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	06/07/2021

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 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00354306. Complaint IN00354306 - Substantiated. Federal/State deficiencies related to the allegations are cited at F921. Survey dates: June 1, 2, 3, 4 and 7, 2021 Facility number: 000025 Provider number: 155064 AIM number: 100274850 Census Bed Type: SNF/NF: 41 Total: 41 Census Payor Type: Medicaid: 27 Other: 14 Total: 41 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review was completed on June 15, 2021.	F 0000	**The facility requests paper compliance for this citation.** *This Plan of Correction is the facility'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 of federal and state law.*	
F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident-			

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.

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	§483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet.			
	Based on record review and interview, the facility failed to re-weigh a resident for a potential significant weight gain and a potential significant weight loss for 1 of 2 residents reviewed for nutrition (Resident 41). Finding includes: The record for Resident 41 was reviewed on 6/3/21 at 4:22 p.m. Diagnoses included, but were not limited to, Alzheimer's with late onset, type 2 diabetes mellitus, stage 3 chronic kidney disease and vitamin d deficiency. The resident had the following weights: a. On 4/2/21, weighed 155 pounds. b. On 4/7/21, weighed 171.6 pounds which was a 10.71% weight gain in 5 days. c. On 5/2/21, weighed 173.3 pounds. d. On 5/5/21, weighed 160.5 pounds which was a 7.39% weight loss in 3 days. There was no re-weight on 4/7/21 and no	F 0692	F 692 G Nutrition Hydration Status 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 of federal and state law.*	06/30/2021

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	re-weight on 5/5/21. A nutrition progress note, dated 5/4/21, indicated the residents weight on 5/2/21 was 173.3 pounds which was a gain of 11.8% in 30 days and triggered a significant weight gain for 30 days. The resident ate whatever she could find and may be related to weight gain. She did not recommend a re-weight. During an interview, on 6/4/21 at 3:46 p.m., the DON indicated the resident was not re-weighed when her weight had shown a significant gain and not re-weighed when her weight showed a significant loss. The DON had talked to the physician and they determined all the weights between 4/7/21 and 5/2/21 were not accurate and had them crossed out on the electronic record on 6/3/21. A current policy, titled "Weights," dated as revised on 10/17/19 and received from the DON on 6/4/21 at 4:16 p.m., indicated "...Re-weight should be obtained if there is a difference of 5# or greater [loss or gain] since previous recorded weight...Re-weight should be taken as soon as possible after an unanticipated weight change is noted and prior to calling the physician. [Usually within 72 hours]...Efforts should be made to obtain all weights and re-weights by the 10th of the month...Undesired or unanticipated weight gains/loss of 5% in 30 days, 7.5% in three months, or 10% in six months shall be reported to the physician, Dietician and/or Dietary Manager as appropriate...." 3.1-46(a)(1)		1) Immediate actions taken for those residents identified: Resident # 41 discharged from the facility. Therefore, no corrective action could be taken for this resident. 2)How the facility identified other residents: Current residents' records were reviewed for current weight loss or gain. Notified physician, registered dietician and responsible parties regarding any identified significant weight loss/gain. Dietary orders and care plans were reviewed and updated. RD requested to assess residents identified to have had any significant weight loss/gain, progress notes were completed, and recommendations made, as appropriate. 3) Measures put into place/ System changes: Licensed Nursing staff were educated relative to Nutrition/Hydration Status Maintenance, including but not limited to, weighing/ re-weighing residents and documentation requirements by 6/29/21. Weights will be reviewed during daily, scheduled stand up meetings. Any identified concerns will be addressed. New admission audits will be conducted post admission to ensure accurate weights have	

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			been obtained and documented correctly. The Registered Dietitian will meet with the DNS/designee at the end of each facility visit to review nutritional recommendations with specific attention made to significant weight loss/gain. Routine orders consist of weekly weights times 4 weeks upon admission, then monthly thereafter unless otherwise indicated. Identification of significant weight changes will be reported timely and documented notification to the physician, registered dietician and responsible parties. Care plans will be updated to reflect new interventions Weights and care plans will be reviewed during scheduled weekly Comprehensive Clinical Review meeting. 4) How the corrective actions will be monitored: Oversight of this plan of correction is the facility Administrator who will review with the Director of Nursing and Dietary Manager audits that are conducted three times weekly to ensure weights have been obtained, documented and notifications made timely. Weights 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	

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			Meeting monthly for 6 months or until 100% compliance 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 5) Date of Compliance: 6/30/21	
F 0921 SS=D Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.			
	Based on observation and interview, the facility failed to ensure toilets were hazard free in 5 of 12 rooms (Rooms 114, 115, 117, 123 and 127) and warm water was available in 2 of 7 rooms (Rooms 122 and 205) reviewed for environment. Findings include: During ongoing observations with Maintenance Director on 6/1/21 at 12:30 p.m., the following were observed: a. Room 114 had bolts sticking up from the floor through the toilet approximately 3 inches. b. Room 115 had bolts sticking up from the floor through the toilet over 1 inch. c. Room 117 had bolts sticking up from the floor through the toilet 2-3 inches. d. Room 123 had bolts sticking up from the floor through the toilet 4-5 inches. e. Room 127 had bolts sticking up from the floor through the toilet over 1 inch. During an interview, on 6/1/21 at 1:41 p.m., the	F 0921	F921 Envirnomental 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 of federal and state law.* 1) Immediate actions taken for	06/30/2021

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	ED (Executive Director) indicated the facility did not have a policy pertaining to the bolts in the bathrooms. During an observation, on 6/1/21 at 1:22 p.m., the Maintenance Director took the temperature of the bathroom water in Room 112 and it only reached 90 degrees. During an observation, on 6/2/21 at 2:42 p.m., the Maintenance Director attempted to take the temperature of the water in the sink of Room 205 and the water did not warm up and only trickled out of the faucet. During an interview, on 6/1/21 at 12:35 p.m., the Maintenance Director indicated the staff began complaining the week prior about the lack of hot water. During an interview, on 6/2/21 at 2:45 p.m., the Maintenance Director indicated the faucet in Room 205 was clogged and would have to be replaced. A facility policy, titled "Maintenance," undated and received from Director of Nursing on 6/7/21 at 3:00 p.m., indicated "...regular environmental tours/safety audits to identify areas of concern...The water is at the appropriate temperature...." This Federal tag relates to Complaint IN00354306 3.1-19(f)(5)		those residents identified: No resident was identified to have been affected 2) How the facility identified other resident: Any resident had the potential to be affected residing in the facility however none were identified. 3) Measures put into place/ System changes: The toilet risers were cut down in rooms 114, 115, 117, 123, and 127. A mixing valve was installed on June 8, 2021 and rooms 122 and 205 have hot water. 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 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	

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			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. Log book will reviewed weekly by administrator with DON oversight. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive month 5) Date of compliance: 6/30/21	
F 0924 SS=D Bldg. 00	483.90(i)(3) Corridors have Firmly Secured Handrails §483.90(i)(3) Equip corridors with firmly secured handrails on each side. Based on observation and interview, the facility failed to ensure the handrails were secured to the side of the corridors in 3 of 3 locations reviewed for secure handrails.	F 0924	F924 Corridors have Firmly Secured Handrails The facility requests paper	06/30/2021

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	Findings include: During an observation, on 06/01/21 at 12:30 p.m., the following were observed: a. The handrails next to the Executive Director's (ED) office were separated from the wall 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. c. The handrails between rooms 109 and 111 were loose. During an interview, on 06/01/21 at 12:57 p.m., the Director of Housekeeping indicated she would notify maintenance of the loose rails. During an interview, on 06/01/21 at 1:41 p.m., the ED indicated she was also aware of the handrails coming loose from the walls. A current policy, titled "Maintenance," undated and received from Director of Nursing (DON) on 6/7/21 at 3:00 p.m., indicated "...Purpose: To conduct regular environmental tour/safety audits to identify areas of concern within the facility...Are handrails present and in working condition...Summary: Rounds conducted must be kept in writing, signed and dated. The results should be summarized and discussed on a monthly basis at Quality Assurance Meeting and on an as needed basis...." 3.1-19(f)(3)		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 of federal and state law.* 1) Immediate actions taken for those residents identified: No resident was identified to have been affected 2) How the facility identified other resident: Any resident had the potential to be affected residing in the facility however none were identified. 3) Measures put into place/ System changes: All handrails in the facility were checked and tightened on June 8, 2021.	

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			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 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. Log book will reviewed weekly by administrator with DON oversight.	

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			The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive month 5) Date of compliance: 6/30/21	