STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155819	A. Building B. Wing	08/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wellbrooke of Kokomo	2200 South Dixon Road Kokomo, IN 46902

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a resident was assessed timely after an unwitnessed fall and to ensure monitoring and measurements of a bruise which resulted from the fall was completed for 1 of 3 residents reviewed for quality of care. (Resident C)Findings include:The clinical record for Resident C was reviewed on 8/27/25 at 10:43 a.m. The diagnoses included, but were not limited to, Parkinson's disease with dyskinesia, squamous cell carcinoma of the skin, cerebral ischemia, difficulty in walking, mental disorder, lack of coordination, and repeated falls.A nursing progress note, dated 6/22/25 at 9:13 a.m., indicated Resident C was moved from room [ROOM NUMBER] to 229 due to his toilet being broken. A nursing progress note, dated 6/22/25 at 10:18 a.m., indicated Resident C was on a fall follow-up. He had a bruise observed to his lower back and right lateral side of his chest. He took an as needed Percocet for pain this morning.A nursing progress note, dated 6/22/25 at 1:41 p.m., indicated the occurrence date and time of the fall was on 6/21/25 at 10:30 p.m. Resident C had self-reported a fall in his bathroom. There were no complaints of pain and no limitations with range of motion when he was assessed the next morning. The new intervention was to remind the resident to keep his nonskid footwear on while transferring. The resident's representative was notified of the fall.A nursing progress note, dated 6/22/25 at 5:21p.m., indicated the resident remained on a fall follow-up. He took Tylenol for complaints of lower back pain, where the bruise was located, from the fall he had on 6/21/25.An Intradisciplinary (IDT) note, dated 6/23/25 at 4:43 p.m., indicated Resident C had an unwitnessed self-reported fall in his bathroom on 6/21/25 at 10:30 p.m. He was cognitively intact and reported he transferred himself into his wheelchair, propelled himself into the bathroom, toileted himself, then lost his balance and fell when attempting to transfer himself onto the toilet from his wheelchair. He had a 22-inch wheelchair, which could be difficult for him to maneuver independently in small spaces. He had bare feet at the time of the fall. Resident C reported he got himself up off the floor into his wheelchair, then propelled himself back to his room and turned on his call light to notify staff water was leaking from his toilet. When the nurse assessed the resident, he had bruising to his lower back. He was educated to call for assistance using his call light and was provided with additional nonslip socks. He was offered the chance to move to a different room closer to the nurse's station or with a different bathroom set up, but he declined both offers. The root cause of the fall was the resident lost his balance when he was transferring from the toilet to his wheelchair. The new intervention initiated was a sign was placed in the bathroom and the resident was educated to ask for assistance and wear nonslip footwear when transferring.The resident's record lacked documentation of a post fall assessment the evening the resident fell. The record also lacked an assessment of the bruise to Resident C's back area including a description of the bruise and measurements.During a phone interview, on 8/27/25 at 3:25 p.m., CNA 2 indicated Resident C had his call light on and was sitting in his wheelchair in the doorway to his room. Resident C told her he (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	fallen in the bathroom and broke his toilet, then got himself back up into his wheelchair. He told her he had gotten his own towels out of the linen closet and put them on the bathroom floor. She immediately went to LPN 1 and informed her Resident C fell. She had made it clear which resident had fallen.During a phone interview, on 8/27/25 at 4:22 p.m., QMA 6 indicated, on 6/21/25 at 10:30 p.m., CNA 2 told her a resident fell. The resident she was told had fallen had the same first name as Resident C. QMA 6 indicated she went to the other resident's room (not Resident C) to check on him and he indicated he did not fall. QMA 6 then informed LPN 1 she a resident fell, she checked on him, and he indicated he did not fall. When QMA 6 went into Resident C's room the next morning (on 6/22/25 at approximately 4:00 a.m.) to administer his medications, he indicated his bathroom had been flooded with water from his toilet. QMA 6 then realized Resident C was the resident who had fallen the night before. QMA 6 then went to LPN 5 and reported Resident C had fallen last night.During a phone interview, on 8/27/25 at 12:05 p.m., LPN 1 indicated she was working Resident C's unit, on 6/21/25 from 10 a.m. to 10 p.m., but she was not taking care of Resident C during the shift.During a phone interview, on 8/27/25 at 3:52 p.m., LPN 5 indicated he was notified by QMA 6, on 6/22/25 at approximately 5:00 a.m., Resident C had fallen on 6/21/25 at 10:30 p.m. LPN 5 went to Resident C's room and seen his toilet was broken. He completed a fall assessment with neurological checks at that time.During an interview, on 8/27/25 at 3:30 p.m., Clinical Support 8 indicated Resident C's bruise to his back which was noticed after his fall was not measured and followed according to the facility policy and procedure.A current facility policy, titled Bruise, Rash, Lesion, Skin Tear, Laceration Assessment Guidelines, dated 5/10/16 and provided by Clinical Support 8 on 8/27/25 at 1:09 p.m., indicated .utilized to describe and monitor bruises, rashes, lesions, skin tears and lacerations.If skin alteration occurs post admission, follow the below steps: a. Complete Bruise incident in EHR (electronic health record) by an RN/LPN along with the template/assessment progress note. IDT should review this timely and wound nurse or designee complete an assessment in wound management or Wound Zoom. This may not include hemosiderin staining, petechiae, and senile purpura. B. Continue to monitor weekly in wound management or Wound Zoom. C. Must review for at least 1 week in wound management or Wound Zoom. Once wound nurse/designee determines that the wound is healing as expected, resolved or becomes a chronic skin condition this wound nurse/designee may heal the wound in wound management or Wound Zoom.This citation related to Intakes 1376644, 1376646 and 13766473.1-37(a)