STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	05/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KOKOMO PLACE	3025 W SYCAMORE ST KOKOMO, IN 46901

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaint IN00351705. Complaint IN00351705 - Substantiated. State Residential Findings are cited at R0064. Survey dates: May 3 and 4, 2021 Facility number: 011075 Residential Census: 35 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review was completed on May 10, 2021.	R 0000		
R 0064 Bldg. 00	410 IAC 16.2-5-1.2(hh) Residents' Rights- Noncompliance (hh) The facility shall exercise reasonable care for the protection of residents ' property from loss and theft. The administrator or his or her designee is responsible for investigating reports of lost or stolen resident property and that the results of the investigation are reported to the resident. Based on interview and record review, the facility failed to ensure residents' medications were safe from theft by staff for 2 of 3 residents reviewed for misappropriation of property (Residents B and C). Findings include: 1. A facility incident report, dated 4/13/2021 at	R 0064	1. Resident B was assessed by nursing for adverse drug reactions related to the missing medications on 4/13/2021. PCP and family were notified by the staff nurse on 4/13/2021. Local police were notified of the incident by the Executive Director on 4/13/2021.	06/03/2021

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

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	8:15 a.m., indicated during the counting of narcotic medications, Resident B was missing 5 Norco (an opioid pain reliever). The facility was unable to determine what happened to the missing medications. The record for Resident B was reviewed on 5/4/2021 at 10:10 a.m. Diagnoses included, but were not limited to, dementia, end stage renal disease and type 2 diabetes mellitus. A physician's order, dated 4/12/2021, indicated Norco 5/325 mg (milligram), give one tablet every 8 hours as needed for pain. 2. A facility incident report, dated 4/19/2021 at 9:03 a.m., indicated on 4/18/2021, the day shift nurse noted there was one missing Norco for Resident C. The investigation was completed and RN 2 reported she gave Resident C and extra dose of Norco and the staff were inserviced on abuse and resident rights. The report did not include RN 2 was terminated from the facility. The record for Resident C was reviewed on 5/4/2021 at 10:45 a.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary diseases, congestive heart failure and arthritis. A physician's order, dated 4/19/21 indicated hydrocodone/acetaminophen 7.5/325 mg, give one tablet two times daily. A facility email, dated 4/29/2021, indicated RN 2 was educated on the proper procedure for counting narcotics. As soon as the facility investigation was completed for the incident on		Resident C was assessed by nursing for adverse drug reactions related to the missing medications on 4/18/2021. PCP and family were notified by the staff nurse on 4/19/2021. Local police were notified of the incident by the Executive Director on 4/19/2021. RN 2 is no longer employed at the community effective 4/29/2021. 2. The medication cart, medication room, and medication refrigerator audited on 5/20/2021 by the Regional Care Specialist (RCS) to ensure resident medications were safe from theft. No concerns noted. Attachment 1. 3. The RCS was retrained on 5/17/2021 by Regional Director of Care Services (RDCS) regarding resident rights and exploitation. Attachment 2. Medication passers were retrained on resident rights and abuse on 5/20/2021 by the RCS. Attachment 3. 4. The Care Services Manager (CSM) is responsible for sustained compliance. The CSM and/or designee will complete medication cart, medication room, and medication refrigerator audits weekly for four weeks, biweekly for four weeks, then monthly for one month to ensure medications are secured and safe from theft. Results of audits will be reviewed at monthly QI meeting x 3 months. The QI Committee will determine if	

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	4/13/2021, there was another incident of a missing narcotic on 4/17/2021. RN 2 was terminated from the facility. RN 2 was terminated from the facility after she stated she gave Resident C an extra dose of Norco, did not record the extra dose and did not have a physician's order to administer the extra dose of medication. During an interview, on 5/3/2021 at 4:05 p.m., the Executive Director (ED) indicated RN 2 was suspended pending the investigation of the missing Norco and it appeared she had taken the missing medications for Residents B and Resident C. RN 2 was released from duty after the investigation was completed. A current policy, titled "Abuse, Neglect and Exploitation," dated 9/1/2016 and received from the Director of Nursing (DON) on 5/5/2021 at 12:48 p.m., indicated "...It is our duty to protect residents from physical, mental, fiduciary [financial] sexual and verbal abuse or neglect...." A current policy, titled "Resident Rights," dated 9/1/2016 and received from the DON on 5/5/2021 at 4:00 p.m., indicated "...Each resident has the right to, at minimum...Be free from mental, verbal, sexual and physical abuse and neglect...Employees will receive education and training on state-specific resident rights during initial orientation and as part of their on-going continuing education...." This state residential finding relates to complaint IN00351705.		continued audits are necessary based on 3 consecutive months of compliance. Monitoring will be on-going 5. Completion date 6/3/2021	
R 0117 Bldg. 00	410 IAC 16.2-5-1.4(b) Personnel - Deficiency (b) Staff shall be sufficient in number,			

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	qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions. Based on observation, interview and record review, the facility failed to ensure there were staff available to administer medications as prescribed for 1 of 5 residents observed for medication administration (Resident 6) and to have CPR or first aid coverage for 1 out of 7 night shifts. (4/28/2021) Findings include: 1. During a medication administration observation, on 5/3/2021 at 3:38 p.m., LPN 3 administered Zofran (an anti nausea) medication to Resident 6.	R 0117	1. Resident 6's physician was notified of findings and medication order was revised per MD order on 5/12/2021. Attachment 4. On 5/17/2021, the Executive Director reviewed and updated staffing schedule to ensure minimum of one employee with current CPR and first aid certification was present on each shift. 2. An audit of the medication administration record was completed on 5/20/2021 by the RCS to ensure medications are	06/03/2021

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	The record for Resident 6 was reviewed on 5/4/2021 at 3:30 p.m. Diagnoses included, but were not limited to osteoarthritis, gastroesophageal reflux and iron deficiency anemia. A physician's order, dated 7/30/20, indicated to give Zofran 8 mg (milligram) every 8 hours. The Medication Administration Records (MAR), dated 12/2020 through 5/2021, indicated the administration times for the Zofran were from 6:00 a.m. through 10:00 a.m., 11:00 a.m. through 2:00 p.m., and 3:00 p.m. through 6:00 p.m. This schedule was not every 8 hours as prescribed by the physician. During an interview, on 5/3/2021 at 2:57 p.m., LPN 3 indicated she worked from 7:00 a.m. through 7:00 p.m. and there was no nurse coverage after 7:00 p.m. During an interview, on 5/4/2021 at 3:47 p.m., the DON indicated the facility was administering the medication three times a day and not every 8 hours as prescribed by the physician. In November 2020, the facility went from set times a day for medication administration to a range of times to administer the medications. The facility previously had four nurses, one QMA (qualified medication aid) and a DON. Then the facility only had two nurses and one QMA. There was not enough staff and the facility only had one nurse working from 7:00 a.m. through 7:00 p.m. daily. However, the nurses would arrive to work at 5:30 a.m. since they were not comfortable coming in at 7:00 a.m. to get all the medications administered. The facility had tried to work with an agency to provide nurse staffing and was not		administered as prescribed. No issues identified. Attachment 1. An audit of employee first aid/CPR certification was completed on 05/06/2021 by the Executive Director. Employees without current first aid/CPR certification will obtain certification by 6/3/2021. Attachment 6. 3. The RCS was retrained on 5/17/2021 by the RDCS regarding the requirement for medications to be administered as ordered by the physician. Attachment 2. The Executive Director was re-trained by the RDCS on 05/20/2021 regarding the first aid/CPR regulation requirement. Attachment 7. 4. The Executive Director is responsible for sustained compliance. The CSM and/or designee will audit the medication administration record weekly for 4 weeks, biweekly for 4 weeks, then monthly for one month to ensure medications are administered as ordered by the physician. The CSM and/or designee will audit the staffing schedule weekly for 4 weeks, biweekly for 4 weeks, then monthly for one month to ensure a first aid/CPR certified employee is on site at all times. The audits will be discussed at monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on 3 consecutive months of compliance. Monitoring will be	

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	successful. A current policy, titled " Physician Orders," dated 9/1/2016 and received from the DON on 5/4/2021 at 4:10 P.M., indicated "...The Community must have proper physician's orders before providing assistance with any medication or treatment...Any requested deviation from the physician's orders must be communicated to the physician and new orders obtained should the physician agree with the change requested...."2. During a staffing review, on 5/4/21 at 2:45 p.m., there were no staff certified for CPR or first aid for the night shift on 4/28/2021. During an interview, on 5/4/21 at 3:54 p.m., the DON indicated they did not have coverage for the night shift on 4/28/21. The facility did not have a policy and followed the state regulations.		on-going. 5. Completion date 6/3/2021	
R 0247 Bldg. 00	410 IAC 16.2-5-4(e)(7) Health Services - Deficiency (7) Any error in medication administration shall be noted in the resident ' s record. The physician shall be notified of any error in medication administration when there are any actual or potential detrimental effects to the resident. Based on observation, interview and record review, the facility failed to ensure medications were administered as prescribed by the physician for 1 of 5 residents reviewed for medication administration (Resident 6). Finding includes: During a medication administration observation, on 5/3/2021 at 3:38 p.m., LPN 3 administered Zofran (an anti nausea) medication to Resident 6.	R 0247	1. Resident 6's physician was notified of findings and medication order was revised per MD order on 5/12/2021. Attachment 4. 2. An audit of the medication administration record was completed on 5/20/2021 by the RCS to ensure medications are administered as prescribed. No issues identified. Attachment 1. 3. The RCS was retrained on 5/17/2021 by the RDCS regarding	06/03/2021

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	The record for Resident 6 was reviewed on 5/4/2021 at 3:30 p.m. Diagnoses included, but were not limited to osteoarthritis, gastroesophageal reflux and iron deficiency anemia. A physician's order, dated 7/30/20, indicated to give Zofran 8 mg (milligram) every 8 hours. The Medication Administration Records(MAR), dated 12/2020 through 5/2021, indicated the administration times for the Zofran were from 6:00 a.m. through 10:00 a.m., 11:00 a.m. through 2:00 p.m. and 3:00 p.m. through 6:00 p.m. The MARs did not indicate the exact time the medication was administered and only included the time range. The time ranges between administration of the medication could be from one to five hours. This schedule was not every 8 hours as prescribed by the physician. During an interview, on 5/3/2021 at 2:57 p.m., LPN 3 indicated the medication was not given every 8 hours as prescribed. During an interview, on 5/4/2021 at 3:47 p.m., the DON, indicated the facility was administering the medication three times a day and not every 8 hours as prescribed by the physician. The Nursing Drug Handbook, dated 2017 and updated 2021, indicated older adult may be more sensitive to the side effects of this medication, especially QT prolongation which can cause fast/irregular heartbeat and dizziness or fainting which needs medical attention right away.		the requirement for medications to be administered as ordered by the physician. Attachment 2. 4. The CSM is responsible for sustained compliance. The CSM or designee will audit the medication administration record weekly for 4 weeks, biweekly for 4 weeks, then monthly for one month to ensure medications are administered as ordered by the physician. The audits will be discussed at monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on 3 consecutive months of compliance. Monitoring will be on-going. 5. Completion date 6/3/2021	

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	A current policy, titled "Physician Orders," dated 9/1/2016 and received from the DON on 5/4/2021 at 4:10 P.M., indicated "...The Community must have proper physician's orders before providing assistance with any medication or treatment...Any requested deviation from the physician's orders must be communicated to the physician and new orders obtained should the physician agree with the change requested...."			
R 0305 Bldg. 00	410 IAC 16.2-5-6(f)(1-3) Pharmaceutical Services - Noncompliance (f) Residents may use the pharmacy of their choice for medications administered by the facility, as long as the pharmacy: (1) complies with the facility policy receiving, packaging, and labeling of pharmaceutical products unless contrary to state and federal laws; (2) provides prescribed service on a prompt and timely basis; and (3) refills prescription drugs when needed, in order to prevent interruption of drug regimens. Based on observation, interview and record review, the facility failed to ensure narcotic medications were stored in a tamper free container and medications were labeled for 1 of 2 medication carts observed for medication storage. (Medication Cart 1) Finding includes: During a medication storage observation, on 5/3/2021 at 1:45 p.m., the following was observed: 1. One card of hydrocodone/acetaminophen 5/325 mg (milligram) for Resident F. The foil was torn on the back of the card over doses 10,	R 0305	1. Resident F's unsecured doses of hydrocodone were destroyed on 5/3/2021 by the RCS and the staff nurse. The skelaxin was destroyed on 5/3/2021 by the staff nurse. 2. An audit of the medication cart was completed on 5/20/20201 by the Regional Care Specialist (RCS) to ensure narcotic medications are stored properly and medications are labeled. No issues identified. Attachment 1. 3. Medication passers were retrained on medication storage on 5/20/2021 by the RCS.	06/03/2021

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	20, 24, 25 and 27 with tape covering the back to hold the medication in the card. 2. One skelaxin (a muscle relaxant) 800 mg was not labeled with a resident name and was in the left side bottom drawer. During an interview, on 5/3/2021 at 1:50 p.m., LPN 3 indicated the doses of hydrocodone should have been wasted with two witnesses since the back of the card was compromised. The skelaxin probably belonged to resident E and she did not know why it was located in the bottom of the drawer. A physician order for Resident E, dated 2/8/21, indicated skelaxin 800 mg two times daily. A current policy, titled "Storage of Medications," dated 9/1/2016 and received from the Director of Nursing (DON) on 5/3/2021 at 4:03 p.m., indicated "...All medications stored by the community must be maintained in a clean, neat, locked container or area...." A current policy, titled " Controlled Drugs Management," dated 9/1/2016 and received from the DON on 5/3/2021 at 4:03 p.m., indicated "...To ensure safe delivery, storage and administration of controlled drugs...Upon receipt of a controlled narcotic, the medication label and quantity is to be verified and logged onto the narcotic inventory sheet. If the medication is delivered through a courier from a pharmacy, the narcotic medication is to be verified prior to signing the manifest... Follow the procedures outlined in the section on 'Destruction and Disposal of Medications in this manual for proper disposal of controlled narcotics...Recommended and preferred		Attachment 3. 4. The CSM is responsible for sustained compliance. The CSM and/or designee will complete medication cart audits weekly for four weeks, biweekly for four weeks, then monthly for one month to ensure medications are stored and labeled appropriately. The audits will be discussed at monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on 3 consecutive months of compliance. Monitoring will be on-going. 5. Completion date 6/3/2021	

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	packaging for controlled drugs is bubble packaging...."			
R 0407 Bldg. 00	410 IAC 16.2-5-12(b)(1-4) Infection Control - Noncompliance (b) The facility must establish an infection control program that includes the following: (1) A system that enables the facility to analyze patterns of known infectious symptoms. (2) Provides orientation and in-service education on infection prevention and control, including universal precautions. (3) Offering health information to residents, including, but not limited to, infection transmission and immunizations. (4) Reporting communicable disease to public health authorities. Based on observation, record review and interview, the facility failed to establish an infection control program to analyze pattens of known infectious symptoms and to review screening of visitors for signs/symptoms of Covid-19 prior to entrance to the facility. The deficient practice had the potential to effect 35 of 35 residents who resided in the facility. Findings include: 1. During the entrance to the facility, on 5/3/21 at 11:15 a.m., the staff did not ensure documentation of signs/symptoms of Covid-19 during entrance screening were reviewed and failed to instruct visitors of infection control practices. 2. During a review of the infection control log, on 5/3/21 at 3:00 p.m., there were no entries of infections currently or in previous months in the log.	R 0407	1. Staff were retrained on the process for screening visitors by the Executive Director on 5/4/2021 Attachment 8. The infection control log was updated on 5/4/2021 by the RCS. 2. An audit of resident records was completed on 5/4/2021 by RCS to identify any infections from 5/1/2021 onward. Any infections identified were documented on the infection control log. 3. The Executive Director was retrained on the process for screening visitors on 5/20/2021 by the RDCS. Attachment 7. The RCS was retrained on 5/17/2021 by the RDCS regarding the infection control program. Attachment 2. 4. The Executive Director is	06/03/2021

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	3. During an interview, on 5/3/21 at 3:00 p.m., the DON (director of nursing) indicated she knew the log was not being utilized. A current policy, titled "Infection Control," dated 9/1/16 and received from the DON on 5/4/21 at 3:30 p.m., indicated "...Implement daily active surveillance for respiratory illness among ill residents, health care personnel and visitors to the facility...." A current policy, titled "Community Screening Guidance," dated 5/18/20 and received from DON on 5/3/21 at 1:20 p.m., indicated "...Visitors must answer screening questions on paper log and review responses with ED/Manager on Duty...."		responsible for sustained compliance. The Executive Director and/or designee will audit the visitor screening log 5 days per week x 4 weeks, then 3 days per week x 4 weeks, then weekly x 4 weeks to ensure visitors are being screened upon entry to the community. The CSM and/or designee will audit the infection control log weekly for 4 weeks, biweekly for 4 weeks, then monthly for one month to ensure infections are being tracked. Results of the audits will be discussed in the monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on 3 consecutive months of compliance. Monitoring will be on-going. 5. Completion date 6/3/2021	
R 0410 Bldg. 00	410 IAC 16.2-5-12(e)(f)(g) Infection Control - Noncompliance (e) In addition, a tuberculin skin test shall be completed within three (3) months prior to admission or upon admission and read at forty-eight (48) to seventy-two (72) hours. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered and read. (f) For residents who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed within one (1) to three (3) weeks			

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	after the first test. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (g) All residents who have a positive reaction to the tuberculin skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis. Based on record review and interview, the facility failed to administer a second step Mantoux (a tuberculosis test) for 2 out of 7 residents. (Resident 4 and D) Findings include: 1. The record for Resident 4 was reviewed on 5/4/21 at 2:00 p.m. Diagnoses included, but were not limited to, Alzheimer's and dementia. The first step Mantoux was administered without the second step given. 2. The record for Resident D was reviewed on 5/4/21 at 10:44 a.m. Diagnoses included, but were not limited to, diabetes mellitus, history of transient ischemic attack, seizures, hypertension, depression and dementia. The resident received her first step Mantoux on 9/19/20 and read on 9/21/2020. The facility did not give the second step Mantoux. During an interview, on 05/04/21 at 4:14 p.m., the DON (Director of Nursing) indicated no second step TB testing was done and it would have to be restarted. A current policy, titled "TB (Tuberculosis) Testing," effective on 9/1/2016 and received from the DON on 5/4/21 at 3:00 p.m., indicated	R 0410	1. Resident 4 received a first step tuberculin skin test on 4/20/2021 and a second step on 5/5/2021. Resident D received a first step tuberculin skin test on 5/7/2021 and a second step on 5/17/2021. 2. An audit of current resident tuberculin skin test records was completed on 5/21/2021 by the RCS to ensure residents received a first and second step Mantoux. Any issues identified were corrected. Attachment 9. 3. The RCS was retrained on 5/17/2021 by the RDCS on the tuberculin skin test regulation. Attachment 2 4. The Executive Director is responsible for sustained compliance. The CSM and/or designee will audit the resident tuberculin skin test records weekly for 4 weeks, biweekly for 4 weeks, then monthly for one month to ensure compliance. Results of the audit will be discussed in the monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on 3 consecutive months of compliance. Monitoring will be on-going.	06/03/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	05/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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	"...TB testing will be completed per state regulations for residents...The Care Services Manager is responsible for conducting or arranging for Mantoux method TB tests...."		5. Completion date 6/3/2021	