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	09/08/2025

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure discontinued controlled substances were disposed of timely, controlled substances were accounted for while waiting to be disposed of, and to ensure an ordered medication was provided in a timely manner for 11 of 11 residents reviewed for pharmacy services. (Resident 61, 50, 6, 9, 32, 56, 7, 1, 20, 29, and 5) Findings include:1. During an observation and interview, on 9/5/25 at 11:59 a.m., the Director of Nursing (DON) indicated the discontinued controlled substances were kept in a locked box in her desk drawer in her office. The spare key to the desk was also in her office in a safe which could be accessed with a keypad. The DON took a key and unlocked the bottom drawer on the right side of the desk. The DON opened the drawer and removed a small teal colored box with a lock on the front. The locked box was opened and inside contained several narcotic cards wrapped with the narcotic reconciliation count sheets. There were seven (7) narcotic medication cards locked in the bottom drawer of the DON's desk in a small lock box. 1. The clinical record for Resident 61 was reviewed on 9/8/25 at 9:55 a.m. A physician's order, dated 7/31/25 and discontinued on 8/29/25, indicated to give oxycodone 10 milligrams (mg) every 4 hours for chronic pain. A record of disposal for controlled substances, dated 9/5/25, indicated 16 pills were destroyed on 9/5/25, 7 days after the medication was discontinued. 2. The clinical record for Resident 50 was reviewed on 9/8/25 at 9:39 a.m. A physician's order, dated 6/26/25 and discontinued on 8/14/25, indicated to give hydrocodone-acetaminophen 10-325 mg every 4 hours for pain. A record of disposal for controlled substances, dated 8/22/25, indicated 13 pills were destroyed on 8/22/25, 8 days after the medication was discontinued. 3. The clinical record for Resident 6 was reviewed on 9/4/25 at 9:13 a.m. A physician's order, dated 6/3/25 and discontinued on 8/13/25, indicated to give hydrocodone-acetaminophen 10-325 mg every 6 hours as needed for pain. A record of disposal for controlled substances, dated 8/22/25, indicated 14 pills were destroyed on 8/22/25, 9 days after the medication was discontinued. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	4. The clinical record for Resident 9 was reviewed on 9/8/25 at 10:05 a.m. A physician's order, dated 4/17/25 and discontinued on 5/1/25, indicated to give hydrocodone-acetaminophen 5-325 mg every 6 hours as needed for hip pain for 14 days. A shift-change controlled substance inventory tracker dated 7/23/25-7/25/25, indicated a card of hydrocodone-acetaminophen was removed for destruction, on 7/23/25, 83 days after the medication was discontinued. The card was reported stolen by the facility, on 8/9/25, by a former employee while being stored in the Director of Nursing's locked desk waiting to be destroyed, 17 days after removal from the medication cart. 5. The clinical record for Resident 32 was reviewed on 9/8/25 at 10:07 a.m. A physician's order, dated 10/10/24, indicated to give tramadol 50 mg as needed for pain. A shift-change controlled substance inventory tracker dated 7/23/25-7/25/25, indicated a card of tramadol was removed for destruction on 7/23/25. The card was reported stolen by the facility, on 8/9/25, by a former employee while being stored in the Director of Nursing's locked desk waiting to be destroyed, 17 days after removal from the medication cart. 6. The clinical record for Resident 56 was reviewed on 9/8/25 at 10:10 a.m. A physician's order, dated 6/30/25 and discontinued on 7/22/25, indicated to give hydrocodone-acetaminophen 5-325 mg four (4) times a day for pain. A shift-change controlled substance inventory tracker dated 7/23/25-7/25/25, indicated a card of tramadol was removed for destruction on 7/24/25. The card was reported stolen by the facility, on 8/9/25, by a former employee while being stored in the Director of Nursing's locked desk waiting to be destroyed, 16 days after removal from the medication cart. 7. The clinical record for Resident 7 was reviewed on 9/4/25 at 11:56 a.m. a. A physician's order, dated 7/11/25 and discontinued 7/16/25, indicated to give Morphine Sulfate Extended Release (ER) 15 milligrams (mg) twice a day for pain. A controlled substance administration record indicated 29 tablets were destroyed in a RX destroyer, on 7/22/25, six (6) days after being discontinued. b. A physician's order, dated 6/24/25 and discontinued 7/2/25, indicated to apply one (1) fentanyl transdermal patch every 3 days for pain. A controlled substance administration record indicated five (5) patches were destroyed in a RX destroyer, on 7/22/25, 20 days after being discontinued. A controlled substance administration record indicated two (2) patches were destroyed in a RX destroyer, on 7/22/25, 20 days after being discontinued. c. A physician's order, dated 6/16/25 and discontinued 6/24/25, indicated to give morphine sulfate concentrate oral solution 100mg/5ml for pain. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A controlled substance administration record indicated 29.75 ml were destroyed in a RX destroyer, on 6/30/25, 6 days after being discontinued. 8. The clinical record for Resident 1 was reviewed on 9/8/25 at 10:20 a.m. A physician's order, dated 5/21/25 and discontinued on 6/20/25, indicated to give hydrocodone-acetaminophen 10-325 mg every 6 hours as needed for pain for 30 days. A shift-change controlled substance inventory tracker dated 7/23/25-7/25/25, indicated one (1) narcotic card was removed from the medication cart, on 7/21/25, one (1) month after the medication was discontinued. A controlled drug destruction sheet, dated 7/22/25, indicated 24 pills were destroyed. 9. The clinical record for Resident 20 was reviewed on 9/8/25 at 10:25 a.m. A physician's order, dated 6/4/25 and discontinued on 7/10/25, indicated to give tramadol 50 mg every 6 hours for pain. A controlled drug destruction sheet, dated 7/22/25, indicated 18 pills were destroyed, 12 days after being discontinued. 10. The clinical record for Resident 29 was reviewed on 9/8/25 at 10:27 a.m. A physician's order, dated 2/27/25 and discontinued on 3/13/25, indicated to give lorazepam 0.5 mg every 12 hours as needed for anxiety for 14 days. A shift-change controlled substance inventory tracker dated 4/10/25-4/13/25, indicated the lorazepam card was removed from the medication cart, on 4/11/25, 29 days after the order was discontinued. A record of disposal for medications, dated 4/18/25, indicated 42 tablets of lorazepam 0.5 mg were destroyed, on 4/18/25, 7 days after removal from the medication cart. The previous record of disposal for medications was dated 4/4/25. 11. The clinical record for Resident 5 was reviewed on 9/4/25 at 9:30 a.m. The diagnoses included, but were not limited to, asthma, aneurysm of the carotid artery, chronic obstructive pulmonary disease (COPD), aortic valve stenosis, osteoporosis, hypothyroidism, anemia, and dependence on supplemental oxygen. A nursing progress note, dated 3/6/25, indicated Resident 5 was admitted to the hospital for COPD exacerbation and pulmonary effusion. A nursing progress note, dated 3/8/25, indicated Resident 5 returned to the facility from the hospital with new orders for prednisone and an antibiotic. A hospital Discharge summary, dated [DATE], indicated to administer prednisone 40 mg daily with breakfast for 3 days, then administer 20 mg daily with breakfast for 4 days, and to begin (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	administering the medication on 3/8/25. A physician's order, dated 3/9/25, indicated to administer prednisone 40 mg in the morning for 3 days for inflammation. Medication administration notes, dated 3/9/25, 3/10/25, and 3/11/25, indicated the prednisone was on order from the pharmacy and was not given. There was no documentation the pharmacy was called for follow-up related to the medication not being delivered. During an interview, on 9/5/25 at 11:52 a.m., the Administrative Support nurse indicated the facility's policy was to remove discontinued controlled substances from the double locked medication carts and keep the narcotics in the Director of Nursing's office until they were destroyed by the DON and another nurse. The procedure of locking the medications in the DON's office was created to limit access of the discontinued medications by the staff nurses. It was to decrease the number of hands which touched the discontinued controlled substances. The facility did not immediately destroy the medications because of limited nurses available to witness the destruction with the DON and because the DON had so many duties which demanded her attention. The DON tried to destroy medications every Friday. The discontinued medications should be removed from the cart and destroyed as quickly as possible once the order was discontinued to prevent potential theft. The controlled substances were not counted while they were stored in the DON's office. Controlled substances should be counted and accounted for daily until destroyed. During an interview, on 9/5/2025 at 11:59 a.m., the DON indicated the discontinued controlled substances were stored in her office until the medication was destroyed. She pulled out the discontinued medications and would wait until the Unit Manager could destroy them with her. She preferred to destroy discontinued controlled substances with the Unit Manager, but any 2 nurses could destroy medication. The facility had decided this process would be the best and fewer people would handle the discontinued medication if it was not stored in the cart. When the medication was removed from the medication cart, the pills were placed with the narcotic count sheet and therefore the medications were not counted after they were removed from the cart. The medication should be counted daily to make sure they were monitored. The medication was placed in the lock box and not touched until she destroyed them. She had the key to the lock box and did not think about continuing to count the medications. The spare key to her desk and the locked drawer were kept in a safe locked with a keypad code in her office. During an interview, on 9/5/25 at 12:33 p.m., LPN 2 indicated when a resident was discharged , depending on their insurance type, the medication would go with the resident if it was an active order. If the medication was not sent home with the resident, the DON and the Unit Manager would come, take the medication out of the cart, and destroy them. If the medication was sent home with the residents, it was added to the discharge summary. During an interview, on 9/5/25 at 2:04 p.m., the Director of Nursing (DON) indicated the prednisone was on order at the pharmacy and was not received. The nurse practitioner reordered the medication on 3/13/25 and it was administered for four (4) days. During an interview, on 9/8/25 at 10:47 a.m., LPN 2 indicated the time of day the medication was ordered, determined when it would arrive from pharmacy. If it was early in the day, it would arrive in (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	the night drop of medications. If it was a specialty medication, it could take longer. She did not know of a process to receive medications STAT (immediately) if they had not been delivered in a timely manner. A current facility policy, titled Medication Administration, undated and received from the DON on 9/4/25 at 3:30 p.m., indicated .Medications that are refused or withheld or not given will be documented .Critical medications that are refused .will be followed up with physician contact .Documentation of medication will be current for medication administration .Documentation of medications will follow accepted standards of nursing practice A current facility policy, titled Physician Orders, undated and received from the DON on 9/4/25 at 3:50 p.m., indicated .Place orders in electronic Medical Record .Contact pharmacy for changes .The nurse that takes the physician order will be responsible for executing the order or provide for the safe hand-off to the next nurse .Notifying attending or other providers as appropriate .Document contacts in the medical record A current facility policy, titled Chain of Custody for Controlled Substances, undated and received from the DON on 9/4/25 at 3:30 p.m., indicated .Two nurses will provide a count of controlled substances before placing in medication cart(s).Nurses will adjust the shift-to-shift count sheet to reflect addition of new medications.In the event a second nurse is unavailable, the nurse will secure the controlled substances in the double-locked drawer.When the second nurse is available or at the following shift change, two nurses will count and validate the delivery.Controlled substances are to be secured using the double lock method when not in the immediate possession of the nurse.Scheduled drugs require an inventory count sheet.Specific pharmacy delivered sheets are to be used, do not recreate.Doses must be accounted for at all times.two nurses will perform the Shift-to Shift Chain of Custody Count.One nurse from the off-going shift will count with the on-coming nurse.The medications will be secured using a double-lock system until a second nurse witness is available to witness the disposal.Controlled substance medication will be wasted in a drug disposal system) such as Drug Buster.The nurse will remove the medication from the cart in the presence of a second nurse.Both nurses will count and sign the disposition of the drug and count sheet for disposal.The destruction log and the drugs will be kept in separate areas to reduce theft of both items. 3.1-25(e)(2) 3.1-25(e)(3) 3.1-25(g)(2)

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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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. Based on observation, interview and record review, the facility failed to ensure discontinued controlled substances were free from theft of a former employee for 3 of 3 residents reviewed for misappropriation of property. (Resident 9, 32 and 56)Findings include: During an observation and interview, on 9/5/25 at 11:59 a.m., the Director of Nursing (DON) indicated the discontinued controlled substances were kept in a locked box in her desk drawer in her office. The spare key to the desk was also in her office in a safe which could be accessed with a keypad. The DON took a key and unlocked the bottom drawer on the right side of the desk. The DON opened the drawer and removed a small teal colored box with a lock on the front. The locked box was opened and inside contained several narcotic cards wrapped with the narcotic reconciliation count sheets. There were seven (7) narcotic medication cards locked in the bottom drawer of the DON's desk in a small lock box.A facility reported incident, dated 8/9/25 at 1:37 a.m., indicated the DON received a call from a staff member to inform her the former unit manager had entered the building and locked herself in the DON's office. Another staff member reported hearing the former unit manager going through drawers and papers from outside the door. When a staff member knocked on the door and encouraged the former unit manager to exit the office, she refused. The DON arrived at the building at 1:50 a.m., and the former unit manager had already left. Upon searching the office, the DON discovered three discontinued controlled substance prescriptions pending destruction missing from the double locked medication storage in the office.A facility witness statement, dated 8/9/25, indicated CNA 5 went into the hallway and heard rambling from the drawers outside the DON's office. They called the former unit manager, and she answered her phone and told them she was in her old office getting papers. CNA 5 witnessed the former unit manager in the mirror when she left the office.A facility witness statement, dated 8/9/25, indicated CNA 6 was taking a break around 1:05 a.m. She was outside for 1 to 2 minutes when a white car pulled into the parking lot. She called the staff inside to let them know someone entered the building. They called the former unit manager to see if it was her inside the DON's office. The former unit manager came out of the DON's office 30-40 minutes later.A facility witness statement, dated 8/9/25, indicated CNA 8 received a call from CNA 6. CNA 8 walked down the hall with another CNA, and they called the former unit manager's phone. The former unit manager told her she was in the DON's office and would not leave the office until everyone was out of the hallway. The former unit manager exited the DON's office and was witnessed in the mirror in the hallway.A facility witness statement, dated 8/9/25, indicated CNA 7 heard the door alarm sound and then instantly turn off. Shortly after, two co-workers came to ask her if she saw anyone come in the building. She heard a noise coming from the DON's office and witnessed the former unit manager in the mirror when she exited the building. A shift-change controlled substance inventory tracker indicated the following controlled substance cards and count sheets were missing from the DON's locked box after the incident:a. The clinical record for Resident 9 was reviewed on 9/8/25 at 10:05 a.m.A physician's order, dated 4/17/25 and discontinued on 5/1/25, indicated to give hydrocodone-acetaminophen 5-325 mg every 6 hours as needed for hip pain for 14 days. A shift-change controlled substance inventory tracker dated 7/23/25-7/25/25, indicated a card of hydrocodone-acetaminophen was removed for destruction on 7/23/25, 83 days after the medication was discontinued. The card was reported stolen by the facility on 8/9/25 by a former employee while being stored in the Director of Nursing's locked desk waiting to be destroyed, 17 days after removal from the medication cart.b. The clinical record for Resident 32 was reviewed on 9/8/25 at 10:07 a.m.A physician's order, dated 10/10/24, indicated to give tramadol 50 mg as needed for pain.A shift-change controlled substance inventory tracker dated 7/23/25-7/25/25, indicated a card of tramadol was removed for destruction on 7/23/25. The card was reported stolen by the facility on 8/9/25 by a former employee while being stored in the Director of Nursing's locked desk waiting to be destroyed, 17 days after removal from the medication cart.c. The clinical record for Resident 56 was reviewed on 9/8/25 at 10:10 a.m.A (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	physician's order, dated 6/30/25 and discontinued on 7/22/25, indicated to give hydrocodone-acetaminophen 5-325 mg four (4) times a day for pain.A shift-change controlled substance inventory tracker dated 7/23/25-7/25/25, indicated a card of tramadol was removed for destruction on 7/24/25. The card was reported stolen by the facility on 8/9/25 by a former employee while being stored in the Director of Nursing's locked desk waiting to be destroyed, 16 days after removal from the medication cart.During an interview, on 9/4/25 at 11:03 a.m., the Administrative Support indicated the former unit manager took the narcotics out of the DON's drawer. The facility was not aware how the former unit manager entered the office. The former unit manager was let go in May and the pills were taken in August. The former unit manager was believed to have entered the back door and gone directly to the office.During an interview, on 9/4/25 at 2:44 p.m., the DON indicated she received a phone call at 1:30 a.m. and was told staff saw a suspicious person in the building. One of the staff said it was the former unit manager, and they would find out what was going on. The staff saw the former unit manager enter the DON's office, and noticed the door was locked. They heard what sounded like papers rustling and the staff told the former employee to come out of the office. The former unit manager told the staff she would not come out of the office until they left the hallway. The DON arrived shortly after the former employee exited the building. The police were called, a report was filed, and a warrant was placed for her arrest. The former unit manager shared an office with the DON and knew how to get into the safe hanging on the bathroom wall. There were multiple missing narcotics from the locked box which were for Resident 9, 32 and 56. During an interview, on 9/8/35 at 3:39 a.m., CNA 7 indicated a staff member saw someone come into the building using the door by the time clock. CNA 7 and another staff member jumped up and started to search all their residents' rooms. As they were walking around, they heard movement coming from their DON's office. The noise sounded like someone was moving papers around. CNA 6 called the former unit manager, and she told them she was in her old office getting papers. The former unit manager told CNA 6 she would not leave the office until everyone left the hall. They stood further down the hall and could see the former unit manager leaving the building in the mirror hanging up on the wall.During an interview, on 9/8/25 at 3:45 a.m., CNA 5 indicated CNA 6 was going out on break and saw an unknown car in the parking lot. CNA 6 saw someone enter the building and went to tell staff. They started to check on the residents and heard a sound coming from the DON's office. The noise sounded like someone moving papers. CNA 6 called the former unit manager and was told she would not leave the office until everyone was out of the hall. Staff were down the hall when the former unit manager exited the office and could see the former employee in the mirror hanging on the wall. During an interview, on 9/5/2025 at 11:59 a.m., the DON indicated the discontinued controlled substances were stored in her office until the medication was destroyed. She pulled out the discontinued medications and would wait until the Unit Manager could destroy them with her. She preferred to destroy discontinued controlled substances with the Unit Manager, but any 2 nurses could destroy medication. The facility had decided this process would be the best and fewer people would handle the discontinued medication if it was not stored in the cart. When the medication was removed from the medication cart, the pills were placed with the narcotic count sheet and therefore the medications were not counted after they were removed from the cart. The medication should be counted daily to make sure they were monitored. The medication was placed in the lock box and not touched until she destroyed them. She had the key to the lock box and did not think about continuing to count the medications. The spare key to her desk and the locked drawer were kept in a safe locked with a keypad code in her office.During an interview, on 9/5/25 at 11:52 a.m., the Administrative Support nurse indicated the facility's policy was to remove discontinued controlled substances from the double locked medication carts and keep the narcotics in the Director of Nursing's office until they were destroyed by the DON and another nurse. The procedure of locking the medications in the DON's office was created to limit access of the discontinued medications by the staff nurses. It was to decrease the number of hands which touched the discontinued controlled substances. The facility did (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	not immediately destroy the medications because of limited nurses available to witness the destruction with the DON and because the DON had so many duties which demanded her attention. The DON tried to destroy medications every Friday. The discontinued medications should be removed from the cart and destroyed as quickly as possible once the order was discontinued to prevent potential theft. The controlled substances were not counted while they were stored in the DON's office. Controlled substances should be counted and accounted for daily until destroyed.During an interview, on 9/5/25 at 12:33 p.m., LPN 2 indicated when a resident was discharged , depending on their insurance type, the medication would go with the resident if it was an active order. If the medication was not sent home with the resident, the DON and the Unit Manager would come, take the medication out of the cart, and destroy them. If the medication was sent home with the residents, it was added to the discharge summary. A current facility policy, titled INDIANA Abuse & Neglect & Misappropriation of Property, undated and received from the ED at entrance on 9/2/25, indicated .Misappropriation of resident funds or property: In Indiana, the deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident's property or money without the resident's consent. Resident's property includes all residents' possessions, regardless of their apparent value since it may hold intrinsic value to the resident. This includes any medication dispensed in the name of a resident. This does not include medications from an EDK that have not been charged to the resident.It is the intent of this facility to prevent the abuse, mistreatment, or neglect of residents or the misappropriation of their property A current facility policy, titled Chain of Custody for Controlled Substances, undated and received from the DON on 9/4/25 at 3:30 p.m., indicated .Controlled substances are to be secured using the double lock method when not in the immediate possession of the nurse.Scheduled drugs require an inventory count sheet.Specific pharmacy delivered sheets are to be used, do not recreate.Doses must be accounted for at all times.two nurses will perform the Shift-to Shift Chain of Custody Count.One nurse from the off-going shift will count with the on-coming nurse.The medications will be secured using a double-lock system until a second nurse witness is available to witness the disposal.Controlled substance medication will be wasted in a drug disposal system such as Drug Buster.The nurse will remove the medication from the cart in the presence of a second nurse.Both nurses will count and sign the disposition of the drug and count sheet for disposal.The destruction log and the drugs will be kept in separate areas to reduce theft of both items.3.1-28(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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on interview and record review, the facility failed to ensure the ombudsman was notified of a resident's hospitalization and to document a bed hold policy was provided to the resident or resident's representative for 3 of 4 residents reviewed for transfer and discharge. (Resident 1, 20, and 65)Findings include:1. The clinical record for Resident 1 was reviewed on 9/4/25 at 9:00 a.m. The diagnoses included, but were not limited to, hypertensive heart disease with heart failure, stage 4 chronic kidney disease, and a history of a stroke. A nursing progress note, dated 6/3/25, indicated Resident 1 was found face down in front of her wheelchair. A physician's order was received to send her out to the emergency room. The June ombudsman notification log was reviewed, and Resident 1 was not listed on the June notification log. During an interview, on 9/5/25 at 11:00 a.m., the Social Services Director (SSD) indicated it was her responsibility to notify the ombudsman. She sent the notification on the first of the month for the prior month. If the residents' name was not listed, then the ombudsman was not notified. 2. The clinical record for Resident 20 was reviewed on 9/4/25 at 9:46 a.m. The diagnoses included, but were not limited to, hypertension, heart failure, and type 2 diabetes. A nursing progress note, dated 7/24/25, indicated a large amount of blood was found under Resident 20's leg in bed. The physician was called, and the resident was sent out to the hospital. There was no documentation in the electronic health record of a bed hold policy being provided to the resident or resident's representative at the time of transfer. A bed hold authorization form was provided for Resident 20 for the 7/24/25 hospitalization. The signature for the resident or resident's representative was blank, and nothing was marked related to the decision to hold or not hold the bed. During an interview, on 9/5/25 at 12:13 p.m., Licensed Practical Nurse (LPN) 2 indicated the bed hold information should be charted in the progress notes or could be scanned into the electronic health record. During an interview, on 9/5/25 at 1:50 p.m., the Director of Nursing (DON) indicated she did not send out the bed hold information when residents were transferred. The nurses on the floor might send it with the residents. 3. The clinical record for Resident 65 was reviewed on 9/8/25 at 9:30 a.m. The diagnoses included, but were not limited to, malnutrition, weakness, anxiety, chronic obstructive pulmonary disease, anemia, hypothyroid, tongue cancer, depression, dysphagia, psychoactive substance abuse, and gastrostomy status. A nursing progress note, dated 8/22/25, indicated the resident was sent to the emergency room for a decreased level of consciousness and low oxygen levels. (continued on next page)

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	09/08/2025

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A nursing progress note, dated 8/22/25, indicated the resident was admitted to the hospital for aspiration pneumonia. An acute transfer letter form was provided for Resident 65 for the 8/22/25 hospitalization. The signature for the resident was blank and there was a written statement which said the resident was unable to sign due to decreased responsiveness. There was no documentation in the electronic health record of a bed hold policy being provided to the resident or resident representative at the time of transfer or thereafter. A current facility policy, titled Transfer and Discharge, undated and received from the administrative support on 9/5/25 at 11:30 a.m., indicated .Emergency transfers/discharges .provide a notice of the residents bed hold policy to the resident and representative at the time of transfer, as possible, but not later than 24 hours of the transfer. Provide notice as soon as practicable to the residents and representatives. Social services director, or designee, shall provide notice of transfer to a representative of the state long-term care ombudsman via monthly list 3.1-12(a)(6)(A)(i) 3.1-12(a)(6)(A)(ii) 3.1-12(a)(6)(A)(iii) 3.1-12(a)(6)(A)(iv)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 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 the physician was notified of a resident's blood glucose readings according to the physician's order for 1 of 2 residents reviewed for quality of care. (Resident 31)Findings include: The clinical record for Resident 31 was reviewed on 9/4/25 at 9:39 a.m. The diagnoses included, but were not limited to, diabetes mellitus, hypertension, major depressive disorder, visual loss in both eyes, anxiety disorder, and chronic kidney disease.A care plan, dated 1/3/25, indicated Resident 31 had a diagnosis of diabetes mellitus. Interventions included, but were not limited to, obtain blood sugars according to the physician's order and report abnormal findings to the physician, resident, and the resident's representative. A physician's order, dated 1/6/25, indicated to check Resident 31's blood glucose twice a day and to notify the physician if the blood glucose reading was less than 70 or greater than 150. The Medication Administration Record (MAR), dated 7/1/25 through 7/31/25, indicated the following:a. On 7/2/25 at 9:00 a.m., the blood glucose reading was 168 and the physician was not notified.b. On 7/2/25 at 9:00 p.m., the blood glucose reading was 159 and the physician was not notified.c. On 7/3/25 at 9:00 a.m., the blood glucose reading was 160 and the physician was not notified.d. On 7/4/25 at 9:00 a.m., the blood glucose reading was 168 and the physician was not notified.e. On 7/10/25 at 9:00 p.m., the blood glucose reading was 162 and the physician was not notified.f. On 7/14/25 at 9:00 p.m., the blood glucose reading was 177 and the physician was not notified.g. On 7/30/25 at 9:00 a.m., the blood glucose reading was 158 and the physician was not notified. The MAR, dated 8/1/25 through 8/31/25, indicated the following:a. On 8/1/25 at 9:00 a.m., the blood glucose reading was 153 and the physician was not notified.b. On 8/2/25 at 9:00 p.m., the blood glucose reading was 185 and the physician was not notified.c. On 8/22/25 at 9:00 a.m., the blood glucose reading was 151 and the physician was not notified.d. On 8/25/25 at 9:00 a.m., the blood glucose reading was 158 and the physician was not notified.e. On 8/27/25 at 9:00 a.m., the blood glucose reading was 151 and the physician was not notified.f. On 8/29/25 at 9:00 a.m., the blood glucose reading was 153 and the physician was not notified.During an interview, on 9/4/25 at 2:48 p.m., the Support Administrator indicated there was no documentation the physician was notified of the blood glucose readings above 150. A current facility policy, titled Physicians Orders, undated and received from the DON on 9/4/25 at 3:50 p.m., indicated .to accurately document physician and provider orders as determined by the license's Scope of Practice.The nurse that takes the physician order will be responsible for executing the order or provide for the safe hand-off to the next nurse.The MAR/TAR should automatically be updated with the new orders if schedule has been assisted.Notify attending or other providers as appropriate.Document contacts in the medical record.3.1-37(a)