Printed: 05/28/2025
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155678	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waterford Place Health Campus	800 St Joseph Dr 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 the physician's orders for a medication hold parameter was followed, hospice was notified of low blood glucose readings, and staff obtained a blood glucose reading as ordered for 3 of 3 residents reviewed for quality of care. (Resident 30, 54 and 24) Findings include: 1. The clinical record for Resident 30 was reviewed on 2/10/25 at 2:38 p.m. The diagnoses included, but were not limited to, atrial fibrillation, hypertensive heart and chronic kidney disease with heart failure, type 2 diabetes mellitus with diabetic chronic kidney disease and neuropathy, and nonrheumatic aortic valve stenosis. a. A physician's order, dated 1/4/25, indicated to give metoprolol tartrate (a medication used to treat high blood pressure) 25 milligrams (mg) twice a day with special instructions to hold the medication for a systolic blood pressure less than 100. A Medication Administration Record (MAR), dated 1/1/25 through 1/30/25, indicated metoprolol tartrate 25 mg was given with a recorded systolic blood pressure of less than 100 on the following dates: On 1/13/25, with a systolic blood pressure of 84. On 1/16/25, with a systolic blood pressure of 88. On 1/18/25, with a systolic blood pressure of 96. On 1/19/25, with a systolic blood pressure of 97. On 1/20/25, with a systolic blood pressure of 93. On 1/24/25, with a systolic blood pressure of 89. On 1/30/25, with a systolic blood pressure of 99. During an interview, on 2/12/25 at 10:30 a.m., LPN 5 indicated vital signs should be checked and hold parameters should be followed. (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. A physician's order, dated 1/31/25, indicated to call hospice if the resident's blood glucose reading was greater than 250. A MAR, dated 1/31/25 through 2/11/25, indicated Resident 30 had the following blood glucose readings greater than 250: On 2/1/25, the resident's blood glucose reading was 256. On 2/5/25, the resident's blood glucose reading was 273. On 2/9/25, the resident's blood glucose reading was 307. There was no documentation hospice was notified of the resident's blood glucose readings greater than 250 in the medical record. During an interview, on 2/13/25 at 10:11 a.m., the Clinical Support Nurse indicated the facility did not have any documentation of hospice being notified of the elevated blood sugars and the nurse should have called the hospice provider per the order. 50956 2. The clinical record for Resident 54 was reviewed on 2/12/25 at 2:26 p.m. The diagnoses included, but were not limited to, dementia, psychotic disturbance, mood disturbance, and anxiety. A care plan, dated 11/29/23, indicated the resident had the potential for cardiovascular distress related to a diagnosis of hypertension. Interventions included, but were not limited to, administer medications as ordered and obtain vital signs as ordered. A physician's order, dated 10/24/24, indicated to give metoprolol tartrate (a medication used to treat high blood pressure) 12.5 milligrams (mg) twice a day with special instructions to hold the medication for a systolic blood pressure less than 110. A Medication Administration Record (MAR), dated 11/1/24 through 11/30/24, indicated metoprolol tartrate 12.5 mg was given with a recorded systolic blood pressure of less than 110 on the following dates: On 11/1/24, the morning dose was given with a systolic blood pressure of 105. On 11/1/24, the evening dose was given with a systolic blood pressure of 107. On 11/6/24, the morning dose was given with a systolic blood pressure of 100. On 11/12/24, the morning dose was given with a systolic blood pressure of 107. On 11/14/24, the morning dose was given with a systolic blood pressure of 104. On 11/17/24, the morning dose was given with a systolic blood pressure of 103. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/17/24, the evening dose was given with a systolic blood pressure of 108. On 11/18/24, the morning dose was given with a systolic blood pressure of 109. On 11/19/24, the morning dose was given with a systolic blood pressure of 100. On 11/22/24, the morning dose was given with a systolic blood pressure of 100. During an interview, on 2/12/25 at 10:30 a.m., LPN 5 indicated vital signs should be checked and hold parameters should be followed. 44598 3. The clinical record for Resident 24 was reviewed on 2/12/25 at 9:42 a.m. The diagnoses included, but were not limited to, diabetes mellitus, hypertension, and depression. A care plan, dated 4/22/21, indicated the resident was at risk for hypoglycemia and hyperglycemia related to diabetes mellitus. Interventions included, but were not limited to, monitor blood sugar, give medications as ordered, and observe the resident for signs of hypoglycemia or hyperglycemia. A physician's order, dated 5/8/22, indicated to check the resident's blood glucose reading at 4:00 a.m. to prevent hypoglycemia (low blood sugar). There was no documentation in Resident 24's Electric Health Record the 4:00 a.m. blood glucose readings were obtained, or the physician was notified the order was not completed. During an interview, on 2/14/25 at 12:00 p.m., the Clinical Support Nurse indicated the nurse entered the physician's order wrong and the 4 a.m. blood glucose reading was never obtained and recorded as ordered. During an interview, on 2/17/25 at 11:43 a.m., LPN 8 indicated when a physician gave a verbal order she would repeat the order back to the physician, go straight to the computer, and enter the order into the computer. The management team verified the new orders and made sure they were entered into the computer correctly. During an interview, on 2/17/25 at 12:25 p.m., RN 9 indicated verbal orders needed to be entered into the computer and the pharmacy made aware of the new orders. The management team reviewed the orders to ensure they were checked twice. During an interview, on 2/17/25 at 12:35 p.m., the Director of Nursing indicated he did not look at the residents' orders on the Medication Administration Record (MAR). The only reason he would check the orders was if the residents' blood glucose readings were triggered high or low. The facility did not have a policy for blood glucose monitoring. (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 Guidelines for Medication Orders, dated as reviewed 12/17/24 and received by the Clinical Executive Director Support on 2/12/25 at 9:15 a.m., indicated .A current list of orders will be maintained in the electronic clinical record of each resident .Standing orders .The admitting nurse shall review the standing order list with the physician when verifying admission orders .The physician shall inform the admitting nurse if any of the standing orders should be eliminated, modified and/or other standing orders added for the specific resident .Standing orders shall be in the medical record with the other physicians orders 3.1-37(a)

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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. 44598 Based on observation, interview and record review, the facility failed to ensure oxygen was administered at the physician's ordered level and to obtain an order to administer oxygen for 4 of 4 residents reviewed for oxygen. (Resident 118, 51, 9 and 58) Findings include: 1. During an observation, on 2/10/25 at 12:49 p.m., Resident 118 was sitting on her recliner wearing oxygen. The oxygen concentrator was set on 0.5 liters via nasal cannula. During an observation, on 2/11/25 at 3:30 p.m., the resident was sitting on her recliner wearing oxygen. Her oxygen concentrator was set on 1 liter via nasal cannula. During an observation, on 2/14/25 at 10:20 a.m., the resident was lying in bed eating her breakfast. The resident's oxygen concentrator was set on 3 liters via nasal cannula. During an interview, on 2/14/25 at 10:25 a.m., LPN 5 indicated Resident 118's concentrator was set on 3 liters, and she was not sure of the resident's oxygen order. The clinical record for Resident 118 was reviewed on 2/12/25 at 10:01 a.m. The diagnoses included, but were not limited to, chronic obstruction pulmonary disorder (COPD), congestive heart failure (CHF), hypertension, depression, dementia, and anxiety disorder. A physician's order, dated 2/7/25, indicated to administer oxygen at 2 liters when needed. A care plan, dated 2/10/25, indicated the resident had the potential for shortness of breath while lying flat. The interventions included, but were not limited to, administer oxygen per physician's order and elevate head of bed or place in upright position when needed. A care plan, dated 2/10/25, indicated the resident had the potential for complications, functional and cognitive status decline related to respiratory failure. The interventions included, but were not limited to, administer oxygen per physician's order and to monitor lung sounds. During an interview, on 2/13/25 at 9:50 a.m., LPN 7 indicated that when a resident wore oxygen, she would check the Medication Administration Record (MAR) and verify the liter flow the resident was ordered. When a resident was wearing oxygen without an order, she would call the physician a get the order. During an interview, on 2/14/25 at 10:36 a.m., LPN 7 indicated the resident's oxygen should be set on 2 liters. 50956 2. During an observation, on 2/10/25 at 10:43 a.m., Resident 51 was sitting in a Broda chair wearing oxygen. His oxygen concentrator was set on 3 liters per nasal cannula. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The clinical record for Resident 51 was reviewed on 2/13/25 at 10:48 a.m. Diagnoses included, but were not limited to, acute respiratory failure with hypoxia, interstitial pulmonary disease, sick sinus syndrome, atrial fibrillation, and chronic systolic congestive heart failure. A physician's order, dated 1/9/25, indicated the resident was to receive oxygen at 2 liters continuously. A care plan, dated 1/23/25, indicated the resident had the potential for complications related to congestive heart failure. The interventions included, but were not limited to, administer oxygen according to the physician's order. A care plan, dated 1/23/25, indicated the resident had the potential for cardiovascular distress. Interventions included, but were not limited to, administer oxygen according to the physician's order. On the following dates, the resident was documented on the vitals report to have been on oxygen at 3 liters per nasal cannula: On 2/3/25 at 4:32 p.m. On 2/4/25 at 7:23 p.m. On 2/5/25 at 3:59 p.m. On 2/6/25 at 7:30 p.m. On 2/7/25 at 3:41 p.m. On 2/8/25 at 8:19 a.m. On 2/8/25 at 4:23 p.m. On 2/11/25 at 3:36 p.m. On 2/12/25 at 3:11 p.m. On 2/8/25 at 8:19 a.m., the resident was documented to be on oxygen at 1.5 liters. 3. During an observation, on 2/10/25 at 11:04 a.m., Resident 9 was lying in bed wearing oxygen. His oxygen concentrator was set on 4 liters per nasal cannula. During an observation, on 2/11/25 at 4:29 p.m., the resident was sitting up in his bed wearing oxygen. His oxygen concentrator was set on 3.5 liters per nasal cannula. The clinical record for Resident 9 was reviewed on 2/11/25 at 1:32 p.m. The diagnoses included, but were not limited to, chronic obstructive pulmonary disease with acute exacerbation, chronic respiratory failure with hypoxia, chronic respiratory failure with hypercapnia, systolic (congestive) heart failure (CHF), atrial flutter, emphysema, nicotine dependence- cigarettes, and pulmonary fibrosis. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A care plan, dated 1/6/25, indicated the resident had the potential for cardiovascular distress. Interventions included, but were not limited to, administer oxygen per the physician's order. A care plan, dated 1/6/25, indicated the resident had the potential for complications, functional and cognitive status decline related to respiratory disease. Interventions included, but were not limited to, administer oxygen per the physician's order. There was no physician's order for Resident 9 to receive oxygen until after the survey start date. On the following dates, the resident was documented on the vitals report to have been on the following oxygen liters: On 1/27/25 at 4:58 p.m., the resident was on 4 liters of oxygen. On 1/28/25 at 9:09 a.m., the resident was on 4 liters of oxygen. On 1/28/25 at 09:05 p.m., the resident was on 6 liters of oxygen. On 1/29/25 at 4:07 p.m., the resident was on 4 liters of oxygen. On 1/30/25 at 10:41 a.m., the resident was on 7 liters of oxygen. On 1/30/25 at 4:47 p.m., the resident was on 4 liters of oxygen. On 1/31/25 at 4:54 p.m., the resident was on 4 liters of oxygen. On 2/2/25 at 8:09 p.m., the resident was on 4 liters of oxygen. On 2/3/25 at 3:37 p.m., the resident was on 4 liters of oxygen. On 2/4/25 at 3:06 p.m., the resident was on 4 liters of oxygen. On 2/5/25 at 3:57 p.m., the resident was on 4 liters of oxygen. On 2/6/25 at 7:40 p.m., the resident was on 4 liters of oxygen. On 2/7/25 at 8:48 a.m., the resident was on 2 liters of oxygen. On 2/9/25 at 09:01 p.m., the resident was on 4 liters of oxygen. On 2/10/25 at 8:46 p.m., the resident was on 4 liters of oxygen. On 2/11/25 at 3:35 p.m., the resident was on 4 liters of oxygen. 49891 4. During an observation, on 2/10/25 at 11:07 a.m., Resident 58 was sitting in his room wearing 3.5 liters of oxygen via a nasal cannula. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation, on 2/11/25 at 11:02 a.m., the resident was sitting in his room wearing 3.5 liters of oxygen. The clinical record for Resident 58 was reviewed on 2/12/25 at 9:57 a.m. The diagnoses included, but were not limited to, Parkinson's disease, pneumonia, acute respiratory failure with hypoxia (low oxygen), and heart failure. There was no physician's order for Resident 58 to receive oxygen until after the survey start date. During an interview, on 2/12/25 at 10:54 a.m., LPN 8 indicated the resident now had a physician's order for 2 liters of oxygen. She would check the physician's order to verify how much oxygen to give a resident when she was adjusting the flow rate. The resident should have had an order for the oxygen administration. A current facility policy, titled Administration of Oxygen, dated 12/13/24 and provided by the Clinical Support Nurse on 2/11/25 at 4:54 p.m., indicated .Verify physician's order for the procedure .Adjust the oxygen delivery device so that .the proper flow of oxygen is administered A current facility policy, titled Guidelines for Medication Orders, dated as reviewed 12/17/24 and received by the Clinical Executive Director Support on 2/12/25 at 9:15 a.m., indicated .A current list of orders will be maintained in the electronic clinical record of each resident .Oxygen orders When recording oxygen orders specify .The rate of flow, route and rationale (i.e: 02, 2L/min per nasal cannula PRN for SOB) 3.1-47(a)(6)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44598 Based on observation, interview and record review, the facility failed to ensure resident rooms and hallways were maintained and kept in clean and sanitary condition for 3 of 8 rooms (room [ROOM NUMBER], 106 and 107) and 3 of 3 hallways (hallway 100, 200 and 300) reviewed for environment. Findings include: During room observations, starting on 2/10/25 at 11:18 a.m., the following were observed: a. The 100-hallway had a very strong urine and bowel movement odor. b. room [ROOM NUMBER] had a large uneven area with peeling paint and cracks on the wall next to the bathroom. c. room [ROOM NUMBER] had an unsecured outlet on the wall at the foot of the resident's bed. The outlet was pulled away from the wall with black cords plugged into the outlet. The room had a very strong urine and bowel movement odor. d. room [ROOM NUMBER] had a large basketball-size dried blood smear on the wall by the first bed near the door. The resident's sheets had dried blood on both sides of the resident. The bed by the window had two little black bugs flying around the resident and in the bathroom, there was one little black bug sitting on the toilet paper mounted on the wall. The room had a very strong urine and bowel movement odor. e. The 200-hallway had multiple mechanical lifts lined down the hall and resident wheelchairs were stored in the hallway. During an observation, on 2/12/25 at 11:05 p.m., room [ROOM NUMBER] had an unsecured outlet on the wall at the foot of the resident's bed. The outlet was pulled away from the wall and black cords were plugged into the outlet. During an observation, on 2/17/25 at 8:20 a.m., the 100-hallway had a strong urine and bowel odor. There was a very strong urine and bowel odor in rooms [ROOM NUMBERS]. During an interview, on 2/10/25 at 11:10 a.m., LPN 5 indicated he was aware the resident in room [ROOM NUMBER] had blood smeared on the wall and his sheets. The CNA was busy with another resident and had not cleaned the resident up yet. During an interview, on 2/10/25 at 11:28 a.m., the Regional Support Executive Director indicated the dialysis sewer backed up and went into room [ROOM NUMBER]'s bathroom. He indicated there were little flying bugs in the room. (continued on next page)

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