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	03/20/2026

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on interview and record review, the facility failed to ensure a comprehensive person-centered care plan was developed and implemented for 2 of 2 residents reviewed for care plans. (Resident 12 and 13)Findings include: 1. The clinical record for Resident 12 was reviewed on 3/16/26 at 1:40 p.m. The diagnoses included, but were not limited to, post-traumatic stress disorder (PTSD), traumatic brain injury, and diabetes mellitus. The clinical record indicated the diagnosis of post-traumatic stress disorder was added to the resident's diagnoses list on 5/2/25. There was no care plan located in Resident 12's electronic record related to post-traumatic stress disorder. During an interview, on 3/19/26 at 11:18 a.m., RN 5 indicated she was not sure what Resident 12's trauma triggers were related to the diagnosis of PTSD, and she would have to look it up on the computer. During an interview, on 3/20/26 at 10:00 a.m., the DON indicated Resident 12 was admitted with a diagnosis of PTSD, and a care plan was not added until 3/17/26 for her trauma and triggers. She did not have a care plan prior to the survey, and she should have had a care plan which addressed these issues. During an interview, on 3/20/26 at 10:09 a.m., the Medical Record nurse indicated she had never seen Resident 12 experience any triggers. The staff would know how to address Resident 12's triggers by looking at the care plan. The CNA would know what kind of triggers the resident had by looking at the CNA care sheet. The care sheet helped the CNAs better care for the residents. The sheet would tell them all the special care needs and triggers the residents would have. 2. The clinical record for Resident 13 was reviewed on 3/16/26 at 4:00 p.m. The diagnoses included, but were not limited to, vascular dementia, schizophrenia, anxiety, depression, psychotic disorder with delusions due to known physiological condition, and post-traumatic stress disorder (PTSD). The clinical record indicated the diagnosis of post-traumatic stress disorder was added to the resident's diagnoses list on 2/10/20. There was no care plan located in Resident 13's electronic record related to post-traumatic stress disorder. During an interview, on 3/20/26 at 9:00 a.m., RN 4 indicated she was unaware of what Resident 13's (continued on next page)

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PTSD triggers were, but she could look in the chart to find out. She indicated staff had online training, as well as in-services which addressed trauma care. Social service was a resource staff could use as well if they had questions. During an interview, on 3/20/26 at 10:05 a.m., the Director of Nursing (DON) indicated the trauma care plan was not added prior to the survey. The care plan should be added when a resident was admitted with or had a diagnosis of PTSD. A current facility policy, titled Trauma Informed Care, dated as revised 10/22 and received from the Executive Director (ED) on 3/20/26 at 9:59 a.m., indicated .It is the policy of this facility to ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences to eliminate or mitigate triggers that may cause re-traumatization of the resident .Each resident will be screened for a trauma during the Social Services Assessment upon admission to the facility. This screen includes a review of current diagnosis or reported history of PTSD, combat, abuse.behavioral health services will assist the resident and Interdisciplinary Team in developing a plan of care which will be added to the medical record. This plan of care will incorporate individual experiences, customary routines, and cultural preferences of the individual's needs .The plan of care will routinely be evaluated whether the interventions have been able to mitigate (or reduce) the impact of identified triggers on the resident that may cause re-traumatization. If interventions do not appear effective, behavioral health and the IDT will collaborate on revised approaches A current facility policy, titled IDT Comprehensive Care Plan Policy, dated as revised 10/2025 and received from the Executive Director (ED) on 3/20/26 at 9:59 a.m., indicated .It is the policy of this facility that each resident will have an interdisciplinary comprehensive person-centered care plan developed and implemented based on Resident Assessment Instrument (RAI) process. The care plan must include measurable goals and resident specific interventions based on resident needs and preferences to promote the resident's highest level of functioning including medical, nursing, mental, and psychosocial well-being .Create an organized, resident-centered review on a routine basis to improve communication with residents, resident families and/or representative regarding the resident goals, total health status, including functional status, nutritional status, rehabilitation and restorative potential, ability to participate in activities, cognitive status, psychosocial status, sensory and physical impairments, as well as care and services provided to maintain or restore health and well-being, improve functional level or relieve symptoms .Improve relationships between resident, families and/or representative, and facility caregivers through understanding of resident's social history, culture and preferences to enhance the resident's life .Care plan problems, goals, and interventions must be reviewed and revised by the interdisciplinary team periodically and following completion of each OBRA MDS assessment 410 IAC (Indiana Administrative Code) 16.2-3.1-35(a) 410 IAC (Indiana Administrative Code) 16.2-3.1-35(b)(1) 410 IAC (Indiana Administrative Code) 16.2-3.1-35(b)(2)

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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. Based on interview and record review, the facility failed to ensure blood pressures were obtained and documented prior to administering a blood pressure medication with parameter orders and to ensure a physician's order was followed according to the medication parameters for 2 of 6 residents reviewed for quality of care. (Residents 95 and 69)Findings Include: 1. The clinical record for Resident 95 was reviewed on 3/17/26 at 10:43 a.m. The diagnoses included, but were not limited to, end stage renal disease, dependence on renal dialysis, type 2 diabetes mellitus, hypertension, and Parkinson's disease.A care plan, dated 5/29/24, indicated Resident 95 was at risk for ineffective tissue perfusion related to high blood pressure. Interventions included, but were not limited to, administer medications as ordered.A physician's order, dated 2/11/26, indicated to administer 60 milligrams (mg) of nifedipine (a medication used to treat high blood pressure) every morning and to hold the medication if the systolic blood pressure was less than 130.The Medication Administration Record (MAR), dated 2/1/26 through 3/16/26, indicated nifedipine was administered without obtaining a blood pressure reading to determine the systolic blood pressure.During an interview, on 3/17/26 at 2;40 p.m., the Assistant Director of Nursing (ADON) indicated a blood pressure was to be obtained and documented daily prior to the administration of nifedipine. The blood pressure result would determine if the medication would be administered or held. There was no documentation a blood pressure was obtained before the medication had been administered and there should have been.During an interview, on 3/17/26 at 3:54 p.m., the Clinical Support Nurse (CNS) indicated a blood pressure reading should have been obtained and documented prior to the administration of the medication.During an interview, on 3/18/26 at 10:31 a.m., Qualified Medication Aide (QMA) 3 indicated a blood pressure must be obtained prior to administering a blood pressure medication with parameter orders. After the blood pressure was obtained, it would be documented. The blood pressure medication would be administered or held depending on the blood pressure results and the parameter orders.During an interview, on 3/18/26 at 10:37 a.m., LPN 2 indicated a blood pressure must be obtained, prior to administering the blood pressure medication, if there were parameter orders. The blood pressure medication would be administered if the blood pressure results were not out of parameters.2. The clinical record for Resident 69 was reviewed on 3/16/26 at 4:03 p.m. The diagnoses included, but were not limited to, essential (primary) hypertension, vascular dementia, and anxiety disorder.A care plan, dated 9/13/24, indicated the resident was at risk for ineffective tissue perfusion related to hypertension. Interventions included, but were not limited to, administer medications as ordered.A physician's order, dated 11/17/25, indicated to administer propranolol (a blood pressure medication) 20 mg once a day and to hold the medication for a systolic blood pressure less than 120.The Medication Administration Record (MAR), dated 12/1/25 through 12/31/25, indicated propranolol was administered outside of the hold parameters on the following dates: On 12/1/25, with a systolic blood pressure of 118.On 12/8/25, with a systolic blood pressure of 118.On 12/21/25, with a systolic blood pressure of 119.On 12/29/25, with a systolic blood pressure of 115.The MAR, dated 1/1/26 through 1/31/26, indicated propranolol was administered outside of the hold parameters on the following dates: On 1/3/26, with a systolic blood pressure of 117.On 1/26/26, with a systolic blood pressure of 115.On 1/27/26, with a systolic blood pressure of 104.On 1/28/26, with a systolic blood pressure of 118.The MAR, dated 2/1/26 through 2/28/26, indicated propranolol was administered outside of the hold parameters on the following dates: On 2/8/26, with a systolic blood pressure of 112.On 2/23/26, with a systolic blood pressure of 117.During an interview, on 3/18/26 at 3:46 p.m., the MDS (Minimum Data Set) Coordinator indicated medications should not be given outside of the ordered parameters. On the MAR if a medication was held, the nurse's initials would have parenthesis around them and there would be a note below saying it was held.During an interview, on 3/20/26 at 4:03 p.m., the Executive Director indicated medications should not be given outside of the ordered parameters.A current facility skill competency, titled Medication Administration (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(Medication Pass Procedure), dated as revised 4/2025 and received by the Executive Director on 3/18/26 at 9:06 a.m., indicated .Procedure Steps: Standards for all medications.Vital signs obtained, if necessary. 410 IAC (Indiana Administrative Code) 16.2-3.1-37(a)