

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155222	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/11/2024
NAME OF PROVIDER OR SUPPLIER  Kokomo Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>50956</p> <p>Based on observation, interview and record review, the facility failed to ensure the concrete in the outside patio was free of uneven areas for 3 of 3 residents and 1 of 1 family member who voiced concerns for the environment. (Resident 37, 44, 15 and 262)</p> <p>Finding includes:</p> <p>1. During a resident council interview, on 10/10/24 at 2:08 p.m., Resident 37 indicated the patio area was a safety concern due to uneven concrete. Resident 37 and Resident 44 indicated other residents had tripped over the uneven concrete and Resident 15 tipped his wheelchair backwards and hit his head while trying to go over the uneven concrete.</p> <p>During an observation, on 10/10/24, the outdoor patio area had multiple areas of uneven concrete.</p> <p>2. The clinical record for Resident 15 was reviewed on 10/11/24 at 12:06 p.m. The diagnoses included, but were not limited to, acquired absence of the right and left legs below the knee, nicotine dependence, chronic obstructive pulmonary disease, weakness, and anxiety disorder.</p> <p>A post fall evaluation, dated 8/19/24 at 12:37 a.m., indicated Resident 15 was outside smoking. As the resident was finished and going back inside, he tried to pop a wheelie over the small bump and fell backwards hitting his head on the concrete.</p> <p>An annual Minimum Data Set (MDS) assessment, dated 9/5/24, indicated Resident 15 used a manual wheelchair for mobility and required substantial/maximal assistance (helper did more than half the effort).</p> <p>3. During an interview, on 10/11/24 at 12:06 p.m., Resident 262's daughter indicated her father's legs would sometimes drop off his foot pedals when his wheelchair went over the uneven concrete. The resident's wife indicated other residents had issues getting over the uneven concrete when they were propelling themselves in their wheelchairs.</p> <p>During an interview, on 10/11/24 at 12:12 p.m., a staff member indicated the residents would occasionally have trouble getting over the uneven concrete.</p> <p>(continued on next page)</p>

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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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a facility tour, on 10/11/24 at 2:26 p.m., the Executive Director (ED) indicated the concrete was uneven in the patio area.</p> <p>At exit conference, the facility did not provide an environmental policy and indicated they followed the state regulations.</p> <p>3.1-19(f)(5)</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>46961</p> <p>Based on observation, interview and record review, the facility failed to ensure the physician was notified before medications were given when a resident was suspected of being intoxicated from alcohol intake for 1 of 1 resident reviewed for quality of care. (Resident 53)</p> <p>Findings include:</p> <p>During an observation, on 10/7/24 at 3:01 p.m., a bruise was noted on the right side of Resident 53's face.</p> <p>During an interview, on 10/07/24 at 4:12 p.m., the resident indicated she fell and did not remember falling.</p> <p>The clinical record for Resident 53 was reviewed on 10/08/24 at 2:52 pm. The diagnoses included, but were not limited to, moderate protein calorie malnutrition, anemia, major depressive disorder, opioid abuse, alcohol abuse, and anxiety.</p> <p>A physician's order, dated 9/20/24, indicated to give temazepam (a medication used for insomnia) 30 mg (milligrams) at bedtime.</p> <p>A physician's order, dated 9/20/24, indicated to monitor for sedative and hypnotic side effects. The monitoring included, but were not limited to, sedation, drowsiness, increased falls, dizziness, weakness and hangover effect every shift related to hypnotic medication use.</p> <p>A medication administration record, dated 10/1/24 to 10/31/24, indicated the temazepam was administered at 9:36 p.m., on 10/6/24.</p> <p>A telehealth progress note, dated 10/6/24 at 10:38 p.m., indicated the resident had a fall. She was found on the floor with right cheek and eye edema. The resident appeared to be intoxicated. She was out on a leave of absence and when she returned to the facility, she was showing signs of intoxication. She struck her head when she fell . She refused to participate with neurologic checks.</p> <p>A progress note, dated 10/6/24 at 11:01 p.m., indicated the resident was found on the floor at approximately 10:00 p.m. She was alert and oriented. She had a bruise and edema on the left cheek and eye. The resident was not cooperative and refused neurological checks (tests to evaluate the nervous system). An order was obtained to send the resident to the emergency department for evaluation.</p> <p>An interdisciplinary team follow-up progress note, dated 10/7/24 at 1:15 p.m., indicated the resident had an unwitnessed fall upon her return to the facility from a leave of absence. The resident reported to the staff she fell out of bed. She was found by staff on the floor next to her bed. The root cause of the incident indicated when the resident returned from her leave of absence at approximately 9:30 p.m., the staff reported the resident smelled of alcohol and appeared intoxicated. The resident was uncooperative and was not allowing the staff to perform neurological checks after hitting her head during the fall.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>There was no documentation the physician was notified of the resident's suspected intoxication prior to administering the temazepam.</p> <p>During an interview, on 10/11/24 at 3:00 p.m., Director of Nursing indicated if a resident was intoxicated the medication should have been held.</p> <p>A current publication, titled Mobile PDR, indicated . increased central nervous system (CNS) and respiratory depressant effects may be seen when temazepam is used with alcohol .ethanol ingestion should be avoided during temazepam use .ethanol intoxication may increase the risk of serious CNS or respiratory depressant effects</p> <p>A current policy, titled Medication Administration, not dated and received from the Director of Nursing on 10/11/24 at 3:00 p.m., indicated .a resident centered, individualized approach to medication administration will be used for administering medications as possible .safety and avoiding adverse effects are considered a high priority for medication administration and may preclude some preferences</p> <p>A current policy, titled Resident Substance Abuse in Facility, not dated and received from the Director of Nursing on 10/11/24 at 3:00 p.m., indicated .being under the influence of illicit drugs or alcohol places the resident at risk for overdose, falls, and respiratory depression and places other residents at risk for injury by a resident under the influence of illicit or illegal drugs or alcohol .the facility will safeguard the resident under the influence of illicit or illegal drugs to the extent possible, as well as provide a safe environment for other residents, staff and visitors</p> <p>3.1-37(a)</p>		