STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155064	A. BUILDING 00 B. WING	01/24/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00425889. Complaint IN00425889 - Federal/State deficiencies related to the allegations are cited at F550 and F602. Survey date: January 24, 2024 Facility number: 000025 Provider number: 155064 AIM number: 100274850 Census bed type: SNF/NF: 42 Total: 42 Census payor type: Medicare: 4 Medicaid: 29 Other: 9 Total: 42 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1. Quality review was completed on January 31, 2024.	F 0000		
F 0550 SS=D Bldg. 00	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.			

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

Jeff Attinger | RVP of Operations | 03/01/2024

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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.

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	§483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. Based on interview and record review, the facility failed to ensure residents were treated with respect and dignity from a staff member for 4 of 8 residents reviewed respect and dignity. (Residents F, D, E and B)	F 0550	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of*	02/15/2024

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	Findings include: 1. A facility document, titled "Concern/Compliment Form," dated 10/23/23, indicated, on 10/23/23, Resident F asked her roommate to turn on the call button for her at approximately 8:00 p.m. LPN 2 went into her room to ask what she wanted. The resident indicated she wanted a pain pill and LPN 2 responded with "I don't have time for that right now." The summary of pertinent findings indicated the resident received her pain medication, at 8:00 p.m., as routinely scheduled. 2. A facility document, titled "Concern/Compliment Form," dated 12/11/23, indicated, on 12/8/23, Resident D asked to go to the Harmony unit to take her shower. The CNA went to check for a shower chair. The resident waited at the Harmony nurses' station. LPN 2 indicated "I don't know why people can't stay on their own F***ing hallway." The resident went back to her room and took her shower on 12/9/23 instead. The summary of pertinent findings indicated the incident was partially substantiated. LPN 2 was spoken to and told this behavior was unacceptable and was not going to be tolerated. LPN 2 indicated she told Resident D she needed to take a shower on her hallway. She indicated to the resident the Harmony hallway had "a lot" of COVID residents on it at that time, so she should go back down to the Walnut hallway and request her shower be done there. The corrective actions taken indicated LPN 2 had to do customer service training on the computer and she was given a verbal warning, with the next step being a written warning. During an interview, on 1/24/24 at 2:45 p.m.,		*this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1)Immediate actions taken for those residents identified: Resident D and E no longer resides in the facility. Resident B was assessed for any negative psychosocial affects. LPN 2 is no longer employed by facility.** **2) How the facility identified other residents: All residents have the potential to be affected.** **3) Measures put into place/ System changes: All staff will be re-educated on, but not limited to, resident rights/exercise of rights. Moving forward, any allegation of abuse, including resident rights, will be reported to the ISDH and investigated by the facility.** **4) How the corrective actions will be monitored: SSD, or designee, will interview 5 residents to ensure no allegations of abuse or violation of resident rights have**	

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	Resident D indicated, on 12/8/23 at approximately 9 p.m., she asked her CNA if she could use the Harmony shower room to take a shower. She and the CNA went to the Harmony unit. The CNA went to get the shower chair and shower room ready, while the resident waited at the nurses' station. LPN 2 was standing at the medication cart in front of the nurses' station. LPN 2 indicated "I don't know why people can't stay on their own f***ing hallway." Then, LPN 2 started telling Resident D, she should not be on the Harmony hallway due to there was "a lot" of residents with COVID-19, she needed to go back to her own hallway, and request her shower on her hall. The walnut hallway did not have a shower room on it. The resident went back to her room and took her shower the next day. Resident D indicated she was disrespected by LPN 2 by the way she was spoken to. 3. A facility document, titled "Concern/Compliment Form," dated 12/15/23, indicated, on 12/14/23, Resident E woke up at 7:00 p.m., and had not received a room tray, so she went to the kitchen door to notify them. LPN 2 saw her at the kitchen door and yelled at her "with an attitude" indicating to her she could not be in that hallway. The resident indicated to the nurse, no one had been to her room, and she had not gotten dinner. LPN 2 indicated no one was supposed to be on that hallway (it was the COVID hallway at that time.) The summary of pertinent findings indicated the incident was partially substantiated. LPN 2 was spoken to regarding this incident, and she admitted to telling the resident she was not to be on the hallway because it was the COVID hallway. She denied yelling and being aggressive and indicated she spoke loudly. An unidentified kitchen worker had written a		**gone unreported weekly for 4 weeks, then 3 residents weekly for 4 weeks and then 4 residents monthly. Any allegations of any type of abuse will be reported to the Executive Director immediately. The results of these audits will be reviewed in Quality Assurance Meeting monthly. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.**	

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	statement, dated 12/15/23, which indicated while she was attempting to get what Resident E wanted to eat for dinner at the kitchen door, on 12/14/23, LPN 2 came around the corner and started "going off" asking the resident if she wanted COVID-19 again. LPN 2 told her if all the red signs and trash bags were not enough for her to see she was on the COVID hallway, then she was going to end up with COVID-19 again. 4. A document, titled "Indiana State Department of Health Survey Report System," dated 1/8/24, indicated Resident B reported LPN 2 used profanity while speaking to him. After the investigation, LPN 2 was terminated for violating company policy. a. A facility document, titled "Concern/Compliment Form," dated 11/8/23, indicated, on the evening of 11/7/23, Resident B asked LPN 2 to get him up into his wheelchair. She indicated "you're staying in bed." The resident indicated to the nurse he would call the police and the nurse indicated "Don't threaten me." The summary of pertinent findings indicated the incident was unsubstantiated. The corrective actions indicated LPN 2 was instructed to assist the resident up when the CNAs finished his personal care. b. A facility document, titled "Concern/Compliment Form," dated 1/9/24, indicated, on 1/8/24, Resident B turned on his call light for assistance at approximately 7:30 p.m. LPN 2 came into his room at approximately 9:45 p.m. He indicated he wanted to go outside to smoke. LPN 2 indicated to him "You need to Quit hitting that F***ing button. I have things to do. What do you want?" The summary of pertinent findings indicated the incident was substantiated. LPN 2			

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	used profanity towards the resident. LPN 2 already had "multiple complaints" alleged against her regarding her verbal aggression in the recent past. The corrective actions taken indicated she was terminated for misconduct. A facility document, titled "Human Resources Notice of Corrective Action," dated 12/22/23 and provided by the Executive Director (ED) on 1/24/24 at 2:55 p.m., indicated LPN 2 was given a final written warning due to at that time, she had multiple grievances regarding her yelling or speaking rudely to residents. Those residents were not comfortable with asking her for help. A typed statement by the Executive Director (ED), dated 1/12/24, indicated a phone conversation occurred between the ED and LPN 2. LPN 2 was notified she was terminated because she had "several complaints" regarding how she spoke and treated residents, in addition to the concern with Resident B. The ED indicated the Director of Nursing (DON) and the Human Resources Director (HRD) was in attendance during the phone call to LPN 2. A facility document, titled "Human Resources Notice of Corrective Action," dated 1/12/24 and provided by the Executive Director (ED) on 1/24/24 at 2:55 p.m., indicated LPN 2 was terminated due to a resident complained she used profanity and was yelling at him because he used his call light. She was on a final written warning and had been told not to get any other resident complaints against her regarding speaking negatively or yelling at them. She was terminated due to misconduct towards a resident. During a phone interview, on 1/24/24 at 1:19 p.m., LPN 2 indicated from 12/5/23 until the end of			

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	12/2023, Resident B complained about all the nursing staff daily. She wrote progress notes regarding his behavior and threats to get someone in trouble if he did not get to go smoke when it was below the allowed temperature for the residents to go outside and smoke. Resident D came towards the end of her hall, which had COVID-19 residents on it. She indicated to the resident she was not allowed to shower on the COVID-19 hallway. The resident reported her for telling her to get off the "F***ing" hallway. Resident E was walking in the COVID-19 hallway when she asked the resident to come and talk with her a minute. LPN 2 told the resident she could not be on the COVID-19 hallway, and she reported LPN 2 for yelling at her. She was terminated due to the "tone of my voice." A current policy, titled "Resident Rights," dated 1/4/19 and provided by the DON on 1/24/24 at 3:40 p.m., indicated "...Guidelines: Notice of resident rights will be provided upon admission to the facility. These rights include the resident's right to Exercise his or her rights...Exercising rights means that residents have autonomy and choice, to the maximum extent possible, about how they wish to live their everyday lives and receive care, subject to the facility's rules, as long as those rules do not violate a regulatory requirement...." A current facility handbook policy, dated 01/2023 and provided by the ED on 1/24/24 at 1:45 p.m., indicated "...Employee Conduct...it is important that you maintain the highest standards of conduct, courtesy and respect for the dignity of others at all times...Any concerns regarding employee conduct will be addressed through the Corrective Action process...each employee's conduct and performance will conform with the highest standards of professionalism and ethical			

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	practice, the requirements of their job...and applicable federal, state and local laws, rules and regulations...Violations of Aperion's standards of conduct may lead to corrective action, up to and including immediate termination. Violations of Conduct Standards That Constitute Grounds for Immediate Dismissal...Engaging in abusive, discourteous, profane, indecent or unprofessional language or conduct while on duty or on Aperion property...Threatening, intimidating or coercing patients...Violating any federal, state or local laws, rules or regulations applicable to Aperion or any of its programs...Violating any other policy or procedure of Aperion, whether or not set forth in this handbook...." This citation relates to Complaint IN00425889. 3.1-3(t)			
F 0602 SS=D Bldg. 00	483.12 Free from Misappropriation/Exploitation §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. Based on interview and record review, the facility failed to ensure a resident was free from theft, related to a staff member not returning her change after picking up food for her for 1 of 2 residents reviewed for misappropriation of property. (Residents C and K) Finding includes:	F 0602	**1) Immediate actions taken for those residents identified: Resident H has been reimbursed.** **2) How the facility identified other residents: All residents have the potential to be affected.** **3) Measures put into place/**	02/15/2024

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	1. A document, titled "Indiana State Department of Health Survey Report System," dated 11/13/23 and provided by the Executive Director (ED) on 1/24/24 at 11:59 a.m., indicated Resident C gave CNA 3 fifty dollars to purchase Taco Bell for her and the CNA did not return the resident's change. When the investigation was completed, it was determined CNA 3 was given fifteen dollars for the Taco Bell and ten dollars to go pick it up. After the investigation was completed, CNA 3 was terminated for violating the company policy. A facility document, titled "Concern/Compliment Form," dated 11/14/23 and provided by the ED on 1/24/24 at 11:59 a.m., indicated Resident C gave CNA 3 a total of $50. $20 to buy the food and $30 for gas for the CNA to pick up the food for the resident. The resident indicated she did not get any change and now she wanted her thirty dollars in change back. The summary of pertinent findings indicated the theft allegation was substantiated when CNA 3 admitted to taking Resident C's money. CNA 3 indicated Resident C gave her $25. The food cost $15 and she kept $10 for gas because the resident told her she could keep it. The corrective actions taken was CNA 3 was terminated for violating company policy on getting money from a resident. Resident C's $10 the CNA admitted to taking was reimbursed into her personal funds account. A facility handwritten statement by CNA 3, dated 11/13/23, indicated, on 11/13/23, Resident C gave her $25 to go get her Taco Bell and she was offered $10 in gas money to go get the food and she took it. She went to get the resident's food at approximately 7:30 p.m., and came back to work. A typed facility statement, dated 11/14/23, indicated the Executive Director (ED) spoke with		**System changes: All staff will be re-educated on, but not limited to, keeping residents free from misappropriation /exploitation.** **4) How the corrective actions will be monitored: SSD, or designee, will interview 5 residents to ensure no allegations of abuse have gone unreported weekly for 4 weeks, then 3 residents weekly for 4 weeks and then 4 residents monthly. Any allegations of any type of abuse will be reported to the Executive Director immediately. The results of these audits will be reviewed in Quality Assurance Meeting monthly. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.**	

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	CNA 3 regarding the grievance she received from Resident C, who indicated she had given the CNA $50 ($20 for food and $30 for gas). The resident was complaining she did not get her change back and wanted her $30. CNA 3 indicated she went to get Resident C's food at approximately 7:30 p.m. The resident gave her a total of $25, the food was $15, and she kept the $10 for gas because the resident offered it to her. During an interview, on 1/24/24 at 2:18 p.m., Resident C indicated she gave CNA 3 $46 to get her nachos and three tacos at Taco Bell. The CNA asked the resident if she could keep $10 for gas money and the resident agreed, but CNA 3 kept all the resident's change which was owed back to her. The facility was reimbursing the resident her $10 for the gas money she gave CNA 3. The resident indicated this incident was not the first time CNA 3 had asked her to keep money out for gas. On another occasion when the CNA went to get her food, she had asked the resident if she could keep $5 for gas money. She did not realize Taco Bell was basically across the street from the facility or she would not have let her keep the money for gas. A facility document, titled "Human Resources Notice of Corrective Action," dated 11/15/23, indicated CNA 3 was terminated. The rule or policy involved indicated CNA 3 admitted to keeping a resident's $10 for gas money. It was against company policy for any staff member to take any money from a resident. She violated company's policy, which resulted in termination. 2. A facility document, titled "Concern/Compliment Form," dated 11/14/23 and provided by the ED on 1/24/24 at 11:59 a.m., indicated Resident K did not get her sixty five			

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	cents back for change from a $1.50 candy bar and $1.85 drink. The summary of pertinent findings indicated the concerns were partially substantiated. The CNA (CNA 3) admitted the resident gave her $2 for the vending machine and the resident had fifteen cents in change left over, which the CNA placed in the resident's room. The corrective action taken was the CNA was educated and she was terminated on a different finding. A typed facility statement, dated 11/14/23, by the ED, indicated she had received a grievance regarding Resident K gave CNA 3 $4 to get her a candy bar, which cost $1.50 and a drink, which cost $1.85 and the CNA did not give the resident her sixty five cents in change back to her. During an interview, on 1/24/24 at 2:31 p.m., Resident K indicated she had given CNA 3 $4 to get her a candy bar and drink out of the vending machines and the CNA did not give her back her sixty five cents in change. A current facility handbook policy, dated 01/2023 and provided by the ED on 1/24/24 at 1:45 p.m., indicated "...Violations of Conduct Standards That Constitute Grounds for Immediate Dismissal...Violating any federal state or local laws, rules or regulations applicable to Aperion or any of its programs...Asking a resident for money or other gifts or approaching a resident with the intention of solicitating money or other gifts...." This citation relates to Complaint IN00425889. 3.1-28(a)			