direct resident contact. Medications should not come in contact with any surface except for the medication cup 3.1-18(b)