STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED
	155064		03/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE KOKOMO	3518 S LAFOUNTAIN ST KOKOMO, IN 46902

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000 Bldg. 00	This visit was for the Investigation of Complaint #IN00166860. This visit resulted in a Partially Extended survey: Immediate Jeopardy. Complaint #IN00166860- Substantiated. Federal/State deficiencies related to the allegations are cited at F323, F332, F425, F456, & F465. Survey dates: March 3 & 4, 2015 Partially Extended survey dates: March 5 & 6, 2015 Facility number: 000025 Provider number: 155064 AIM number: 100274850 Survey team: Michelle Carter, RN- TC Tammy Alley, RN (3/4/15 & 3/6/15) Census bed type: SNF- 9 SNF/NF- 45 Total- 54 Census payor type: Medicare- 10 Medicaid- 39	F 000	Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute any admission of guilt or liability by the facility and is submitted only in response to the regulatory requirements.	

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED
	155064		03/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE KOKOMO	3518 S LAFOUNTAIN ST KOKOMO, IN 46902

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Other- 5 Total- 54 Sample: 23 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1. Quality Review was completed by Tammy Alley RN on March 12, 2015.			
F 323 SS=K Bldg. 00	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observations, interviews, and record review, the facility failed to maintain resident transfer equipment in a safe working condition (Sara Lift 3000 sit to stand lift slings and knee straps) and failed to properly utilize the Sara Lift 3000 transfer slings, according to manufacturer's guidelines, for 2 of 2 residents observed during a transfer, (Residents B & C), and for 3 of 3 Sara Lift 3000 slings observed for safe, functional use. This deficient practice had the potential to cause harm to 9 of 9 residents utilizing the Sara Lift 3000.	F 323	**F323 Free of Accident Hazards/Supervision/Devices** The filing of this plan of correction does not constitute an admission that the alleged deficiency exists. This plan of correction is provided as evidence of the facility's desire to comply with the regulations and to continue to provide quality care. 1) Immediate actions taken for those residents identified: For identified residents, assessments were reviewed and updated to ensure residents care need matched the method of transfer and needed equipment. The Executive	04/01/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155064	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 03/06/2015
NAME OF PROVIDER OR SUPPLIER APERION CARE KOKOMO		STREET ADDRESS, CITY, STATE, ZIP CODE 3518 S LAFOUNTAIN ST KOKOMO, IN 46902	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	(Residents B, C, D, E, F, G, H, I, & J) The immediate jeopardy began on 2/19/15 when the facility failed to remove dysfunctional transfer equipment when the facility was aware of the condition of the transfer equipment and the potential harm. The HFA and DON were notified of the immediate jeopardy on 3/4/15 at 4:45 p.m. The immediate jeopardy was removed on 3/5/15, but the non-compliance remained at the lower scope and severity level of no actual harm with the potential for more than minimal harm that is not immediate jeopardy. Findings include: During a facility tour with the Healthcare Facility Administrator (HFA) and the Director of Nursing (DON), on 3/3/15 at 1:25 p.m., 3 sit to stand lifts (Sara Lift 3000) were noted with missing belt buckles to the knee support straps. 2 of 3 sit to stand lifts were missing one belt buckle. 1 of 3 sit to stand lifts was missing two belt buckles. A transfer sling was noted with frayed, worn out fabric and broken buckles. The HFA indicated he was not aware of the missing belt buckles. He indicated a		Director lock out tagged out the 2 standing lifts that did not meet all potential resident needs including those without knee straps. All slings were assessed for safe and working conditions, those not meeting safety guidelines were removed from use. An order was placed for additional slings. 2) How the facility identified other residents: There were no other residents affected by this practice. Staff were interviewed about other residents not previously identified or assessed as needing a lift transfer. 3) Measures put into place/ System changes: Staff competencies and education were started by the DON on 3/4/15. No staff completed a transfer until the education and competency were completed. A review was completed with the Restorative Nurse who completes the transfer assessments to ensure no other residents not already identified needed to be a mechanical lift. Nursing staff were in-serviced on how to communicate changes in residents transfer needs. 4) How the corrective actions will be monitored: Prior to each use the staff member using the lift will complete a visual inspection of the sling and lift. This visual inspection will be to ensure the sling and lift are in safe functional order. If the sling or lift is not in safe functional order they will remove the sling or lift from service and alert the nurse	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155064	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 03/06/2015
NAME OF PROVIDER OR SUPPLIER APERION CARE KOKOMO		STREET ADDRESS, CITY, STATE, ZIP CODE 3518 S LAFOUNTAIN ST KOKOMO, IN 46902	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	medical equipment professional was at the facility on 2/19/15 to review and assess equipment. The equipment professional deemed the lifts functional for use. The DON indicated, at this time, during tour, the transfer slings were deemed functionally intact. The issues with the transfer slings were cosmetic and did not affect the actual use during a transfer. During the tour observations, stickers were noted on 3 of 3 lifts. The stickers were dated 2/15 (February 2015). The HFA indicated, during a tour interview, the stickers indicated the lifts were functional for use, as they were put there by the equipment professional. Two Sara Lift 3000's were in use on the East hall. CNA #1 demonstrated the use of the Sara Lift 3000 sit to stand lift (actual residents were not involved with demonstration) on the East hall, on 3/3/15 at 1:40 p.m. CNA #1 indicated she used the knee support straps to secure resident's legs. However, she was not able to use the knee support straps on one of the lifts because the buckle clips (x2) were missing. She indicated there was only one working clip on the other lift used on the East hall. On the South Magnolia hall, on 3/3/15 at		manager on duty or the Administrator. Another safe and functional sling and lift will be used for the transfer. An audit of the lifts will be completed weekly by the Maintenance Director ensuring they are meeting the manufacturer guidelines for operations. Laundry staff will complete an audit on each mechanical lift sling as it comes through the laundry weekly. The DON or designee will complete the mechanical lift sling inspection as they conduct the transfer observations 3 times a week for 4 weeks on various shifts with various residents and staff. They will then be completed 2x week for 4 weeks and then weekly thereafter. The results of these audits will be reviewed in the Quality Assurance Meeting monthly x3 months and quarterly x1 for a total of 6 months. DON/Designee will be responsible for oversight of these audits. 5) Date of compliance: 4/1/15 Aperion Care Kokomo suggests that the ISDH's reviewer consider reducing the level K violation of F323 for the following reasons: As per The Long Term Care Survey Manual, Appendix PP, Page 327 cites: **F323**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155064	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 03/06/2015
NAME OF PROVIDER OR SUPPLIER APERION CARE KOKOMO		STREET ADDRESS, CITY, STATE, ZIP CODE 3518 S LAFOUNTAIN ST KOKOMO, IN 46902	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	2:00 p.m., during an interview, CNA #4 indicated there was one lift for use and demonstrated the use of the Sara Lift 3000 (actual residents were not involved with demonstration). CNA #4 stated, "First, you secure the resident's legs with the buckles." As she demonstrated, she indicated there was only one buckle clip, the other buckle was missing. She indicated she would not use that particular lift and would need to find a lift with 2 buckles clips in place, one strap/buckle for each leg. During an interview, on 3/3/15 at 2:10 p.m., LPN #2 indicated and confirmed the sit to stand lifts were used for 9 residents. (Residents B, C, D, E, F, G, H, I, & J) On 3/3/15 at 2:55 p.m., during an interview, the HFA indicated a former employee notified him about the poor condition of the mechanical lifts on 2/13/15. He (the HFA) notified a medical equipment company. The earliest a company professional could visit was 2/19/15. On 2/19/15, an equipment professional deemed all equipment useable and functional. An email correspondence confirming the equipment review was presented on 3/3/15 at 3:00 p.m., from the HFA.		**(Rev. 27, Issued: 08-17-07, Effective: 08-17-07 Implementation: 08-17-07)** **§483.25(h) Accidents**. **The facility must ensure that –** (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. **INTENT: 42 CFR 483.25(H) (1) AND (2) ACCIDENTS AND SUPERVISION** The intent of this requirement is to ensure the facility provides an environment that is free from accident hazards over which the facility has control and provides supervision and assistive devices to each resident to prevent avoidable accidents. This includes: • Identifying hazard(s) and risk(s); • Evaluating and analyzing hazard(s) and risk(s); • Implementing interventions to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155064	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 03/06/2015
NAME OF PROVIDER OR SUPPLIER APERION CARE KOKOMO		STREET ADDRESS, CITY, STATE, ZIP CODE 3518 S LAFOUNTAIN ST KOKOMO, IN 46902	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Contents of the email included a summary of each Sara 3000 lift, as follows: Control #FR13- ...Missing belt for knee support; needs replaced. Control #FR11- ...Missing belts for knee support; needs replaced. Control #FR16- ...Missing belts for knee support; needs replaced. On 3/4/15 at 11:44 a.m., CNA #1 and CNA #3 were observed using the Sara Lift 3000 and a transfer sling to transfer Resident B to the toilet. The knee support straps were not used. The waist support belt on the sling was not used. It was tucked under Resident B's arms with the belt straps dangling. CNA #1 and CNA #3 indicated the knee support straps did not have belt buckles and the transfer sling was broken and could not be used, properly. CNA #3 demonstrated one belt buckle was missing on the waist support belt part of the transfer sling. CNA #1 indicated as long as 2 nursing staff were attending the transfer, her understanding was it was ok to use the lift. During an observation and interview on 3/4/15 at 11:55 a.m., CNA #3 indicated Resident C was transferred to the toilet with the use of the sit to stand lift and still had the transfer sling around him. The transfer sling was observed without		reduce hazard(s) and risk(s); and • Monitoring for effectiveness and modifying interventions when necessary. Aperion Care Kokomo's environment remains as free as from accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. On 2/13/15 the ED was notified by a staff member of the poor condition of the mechanical lifts. On this date, the ED notified a medical equipment professional to inspect the equipment for its safe operation. The mechanical lift equipment was immediately inspected by the maintenance director and deemed safe for use. On 2/19/15 the Medical Equipment Professional came to the facility and inspected the lifts and the slings. At this time he alerted to the ED, DON and Maintenance Director that there were some "cosmetic" issues with the lifts. The ED asked specifically if the lifts needed to be removed from service. The medical equipment professional indicated to all three employees that the lifts were safe for	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155064	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 03/06/2015
NAME OF PROVIDER OR SUPPLIER APERION CARE KOKOMO		STREET ADDRESS, CITY, STATE, ZIP CODE 3518 S LAFOUNTAIN ST KOKOMO, IN 46902	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	waist support belt buckles. Resident C indicated the transfer sling was used only under his arms and was not buckled because there weren't any buckle clips. Resident C's statement was verbally confirmed by CNA #3. The HFA indicated he was not aware the transfer slings were non functional and would remove them from use, immediately, during an interview and observation of the transfer slings, on 3/4/15 at 12:10 p.m. A phone interview was conducted on 3/4/15 at 3:37 p.m., with the medical equipment professional. He verbally confirmed he visited the facility to inspect equipment on 2/19/15. He indicated he laid 3 transfer slings along the hallway for inspection. He showed and verbally informed the HFA, DON, and the maintenance director, the concerns with the broken, missing buckles, and frayed fabric. He recommended to them, to not to use these slings because they could not be used, appropriately. On 3/4/15 at 3:55 p.m., the maintenance director indicated, during an interview, the medical equipment professional told him, the HFA, and DON, the transfer slings were in bad condition and should		operations. He placed his stickers on them indicating that they had been inspected. At this time he pointed out three slings that he felt were not safe. Those slings were immediately removed from use and were placed in the DON office so staff could not use them in any way. On the 2567 Statement of Deficiencies, indicates that the staff was told the slings were not safe for use and that staff continued to use them. This is not the case. The slings that were indicated as not safe were removed at the time we were informed. In the Medical Equipment Professionals report it also does not indicate that the lifts needed to be removed from use nor that he did not inspect all the slings in the facility. In the Sara 3000 instructions for use, page 10 cites, a Warning of “the sling chest support strap must always be applied and fastened when using the sling”. However, this is referencing the “transfer” sling, not the “standing” which is the type of sling we utilize. The 2567 Statement of Deficiencies survey also indicates that “Warning: Always check that	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155064	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 03/06/2015
NAME OF PROVIDER OR SUPPLIER APERION CARE KOKOMO		STREET ADDRESS, CITY, STATE, ZIP CODE 3518 S LAFOUNTAIN ST KOKOMO, IN 46902	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	not be used. He indicated, during the observation with the equipment professional, the DON indicated the facility had more transfer slings and would not use those transfer slings. The Sara Lift 3000 manufacturer's Instructions For Use was received from the HFA, on 3/4/15 at 12:20 p.m. The instruction guide indicated, on page 8, to "position the sling around the resident's back so that the bottom of the sling lies horizontally about two inches or five centimeters above the resident's waistline, with the resident's arms outside the sling. Ensure that the support strap is separated and brought loosely around the body, and is not twisted or trapped behind the resident's back." A warning box, on page 10, stated, "Warning: The sling chest support strap must always be applied and fastened when using the sling." Another warning box stated, "Warning: Always check that all the sling attachment clips are securely connected and fully in position before and during the lifting cycle, and in tension as the resident's weight is gradually taken up." Preventive Maintenance Schedule, on page 21, provided instructions and obligations for caregivers. The caregiver obligations indicated to "examine the sling, straps and clips for damage or fraying as required, before each use, and		all the sling attachment clips are securely connected and fully in position before and during the lift cycle, and in tension as the resident's weight is gradually taken up." However, this is only a portion of the warning in the box…it goes on to say "Make sure each clip is attached to the correct clip attachment point on the resident support arms, and each loop is attached correctly and secure onto the lug should the Transfer Sling be used." Again, we do not utilize the "transfer sling", we use the "standing sling". The survey implies that the observed residents required the legs straps. According to the Sara 3000 instructional guide the surveyors quoted from it indicates " Warning: An assessment must be made for each individual resident being raised by the Sara 3000 – by a medically qualified person – as to whether the resident REQUIRES the lower leg straps when using the standing sling. **Use if necessary, e.g. with unruly residents, residents w spasms, etc. that were assessed as suitable to be raised.** As per The Long Term Care Survey Manual, Appendix PP,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155064	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 03/06/2015
NAME OF PROVIDER OR SUPPLIER APERION CARE KOKOMO		STREET ADDRESS, CITY, STATE, ZIP CODE 3518 S LAFOUNTAIN ST KOKOMO, IN 46902	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	visually check sling attachment points, before each use. Do not use if damaged." The immediate jeopardy that began on 2/19/15 was removed 3/5/15 when the facility removed the 3 transfer slings from resident use and repaired the knee support belt buckle clips on the 3 Sara 3000 lifts. Nursing staff in-services and competency checks for use of the Sara 3000 lifts were completed prior to the start of each shift. Interviews conducted with facility nursing staff on 3/5/15 and 3/6/15 indicated in-services were provided and competencies were assessed, appropriately. The non-compliance remained a lower scope and severity level of no actual harm with the potential for more than minimal harm that is not immediate jeopardy because the facility continued with staff training and continued on going compliance rounds to ensure proper use of transfer slings. This Federal tag relates to Complaint #IN00166860. 3.1-45(a)(2)		Page 354, cites: Severity Level 4 Considerations: Immediate Jeopardy to Resident Health or Safety Immediate Jeopardy is a situation in which the facility's noncompliance with one or more requirements of participation: • Has allowed, caused, or resulted in (or is likely to allow, cause, or result in) serious injury, harm, impairment, or death to a resident; and • Requires immediate correction, as the facility either created the situation or allowed the situation to continue by failing to implement preventive or corrective measures. Aperion Care Kokomo was **NOT noncompliance**with one or more requirements as noted above.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155064	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 03/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE KOKOMO	3518 S LAFOUNTAIN ST KOKOMO, IN 46902

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			In conclusion, The facility identified equipment in poor condition and immediately removed the equipment from the environment. The facility notified the Medical Equipment Professional in a timely manner. The Medical Equipment Professional assessed the equipment and instructed the ED, DON and Maintenance Man that it was safe to use. Based on the forgoing, it is clear that the facility: 1. Identified hazard(s) and Risk(s); 2. Evaluated and analyzed hazard(s) and Risks(s); 3. Implemented interventions to reduce hazard and risks; and 4. Monitored for effectiveness and modified interventions when necessary.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155064	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 03/06/2015
NAME OF PROVIDER OR SUPPLIER APERION CARE KOKOMO		STREET ADDRESS, CITY, STATE, ZIP CODE 3518 S LAFOUNTAIN ST KOKOMO, IN 46902	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			The facility requests that the deficiency of F 323 at a "K" level be reduced in scope and severity.	
F 332 SS=E Bldg. 00	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater.			
	Based on observations, record reviews and interviews, the facility failed to ensure it was free of a medication error rate of 5% or greater. The facility had a medication error rate of 53%, consisting of 17 errors out of 32 opportunities observed for error, effecting 11 of 16 residents observed during a medication pass, in a sample of 23. (Residents D, F, K, L, M, N, P, Q, R, S & T) Findings Include: A medication administration pass observation was conducted at 4:15 p.m., on 3/5/15. The following medications were scheduled for the 4:00 p.m., medication pass and were not administered within the two hour window (one hour prior to scheduled time to one hour post scheduled time) according to standard nursing practices. 1. A physicians order, dated 1/30/15, for	F 332	**F332 Free of Medication Error Rates of 5% or More** The filing of this plan of correction does not constitute an admission that the alleged deficiency exists. This plan of correction is provided as evidence of the facility's desire to comply with the regulations and to continue to provide quality care. **1) Immediate actions taken for those residents identified:** Residents L, M, G, N, P, Q, D, R, and S all received their medications. Staff were in-serviced on the need for timely medication passes. Resident K's nasal spray was	04/01/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155064	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 03/06/2015
NAME OF PROVIDER OR SUPPLIER APERION CARE KOKOMO		STREET ADDRESS, CITY, STATE, ZIP CODE 3518 S LAFOUNTAIN ST KOKOMO, IN 46902	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Resident K, indicated Fluticasone Propionate Nasal Spray, one spray in both nostrils, two times a day. The March 2015 Medication Administration Record (MAR) indicated the nasal spray was scheduled at 8:00 a.m. and 4:00 p.m. During the medication administration pass observation on 3/5/15 at 4:25 p.m., QMA #7 did not administer the nasal spray and indicated there wasn't any to administer, the medication was not available at the facility. 2. Resident L had a physicians order, dated 1/26/15, for Gabapentin, 600 mg (milligrams), one tablet, by mouth, three times a day, for pain. The March 2015 MAR indicated it was scheduled for administration at 5:00 a.m., 11:00 a.m., & 4:00 p.m. LPN #8 was observed administering the medication to Resident L at 5:10 p.m. 3. Resident M had a physicians order, dated 1/29/15, for Acetaminophen (Tylenol) 500 mg, give 500 mg, by mouth, two times a day, for pain, and a physicians order, dated 1/28/15, for Systane eye drops, instill one drop, in both eyes, four times a day, for dry eyes. The eye drops were scheduled for administration at 7:00 a.m., 12:00 p.m., 4:00 p.m. & 8:00 p.m., on the March 2015 MAR. LPN #8 was observed		obtained by the nursing staff from pharmacy the same night. Medical Director was notified of all the above. **2) How the facility identified other residents:** Staff audited residents who could have their medication combined to be given at the same time to eliminate the need for multiple medication passes. **3) Measures put into place/ System changes:** Staff were educated on the importance of residents receiving medication timely. Staff adjusted the medication order times to stagger the unit as appropriate to better meet the two hour requirement. An audit was started to identify the beginning and ending time of each medication pass to ensure it meets the window of compliance. The DON/Designee will audit the medication time at least 3x/week at varied times to ensure timely results.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155064	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 03/06/2015
NAME OF PROVIDER OR SUPPLIER APERION CARE KOKOMO		STREET ADDRESS, CITY, STATE, ZIP CODE 3518 S LAFOUNTAIN ST KOKOMO, IN 46902	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	administering the medications to Resident M at 5:15 p.m. 4. Physician orders, dated 1/29/15, indicated Hydralazine (for high blood pressure) 25 mg, one tablet, by mouth, four times a day, for Resident G. The March 2015 MAR indicated a scheduled dose at 4:00 p.m. The Hydralazine was administered at 5:20 p.m., by LPN #8. 5. Resident N had physician orders, dated 2/1/15, for Norco (pain reliever) 7.5/325 mg, one tablet, by mouth, four times daily, and orders for Miralax (for constipation) powder, 17 grams mixed with 8 ounces (oz.) of water or juice of choice, two times a day, every other day. The medications were scheduled for administration at 4:00 p.m. LPN #8 administered them to Resident N at 5:23 p.m. 6. The March 2015 MAR indicated Resident P was scheduled at 4:00 p.m. to receive Famotidine (for gastroesophageal reflux disorder) 20 mg, one tablet, by mouth, twice a day, as indicated by a physicians order. Resident P received the Famotidine, from LPN #8, at 5:30 p.m. 7. At 5:33 p.m., LPN #8 administered Sinemet (two tablets) to Resident Q. Physician orders, dated 1/28/15, indicated		**4) How the corrective actions will be monitored:** The results of these audits will be reviewed in the Quality Assurance meeting monthly for 6 months DON/Designee will be responsible for oversight of these audits. **5) Date of compliance: 4/1/2015**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155064	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 03/06/2015
NAME OF PROVIDER OR SUPPLIER APERION CARE KOKOMO		STREET ADDRESS, CITY, STATE, ZIP CODE 3518 S LAFOUNTAIN ST KOKOMO, IN 46902	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Sinemet (for paralysis agitans secondary to Parkinson's disease) 25/100 mg, two tablets, by mouth, four times a day. The medications was scheduled on the March 2015 MAR at 4:00 p.m. 8. Resident D had physician orders, dated 1/26/15, for Metoclopramide (anti-hypertensive) 10 mg, one tablet, by mouth, four times a day; Magnesium Oxide (antacid) 400 mg, one tablet, by mouth, two times a day; and Potassium Chloride (for potassium maintenance) 20 milliequivelents (meq), one tablet, by mouth, two times a day. The March 2015 MAR indicated administration was scheduled at 4:00 p.m. At 5:36 p.m., LPN #8 was observed administering the medications to Resident D. 9. Physician orders, dated 1/30/15, indicated Coreg (for congestive heart failure) 12.5 mg, one tablet, by mouth, two times a day, for Resident R. The medication was scheduled for administration at 4:00 p.m., on the March 2015 MAR. Resident R received the medication, from LPN #8, at 5:43 p.m. 10. Resident S had physician orders, dated 3/3/15, for Benzonatate (for congestive heart failure) 200 mg, one capsule, by mouth, three times a day and Spironolactone (for high blood pressure),			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155064	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 03/06/2015
NAME OF PROVIDER OR SUPPLIER APERION CARE KOKOMO		STREET ADDRESS, CITY, STATE, ZIP CODE 3518 S LAFOUNTAIN ST KOKOMO, IN 46902	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	give 12.5 mg, by mouth, three times a day. The March 2015 MAR indicated these medications were scheduled for administration at 3:00 p.m. Another physician order, dated 3/3/15, for Resident S, indicated Lasix (diuretic) 80 mg, one tablet, by mouth, two times a day. The MAR indicated a 4:00 p.m. administration time. During the medication pass observation, LPN #8 administered the Benzonatate, Spironolactone, and Lasix at 5:46 p.m., to Resident S. 11. At 5:54 p.m., LPN #8 was observed administering Torsemide to Resident T. The March 2015 MAR indicated it was scheduled for administration at 4:00 p.m. Physician orders, dated 1/29/15, indicated Torsemide (a diuretic) 20 mg, one tablet, by mouth, two times a day. During an interview, during the medication pass observations, LPN #8 indicated awareness of the delayed medication administrations. The very busy unit had only one nurse on the schedule, making time management difficult, at times. On 3/5/15 at 6:05 p.m., the DON indicated, during an interview, "We've been trying to alter medication pass times to make the best benefits the residents			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	155064		03/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE KOKOMO	3518 S LAFOUNTAIN ST KOKOMO, IN 46902

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	and to stay within the two hour time range [one hour before and one hour after the pass scheduled time]." The DON was aware of the untimely administration of medications. This Federal tag relates to Complaint #IN00166860. 3.1-48(c)(1)			
F 425 SS=E Bldg. 00	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. Based on observation, record reviews and interviews, the facility failed to maintain availability of medications for 4 of 5	F 425	**F425 Pharmaceutical Svc Accurate Procedures, RPH**	04/01/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155064	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 03/06/2015
NAME OF PROVIDER OR SUPPLIER APERION CARE KOKOMO		STREET ADDRESS, CITY, STATE, ZIP CODE 3518 S LAFOUNTAIN ST KOKOMO, IN 46902	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	residents reviewed for missed medications in a sample of 23. (Resident's D, K, R & Y) Findings include: 1. The clinical record for Resident D was reviewed on 3/5/15. Diagnoses for Resident D included, but were not limited to, high blood pressure, end stage renal disease, and venous embolism and thrombosis to (unspecified) lower extremity. Resident D had physician orders, dated 1/26/15, for Metoclopramide (anti-hypertensive) 10 mg, 1 tablet, by mouth, four times a day. The February 2015 MAR indicated the medication was not administered on 2/23/15. Nurses progress notes, dated 2/23/15 at 7:36 p.m., indicated the medication (metoclopramide) was unavailable. 2. Resident K's clinical record was reviewed on 3/6/15. Diagnoses for Resident K included, but were not limited to, schizophrenia, tremors, and allergies. A physicians order, dated 1/30/15, for Resident K, indicated Fluticasone Propionate Nasal Spray, 1 spray in both nostrils two times a day. The March 2015 MAR indicated the nasal spray was		The filing of this plan of correction does not constitute an admission that the alleged deficiency exists. This plan of correction is provided as evidence of the facility's desire to comply with the regulations and to continue to provide quality care. **1) Immediate actions taken for those residents identified:** Pharmacy was contacted for residents K, D, R, and Y and the medications that were not available were obtained. **2) How the facility identified other residents:** An audit was completed to identify any medications not available at the facility for disbursement. Any medications not available were obtained from the pharmacy.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155064	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 03/06/2015
NAME OF PROVIDER OR SUPPLIER APERION CARE KOKOMO		STREET ADDRESS, CITY, STATE, ZIP CODE 3518 S LAFOUNTAIN ST KOKOMO, IN 46902	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	scheduled at 8:00 a.m. and 4:00 p.m. During the medication administration pass observation on 3/5/15 at 4:25 p.m., QMA #7 did not administer the nasal spray and indicated there wasn't any to administer, the medication was not available at the facility. Nurses progress notes, dated 3/5/15 at 4:32 p.m. and 3/6/15 at 8:43 a.m., indicated the nasal spray was not available for administration. A physicians order, dated 1/30/15, indicated Benztropine Mesylate 0.5 mg, 1 tablet, by mouth, two times a day, for tremors. The March 2015 MAR indicated it was not administered on 3/6/15 at 8:00 a.m. Nurses progress notes, dated 3/6/15 at 8:45 a.m., indicated, "not available, pharm (pharmacy) notified." 3. Resident R's clinical record was reviewed on 3/6/15. Diagnoses for Resident R included, but were not limited to, high cholesterol, congestive heart failure, and diabetes. A physicians order, dated 1/29/15, indicated Pravastatin (to lower cholesterol) 40 mg, 1 by mouth, at bedtime. It was indicated as not administered on 3/2, 3/3, and 3/4/15 on		**3) Measures put into place/ System changes:** Nurses must immediately notify the DON of any unavailable or low quantity medications. The DON will then notify pharmacy to obtain said medication as to not allow the resident to miss a dose. We will also perform random medication availability audit on at least 5 residents per week to ensure medications are available and re-ordered timely. **4) How the corrective actions will be monitored:** The DON will run a report that shows any documented missed doses. This audit will be conducted 5 times weekly. The results of these audits will be reviewed in the quality assurance meeting monthly for 6 months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155064	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 03/06/2015
NAME OF PROVIDER OR SUPPLIER APERION CARE KOKOMO		STREET ADDRESS, CITY, STATE, ZIP CODE 3518 S LAFOUNTAIN ST KOKOMO, IN 46902	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	the March 2015 MAR. Nursing progress notes indicated the following: 3/2/15 at 8:02 p.m. "Unavailable, pharmacy notified." 3/3/15 at 7:31 p.m. "Unavailable, pharmacy notified." 3/4/15 at 7:55 p.m. "No medication available. Ordered from pharmacy." 4. Resident Y's clinical record was reviewed on 3/6/15. Diagnoses for Resident Y included, but were not limited to, congestive heart failure, diabetes, and generalized and localized pain. A physicians order, dated 2/13/15, indicated a neuropathic, compounded, topical cream to be applied, 1 to 2 pumps, to upper and lower back, bilateral knees and right shoulder, four times a day, for pain. The March 2015 MAR indicated it was not applied on 3/5/15 at 8:00 a.m., 12:00 p.m., and 4:00 p.m. Nursing progress notes indicated the following: 3/5/15 at 9:37 a.m. "Medication unavailable this shift." 3/5/15 at 12:02 p.m. "Not available, pharm [pharmacy] notified." 3/5/15 at 3:56 p.m. "Medication unavailable this shift." On 3/5/15 at 5:05 p.m., RN #9 indicated, during an interview, nurses were		**5) Date of compliance:** **4/1/2015**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155064	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 03/06/2015
NAME OF PROVIDER OR SUPPLIER APERION CARE KOKOMO		STREET ADDRESS, CITY, STATE, ZIP CODE 3518 S LAFOUNTAIN ST KOKOMO, IN 46902	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	expected to notify the pharmacy when a medication supply was low, or when the supply had 6 to 7 days left. QMA's were expected to notify the charge nurse when a medication supply was getting low. The nurse was expected to notify the pharmacy to ensure enough supply was available for administration. The DON indicated awareness of the unavailability of medications and missed doses, during an interview on 3/6/15 at 3:45 p.m. This Federal tag relates to Complaint #IN00166860. 3.1-25(a)			
F 456 SS=E Bldg. 00	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. Based on observations, record review and interviews, the facility failed to ensure transfer equipment was in safe, functional	F 456	**F456 Essential Equipment, Safe Operating Condition**	04/01/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155064	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 03/06/2015
NAME OF PROVIDER OR SUPPLIER APERION CARE KOKOMO		STREET ADDRESS, CITY, STATE, ZIP CODE 3518 S LAFOUNTAIN ST KOKOMO, IN 46902	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	condition, according to manufacturer's instructions for use for 3 of 3 Sara 3000 sit to stand lifts. This deficiency had the potential to affect 9 of 9 residents that used the Sara 3000 lift. Findings include: During a facility tour with the HFA and the DON, on 3/3/15 at 1:25 p.m., 3 sit to stand lifts (Sara Lift 3000) were noted with missing belt buckles to the knee support straps. 2 of 3 sit to stand lifts were missing one belt buckle. 1 of 3 sit to stand lifts was missing two belt buckles. The HFA indicated he was not aware of the missing belt buckles. He indicated a medical equipment professional was at the facility on 2/19/15 to review and assess equipment. The equipment professional deemed the lifts functional for use. During the tour observations, stickers were noted on 3 of 3 lifts. The stickers were dated 2/15 (February 2015). The HFA indicated, during a tour interview, the stickers indicated the lifts were functional for use, as they were put there by the equipment professional. Two Sara Lift 3000's were in use on the		The filing of this plan of correction does not constitute an admission that the alleged deficiency exists. This plan of correction is provided as evidence of the facility's desire to comply with the regulations and to continue to provide quality care. **1) Immediate actions taken for those residents identified:** The knee support straps were replaced on one of the Sara 3000 lifts. The other two lifts were removed from service. **2) How the facility identified other residents:** There are no other Sara 3000 lifts in the facility. **3) Measures put into place/ System changes:** A visual audit is conducted prior	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155064	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 03/06/2015
NAME OF PROVIDER OR SUPPLIER APERION CARE KOKOMO		STREET ADDRESS, CITY, STATE, ZIP CODE 3518 S LAFOUNTAIN ST KOKOMO, IN 46902	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	East hall. CNA #1 demonstrated the use of the Sara Lift 3000 sit to stand lift (actual residents were not involved with demonstration) on the East hall, on 3/3/15 at 1:40 p.m. CNA #1 indicated she used the knee support straps to secure resident's legs. However, she was not able to use the knee support straps on one of the lifts because the buckle clips (x2) were missing. She indicated there was only one working clip on the other lift used on the East hall. On the South Magnolia hall, on 3/3/15 at 2:00 p.m., during an interview, CNA #4 indicated there was one lift for use and demonstrated the use of the Sara Lift 3000 (actual residents were not involved with demonstration). CNA #4 stated, "First, you secure the resident's legs with the buckles." As she demonstrated, she indicated there was only one buckle clip, the other buckle was missing. She indicated she would not use that particular lift and would need to find a lift with 2 buckles clips in place, one strap/buckle for each leg. During an interview, on 3/3/15 at 2:10 p.m., LPN #2 indicated and confirmed the sit to stand lifts were used for 9 residents. (Residents B, C, D, E, F, G, H, I, & J)		to every transfer to ensure the knee straps are in place. Maintenance conducts a weekly audit to ensure the straps are present and in working condition. **4) How the corrective actions will be monitored:** These audits will be reviewed weekly by the Executive Director weekly x 4 weeks, bi monthly for 2 months and monthly for a total of 6 months **5) Date of compliance: 4/1/2015**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155064	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 03/06/2015
NAME OF PROVIDER OR SUPPLIER APERION CARE KOKOMO		STREET ADDRESS, CITY, STATE, ZIP CODE 3518 S LAFOUNTAIN ST KOKOMO, IN 46902	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	On 3/3/15 at 2:55 p.m., during an interview, the HFA indicated a former employee notified him about the poor condition of the mechanical lifts on 2/13/15. He (the HFA) notified a medical equipment company. The earliest a company professional could visit was 2/19/15. On 2/19/15, an equipment professional deemed all equipment useable and functional. An email correspondence confirming the equipment review was presented on 3/3/15 at 3:00 p.m., from the HFA. Contents of the email included a summary of each Sara 3000 lift, as follows: Control #FR13- ...Missing belt for knee support; needs replaced. Control #FR11- ...Missing belts for knee support; needs replaced. Control #FR16- ...Missing belts for knee support; needs replaced. On 3/4/15 at 11:44 a.m., CNA #1 and CNA #3 were observed using the Sara Lift 3000 to transfer Resident B to the toilet. The knee support straps were not used. CNA #1 and CNA #3 indicated the knee support straps did not have belt buckles and could not be used, properly. CNA #1 indicated as long as 2 nursing staff were attending the transfer, her understanding was it was ok to use the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155064	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 03/06/2015
NAME OF PROVIDER OR SUPPLIER APERION CARE KOKOMO		STREET ADDRESS, CITY, STATE, ZIP CODE 3518 S LAFOUNTAIN ST KOKOMO, IN 46902	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	lift. A phone interview was conducted on 3/4/15 at 3:37 p.m. with the medical equipment professional. He indicated he visited the facility to inspect equipment on 2/19/15. Additionally, he indicated he provided the facility with a summary of replacement and maintenance needs for each piece of equipment, including the need to replace the missing belt buckle clips for the knee support straps on the Sara 3000's. On 3/4/15 at 3:55 p.m., during an interview, the maintenance director indicated the medical equipment professional told him, the HFA, and the DON of the missing belt buckles on the lifts. This Federal tag relates to Complaint #IN00166860. 3.1-19(bb)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	155064		03/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE KOKOMO	3518 S LAFOUNTAIN ST KOKOMO, IN 46902

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 465 SS=F Bldg. 00	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFOR TABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observations and interviews, the facility failed to maintain clean transfer equipment (Sara 3000 Lift) for 3 of 3 sit to stand lifts observed for cleanliness and failed to maintain a safe, clean environment for residents, staff, and the public. This deficient practice had the potential to affect 54 of 54 residents residing in the facility. Findings include: During a facility tour on 3/3/15 at 2:00 p.m., with the DON, two Sara 3000 Lifts were noted on the East hall and one Sara 3000 Lift was noted on the South Magnolia hall. Each lift was noted with heavy dust, dirt and debris on the foot supports, base of chassis', chassis vertical masts, wheel castors, and legs. The DON indicated the three Sara 3000 Lifts were not clean. A request was made for an equipment cleaning schedule, including the Sara 3000 Lifts, on 3/3/15 at 3:00	F 465	**F465 Safe Functional Sanitary Comfortable Environment** The filing of this plan of correction does not constitute an admission that the alleged deficiency exists. This plan of correction is provided as evidence of the facility's desire to comply with the regulations and to continue to provide quality care. **1) Immediate actions taken for those residents identified:** The Sara 3000 lifts were cleaned. All the floors and cove base on the 100, 200, and 300 hall have been cleaned including areas around fire doors and the cove base.	04/01/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155064	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 03/06/2015
NAME OF PROVIDER OR SUPPLIER APERION CARE KOKOMO		STREET ADDRESS, CITY, STATE, ZIP CODE 3518 S LAFOUNTAIN ST KOKOMO, IN 46902	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	p.m. As of the exit date of 3/6/15, an equipment cleaning schedule was not presented. CNA #4, CNA #5 & CNA #6, indicated equipment was not cleaned on their shift. During interviews on 3/3/15 at 2:04 p.m., each CNA indicated if there was an equipment cleaning schedule, she was not aware of it. During a facility tour on 3/4/15 at 11:30 a.m., the following was observed: The floors on the 100 hall, 200 hall, and 300 hall were dirty and noted with build-up of dirt and debris on the cove boards. Brown splatters were observed on the lower wall in the Redbud hallway, near the dining room. Build up of debris and dirt was noted at fire doors. Chipped door frames were observed to rooms 104, 106, 108, 110, 115, 119, 121 and the activity room. The door entries to rooms 206, 208, 211, 305, 300, 302, 307, 304, 101 and 102 were dirty with dust and debris and notable mars and chips to the woodwork.		The walls on the Redbud hallway were all wiped down. The chipped door frames are continuing to be on the maintenance remodel schedule in place from the 1-13-15 plan of correction. The call light in room 106 was replaced. The bed remote in room 106 was replaced. **2) How the facility identified other residents:** All the lifts were cleaned. An audit was conducted on the call lights with any needing replaced done so. An audit was conducted on the bed remotes to ensure none had rough edges to them. Any that had sharp, broken edges or exposed wires were replaced or removed. **3) Measures put into place/ System changes:** A cleaning schedule was created for all the lifts in the facility and added to the staff's daily tasks.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155064	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 03/06/2015
NAME OF PROVIDER OR SUPPLIER APERION CARE KOKOMO		STREET ADDRESS, CITY, STATE, ZIP CODE 3518 S LAFOUNTAIN ST KOKOMO, IN 46902	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	The HFA indicated, during an interview and facility observations, on 3/4/15 at 12:50 p.m., awareness of the environmental cleanliness issues. He indicated renovations were in progress, but that did not have an impact on the cleanliness of the facility. On 3/6/15 at 1:25 p.m., during an observation and interview with the DON, in Room 106, the call light activator for bed B was noted without a plastic shell and broken edges. The bed remote had sharp, broken edges and exposed electrical wires. The DON indicated the call light activator and bed remote needed repaired or replaced. This Federal tag relates to Complaint #IN00166860. 3.1-19(f)		The Environmental Supervisor or designee will audit the facility for proper environmental standards 3 times weekly. The call light and be remotes will be audited on the environmental rounds. **4) How the corrective actions will be monitored:** The DON or Designee will monitor the lifts and the scheduled check offs to ensure this is being completed daily. This audit will be completed 3 x a week for 4 weeks, then 2 times a week for 2 months and then weekly for a total of 6 months. The ED or Designee will monitor the environmental rounds. This audit will be completed 3 x a week for 4 weeks, then 2 times a week for 2 months and then weekly for a total of 6 months. **5) Date of compliance: 4/1/2015**	