STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	ЛLDING	00	COMPLETED	
		155064	B. W	ING		06/07/	/2021
				CTDEET	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	ROVIDER OR SUPPLIE	R			LAFOUNTAIN ST		
 ∧DEDI∩N	N CARE KOKOMO				MO, IN 46902		
AFERIO	V CARE ROROWO			KOKOK	WO, IN 40902		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F 0000							
Bldg. 00		7					
		Recertification and State	F 00)00	The facility requests paper		
		This visit included the			compliance for this citation.		
	Investigation of Co	omplaint IN00354306.			This Plan of Correction is the		
	G 1 : DI0025	4206 6 1 4 4 4 4			facility's credible allegation of		
		4306 - Substantiated.			compliance.		
		iencies related to the					
	allegations are cited	d at F921.			Preparation and/or execution		
	C 1-4 I	1 2 2 4 17 2021			this plan of correction does no	ot .	
	Survey dates: June	1, 2, 3, 4 and 7, 2021			constitute admission or		
	E:1:41 00	20025			agreement by the provider of t	the	
	Facility number: 000025 Provider number: 155064				truth of the facts alleged or		
	AIM number: 1002				conclusions set forth in the		
	Alivi liullibel. 1002	.74830			statement of deficiencies. The	9	
	Census Bed Type:				plan of correction is prepared		
	SNF/NF: 41				and/or executed solely because	se	
	Total: 41				it is required by the provisions	of	
	10141. 41				federal and state law.		
	Census Payor Type						
	Medicaid: 27	•					
	Other: 14						
	Total: 41						
	10441. 11						
	These deficiencies	reflect State Findings cited in					
	accordance with 41	_					
	Ouality review was	s completed on June 15, 2021.					
		•					
F 0692	483.25(g)(1)-(3)						
SS=D	Nutrition/Hydratio	n Status Maintenance					
Bldg. 00	§483.25(g) Assist	ed nutrition and hydration.					
	(Includes naso-ga	astric and gastrostomy					
	tubes, both percu	taneous endoscopic					
	gastrostomy and	percutaneous endoscopic					
	jejunostomy, and	enteral fluids). Based on a					
	resident's compre	hensive assessment, the					
	facility must ensu	re that a resident-					
I			ı		Î		I

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement 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.

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155064	· /	ILDING	nstruction <u>00</u>	(X3) DATE : COMPL 06/07/	ETED
	PROVIDER OR SUPPLIER			3518 S	NDDRESS, CITY, STATE, ZIP CODE LAFOUNTAIN ST MO, IN 46902		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	usual body weight range and electrol resident's clinical of this is not possible indicate otherwise §483.25(g)(2) Is of intake to maintain health; §483.25(g)(3) Is of when there is a numbealth care provided diet. Based on record reversarily failed to respond the indicate of the reviewed for nutrition of the indicate of the reviewed for nutrition of the indicate of the record for Resident failed to the reviewed for nutrition of the record for Resident failed to the indicate of the record for Resident failed to the indicate of the resident had the a. On 4/2/21, weigh b. On 4/7/21, weigh 10.71% weight gain c. On 5/2/21, weigh 7.39% weight loss in the resident has in the indicate of the indicate of the resident had the indicate of the indicate	or desirable body weight yet balance, unless the condition demonstrates that or resident preferences; ffered sufficient fluid proper hydration and ffered a therapeutic diet attritional problem and the er orders a therapeutic diew and interview, the weigh a resident for a weight gain and a potential loss for 1 of 2 residents on (Resident 41). dent 41 was reviewed on Diagnoses included, but were eimer's with late onset, type 2 age 3 chronic kidney disease ency. et following weights: ed 155 pounds. ed 171.6 pounds which was a in 5 days. ed 173.3 pounds. ed 160.5 pounds which was a	F 06	592	F 692 G Nutrition Hydration St Maintenance The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of 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 federal and state law.	of t the	06/30/2021

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Event ID:

4GXF11

Facility ID: 000025

If continuation sheet

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STATEMEN	TEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SUF				SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPLI	ETED
		155064	B. W	NG		06/07/	2021
				CEDELET	ADDRESS OF A STATE OF CODE		
NAME OF I	PROVIDER OR SUPPLIER	t			ADDRESS, CITY, STATE, ZIP CODE		
					LAFOUNTAIN ST		
APERIO	N CARE KOKOMO			KOKON	лО, IN 46902		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	DROWIDERS BY AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	15	DATE
	re-weight on 5/5/21				1) Immediate actions taken for	-	
					those residents identified:		
	A nutrition progress	s note, dated 5/4/21, indicated			Resident # 41 discharged fron	ı	
		t on 5/2/21 was 173.3 pounds			the facility. Therefore, no		
	_	f 11.8% in 30 days and			corrective action could be take	en	
	_	ant weight gain for 30 days.			for this resident.		
	The resident ate whatever she could find and may						
	be related to weight gain. She did not recommend				2)How the facility identified oth	ner	
	a re-weight.				residents:		
					Current residents' records wer	e l	
	During an interview, on 6/4/21 at 3:46 p.m., the				reviewed for current weight los	ss or	
	DON indicated the resident was not re-weighed				gain. Notified physician,		
	when her weight had shown a significant gain and				registered dietician and		
	not re-weighed when her weight showed a				responsible parties regarding	any	
	significant loss. The DON had talked to the				identified significant		
	_	determined all the weights			weight loss/gain. Dietary orde	rs	
	between 4/7/21 and	5/2/21 were not accurate and			and care plans were reviewed	and	
	had them crossed or	ut on the electronic record on			updated. RD requested to		
	6/3/21.				assess residents identified to I	nave	
					had any significant weight		
	A current policy, tit	led "Weights," dated as			loss/gain, progress notes were	•	
	revised on 10/17/19	and received from the DON			completed, and recommendat	ions	
	on 6/4/21 at 4:16 p.	m., indicated "Re-weight			made, as appropriate.		
	should be obtained	if there is a difference of 5#					
	or greater [loss or g	ain] since previous recorded			3) Measures put into place/		
	weightRe-weight	should be taken as soon as			System changes:		
	possible after an un	anticipated weight change is			Licensed Nursing staff were		
	noted and prior to c	alling the physician. [Usually			educated relative to		
	within 72 hours]E	Efforts should be made to			Nutrition/Hydration Status		
	obtain all weights a	nd re-weights by the 10th of			Maintenance, including but no	t	
	the monthUndesing	ed or unanticipated weight			limited to, weighing/ re-weighi	ng	
	gains/loss of 5% in	30 days, 7.5% in three			residents and documentation		
	months, or 10% in s	six months shall be reported			requirements by 6/29/21.		
	to the physician, Di	etician and/or Dietary			Weights will be reviewed during	ıg 📗	
	Manager as appropr	riate"			daily, scheduled stand up		
					meetings. Any identified		
	3.1-46(a)(1)				concerns will be addressed.		
					New admission audits will be		
					conducted post admission to		
					ensure accurate weights have		

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Facility ID: 000025

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PRINTED: 07/06/2021 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER: 155064	A. BUILDING B. WING	<u>00</u>	COMPLETED 06/07/2021
	ROVIDER OR SUPPLIER	t.	3518 S	ADDRESS, CITY, STATE, ZIP CODE LAFOUNTAIN ST MO, IN 46902	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				been obtained and documented correctly. The Registered Diet will meet with the DNS/designathe end of each facility visit to review nutritional recommendations with specific attention made to significant weight loss/gain. Routine order consist of weekly weights time weeks upon admission, then monthly thereafter unless otherwise indicated. Identification of significant weight changes where the physician is registered dietician and responsible parties. Care plans will be updated to reflect new interventions Weights and care plans will be reviewed duscheduled weekly Comprehent Clinical Review meeting. 4) How the corrective actions where the facility Administrator who will review with the Director of Nursing and Dietary Manager audits that are conducted three times weekly ensure weights have been obtained, documented and notifications made timely. Weight will be reviewed daily during clinical stand up meeting and weekly during Comprehensive Clinical Review Meeting. The results of these audits will be reviewed in Quality Assurance.	itian ee at crs is 4 is itian et d ring ition will ction co to ghts

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

4GXF11

Facility ID: 000025

If continuation sheet

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		155064	B. WI	NG		06/07/	2021
				CTDEET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER						
ADEDION	LOADE KOKOMO				LAFOUNTAIN ST		
APERION	I CARE KOKOMO			KUKUN	MO, IN 46902		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCE	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
					Meeting monthly for 6 months	or	
					until 100% compliance is		
					achieved x3 consecutive mont	hs.	
					The QA Committee will identify		
					any trends or patterns and ma		
					recommendations to revise the		
					plan of correction as indicated	•	
					pian or correction as indicated		
					5) Date of Compliance: 6/30/2	21	
F 0921	483.90(i)						
SS=D		anitary/Comfortable					
Bldg. 00	Environ						
§483.90(i) Other Environmental Conditions							
	The facility must provide a safe, functional,						
	sanitary, and comf	fortable environment for					
	residents, staff and	d the public.					
		on and interview, the facility	F 09	921	F921 Envirnomental		06/30/2021
	failed to ensure toile	ets were hazard free in 5 of					
		14, 115, 117, 123 and 127)			The facility requests paper		
	and warm water was	s available in 2 of 7 rooms			compliance for this citation.		
	(Rooms 122 and 203	5) reviewed for environment.					
					This Plan of Correction is the		
	Findings include:				center's credible allegation of		
					compliance.		
		ervations with Maintenance					
	Director on 6/1/21 a	t 12:30 p.m., the following			Preparation and/or execution of	of .	
	were observed:				this plan of correction does no		
	a. Room 114 had bo	lts sticking up from the floor			constitute admission or	•	
	through the toilet ap	proximately 3 inches.				ho	
	b. Room 115 had bo	olts sticking up from the floor			agreement by the provider of t	i i C	
	through the toilet ov	~ .			truth of the facts alleged or		
	•	olts sticking up from the floor			conclusions set forth in the		
	through the toilet 2-				statement of deficiencies. The	;	
	-	olts sticking up from the floor			plan of correction is prepared		
	through the toilet 4-				and/or executed solely becaus	e	
	-	lts sticking up from the floor			it is required by the provisions	of	
	through the toilet ov				federal and state law.		
	anough the tollet ov	or i mon.					
	During an interview	y, on 6/1/21 at 1:41 p.m., the			1) Immediate actions taken for	•	
	Dailing an interview	, on o/ 1/21 at 1.71 p.m., the	1		l ′		

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Event ID:

4GXF11 Facility ID: 000025

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPLETE	ED.
		155064	B. W	NG		06/07/202	21
		l .		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	R			LAFOUNTAIN ST		
ADEDION	LCARE KOKOMO						
APERIOR	N CARE KOKOMO			KUKUK	MO, IN 46902		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE CO	OMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	ED (Executive Dire	ector) indicated the facility			those residents identified:		
	did not have a polic	y pertaining to the bolts in the					
	bathrooms.				No resident was identified to h	ave	
					been affected		
	During an observati	ion, on 6/1/21 at 1:22 p.m.,					
	the Maintenance Di	rector took the temperature					
	of the bathroom wa	ter in Room 112 and it only			2) How the facility identified o	ther	
	reached 90 degrees.				resident:		
		ion, on 6/2/21 at 2:42 p.m.,			Any resident had the potential		
	the Maintenance Director attempted to take the				be affected residing in the faci	lity	
	_	water in the sink of Room			however none were identified.		
	205 and the water d	lid not warm up and only					
	trickled out of the fa	aucet.					
					3) Measures put into place/		
	_	v, on 6/1/21 at 12:35 p.m., the			System changes:		
		tor indicated the staff began					
	complaining the we	ek prior about the lack of hot			The toilet risers were cut dowr		
	water.				rooms 114, 115, 117, 123, and	d	
					127.		
	_	v, on 6/2/21 at 2:45 p.m., the					
		tor indicated the faucet in			A mixing valve was installed o		
	_	gged and would have to be			June 8, 2021 and rooms 122 a	and	
	replaced.				205 have hot water.		
					 . 		
		tled "Maintenance," undated			Maintenance Director and		
		Director of Nursing on 6/7/21			Department Heads through Ar	-	
	_	ted "regular environmental			rounds will make rounds (5 tim		
	tours/safety audits t	•			weekly) of all rooms and comr	non	
		r is at the appropriate			areas and report any needed		
	temperature"				repairs Staff was re-educated		
					the maintenance request form	s by	
	This Federal tag rel	ates to Complaint			6/29/21, to be checked by the	_	
	IN00354306				Maintenance Director/designe		
	2.1.10(0(5)				and prioritized with the Execut	ive	
	3.1-19(f)(5)				Director during daily stand up		
					meeting. Repairs are made		
					based on this prioritization.		
					The Maintenance Director will		
					record/ log when repairs are		

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Event ID:

4GXF11

Facility ID: 000025

If continuation sheet

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI	LTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	ETED
		155064	B. WIN	G		06/07/	2021
			Ь,				
NAME OF F	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE		
4050101					LAFOUNTAIN ST		
APERIO	N CARE KOKOMO			KOKON	1O, IN 46902		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	P	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	·-	DATE
					completed, and the		
					Administrator/designee will rev	view	
					logs weekly.		
					4) How the corrective actions	will	
					be monitored:		
					Maintenance Director will audi	_	
					times weekly to determine fac	ility	
					needed repairs are		
					being identified, addressed tim	nely	
					and placed on a preventative		
					maintenance program as		
					necessary,		
					Management team while	, da	
					completing routine facility rour will observe for areas that nee		
					repair and report areas on the		
					Angel Round Forms for review		
					during stand-up meetings Rep		
					will be logged when completed		
					Log book will reviewed weekly		
					administrator with DON oversi	-	
					The results of these audits wil	-	
					reviewed in Quality Assurance		
					Meeting monthly for 6 months		
					until 100% compliance is		
					achieved x3 consecutive mon	th	
					-		
					5) Date of compliance: 6/30/2	:1	
					,		
F 0924	483.90(i)(3)						
SS=D	Corridors have Fi	rmly Secured Handrails					
Bldg. 00	§483.90(i)(3) Equ	ip corridors with firmly					
	secured handrails	s on each side.					
		on and interview, the facility	F 092	24	F924 Corridors have Firmly		06/30/2021
	failed to ensure the	handrails were secured to the			Secured Handrails		
	side of the corridor	s in 3 of 3 locations reviewed					
	for secure handrails	S.			The facility requests paper		

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Event ID:

4GXF11

Facility ID: 000025

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	(3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPLE	ETED	
		155064	B. W	NG		06/07/2	2021	
				CTREET	ADDRESS SITE STATE SID CODE			
NAME OF P	ROVIDER OR SUPPLIER	3			ADDRESS, CITY, STATE, ZIP CODE			
4555101					LAFOUNTAIN ST			
APERION	N CARE KOKOMO			KOKON	ЛО, IN 46902			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TC	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
					compliance for this citation.			
	Findings include:							
	_				This Plan of Correction is the			
	During an observati	ion, on 06/01/21 at 12:30			center's credible allegation of			
	p.m., the following were observed:				compliance.			
	a. The handrails nex	xt to the Executive Director's			, ,			
	(ED) office were se	parated from the wall			Preparation and/or execution of	of		
	exposing the bolt. b. The handrails in the dining room, off the Walnut Hall, were loose and the handrails could be pulled away from the wall.				this plan of correction does no			
					constitute admission or			
					agreement by the provider of t	the		
					truth of the facts alleged or			
	c. The handrails between rooms 109 and 111				conclusions set forth in the			
	were loose.				statement of deficiencies. The	_		
					plan of correction is prepared	´		
	During an interview, on 06/01/21 at 12:57 p.m.,				and/or executed solely because	.		
		sekeeping indicated she			it is required by the provisions			
	would notify mainte	enance of the loose rails.			federal and state law.	01		
					l lederal and state law.			
		v, on 06/01/21 at 1:41 p.m.,			1) Immediate actions taken for	_		
		ne was also aware of the			those residents identified:			
	handrails coming lo	pose from the walls.			those residents identified.			
					No resident was identified to h	121/6		
		tled "Maintenance," undated			been affected	lave		
		Director of Nursing (DON)						
		m., indicated "Purpose: To						
	to identify areas of	vironmental tour/safety audits			2) How the facility identified o	ther		
	•	ails present and in working			resident:			
		ry: Rounds conducted must be						
		ned and dated. The results			Any resident had the potential	to		
		zed and discussed on a			be affected residing in the faci			
		uality Assurance Meeting and			however none were identified.	, ,		
	on an as needed bas	-						
	on an as needed bas							
	3.1-19(f)(3)				3) Measures put into place/			
	- (-)(-)				System changes:			
					All handrails in the facility were	e		
					checked and tightened on Jun	e 8,		
					2021.			
			1					

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Event ID:

4GXF11

Facility ID: 000025

If continuation sheet

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PRINTED: 07/06/2021 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155064 NAME OF PROVIDER OR SUPPLIER APERION CARE KOKOMO IDENTIFICATION NUMBER: 155064 STREET ADDRESS, CITY, STATE, ZIP CODE 3518 S LAFOUNTAIN ST KOKOMO, IN 46902 ID PROVIDER SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Maintenance Director and Department Heads through Angel rounds will make rounds (5 times weekly) of all rooms and common areas and report any needed repairs. Staff was re-educated on	STATEMENT C	OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
NAME OF PROVIDER OR SUPPLIER APERION CARE KOKOMO STREET ADDRESS, CITY, STATE, ZIP CODE 3518 S LAFOUNTAIN ST KOKOMO, IN 46902 (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) Maintenance Director and Department Heads through Angel rounds will make rounds (5 times weekly) of all rooms and common areas and report any needed	AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
NAME OF PROVIDER OR SUPPLIER APERION CARE KOKOMO (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) Maintenance Director and Department Heads through Angel rounds will make rounds (5 times weekly) of all rooms and common areas and report any needed STREET ADDRESS, CITY, STATE, ZIP CODE 3518 S LAFOUNTAIN ST KOKOMO, IN 46902 (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Maintenance Director and Department Heads through Angel rounds will make rounds (5 times weekly) of all rooms and common areas and report any needed			155064	B. W	ING		06/07/	2021
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Department Heads through Angel rounds will make rounds (5 times weekly) of all rooms and common areas and report any needed	TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
the maintenance request forms by 6/29/21, to be checked by the Maintenance Director/designee and prioritized with the Executive Director during daily stand up meeting. Repairs are made based on this prioritization. The Maintenance Director will record/ log when repairs are completed, and the Administrator/designee will review logs weekly. 4) How the corrective actions will be monitored: Maintenance Director will audit 3 times weekly to determine facility needed repairs are being identified, addressed timely and placed on a preventative maintenance program as necessary. Management team while completing routine facility rounds will observe for areas that need repair and report areas on their Angel Round Forms for review during stand-up meetings Repairs will be logged when completed.						Department Heads through Arrounds will make rounds (5 tin weekly) of all rooms and commareas and report any needed repairs. Staff was re-educated the maintenance request form 6/29/21, to be checked by the Maintenance Director/designer and prioritized with the Execut Director during daily stand up meeting. Repairs are made based on this prioritization. The Maintenance Director will record/ log when repairs are completed, and the Administrator/designee will revolute logs weekly. 4) How the corrective actions be monitored: Maintenance Director will auditimes weekly to determine factorized repairs are being identified, addressed tin and placed on a preventative maintenance program as necessary, Management team while completing routine facility rour will observe for areas that need repair and report areas on the Angel Round Forms for review during stand-up meetings Report areas Report areas on the Angel Round Forms for review during stand-up meetings Report areas Repo	nes mon don s by lee tive will lit 3 ility mely led ir words ed ir	

FORM CMS-2567(02-99) Previous Versions Obsolete

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	VT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155064	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 06/07/2021		
NAME OF PROVIDER OR SUPPLIER APERION CARE KOKOMO (VALID SUMMARY STATEMENT OF DEFICIENCIES				STREET ADDRESS, CITY, STATE, ZIP CODE 3518 S LAFOUNTAIN ST KOKOMO, IN 46902				
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mo	REGUENTORT OR	ESC IDENTIFY THAT HAVE AN ORGANITION	174	O .	The results of these audits will reviewed in Quality Assurance Meeting monthly for 6 months until 100% compliance is achieved x3 consecutive mont 5) Date of compliance: 6/30/2	or h	BAIL	

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 4GXF11 Facility ID: 000025 If continuation sheet Page 10 of 10