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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kokomo Healthcare Center	429 W Lincoln Rd Kokomo, IN 46902

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. 36454 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 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. (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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 49891 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. 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. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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., 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., 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)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. 36454 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 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. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 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)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 44598 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 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 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. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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)