STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155064	A. BUILDING -- B. WING	07/01/2021

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
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 07/01/21 Facility Number: 000025 Provider Number: 155064 AIM Number: 100274850 At this Emergency Preparedness survey, Aperion Care Kokomo was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 105 certified beds. At the time of the survey, the census was 41. Quality Review completed on 07/08/21	E 0000	*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.*	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 07/01/21 Facility Number: 000025 Provider Number: 155064 AIM Number: 100274850 At this Life Safety Code survey, Aperion Care Kokomo was found not in compliance with	K 0000	*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*	

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

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	Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type II (111) construction and fully sprinkled. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors and battery powered smoke detectors in all resident sleeping rooms. The facility has a capacity of 105 and had a census of 41 at the time of this visit. All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered. Quality Review completed on 07/08/21		*required by the provisions of federal and state law.*	
K 0291 SS=C Bldg. 01	NFPA 101 Emergency Lighting Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 Based on observation and interview, the facility failed to ensure 1 of 2 battery backup lights was tested monthly for 30 seconds and annually for 90 minutes over the past year to ensure the light would provide lighting during periods of power outages and a written record of visual inspections and tests was provided. LSC 19.2.9.1 requires emergency lighting shall be provided in accordance with Section 7.9. Section 7.9.3.1.1 (1) requires functional testing shall be conducted monthly, with a minimum of 3 weeks and a	K 0291	K 291 1. Immediate actions taken for those residents identified: No residents were directly affected.2. All residents, visitors and staff could be affected. However, no one was affected.3. Measures put into place / system changes: Maintenance director / designee will begin using the Tels log system to emergency lights	07/23/2021

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	maximum of 5 weeks between tests, for not less than 30 seconds, (3) Functional testing shall be conducted annually for a minimum of 1 1/2 hours if the emergency lighting system is battery powered and (5) Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all residents in the facility. Findings include: Based on record review on 07/01/21 at 12:00 p.m. with the Maintenance Supervisor (MS), the Battery Backup Light Test Log for 2020 to 2021 indicated only the battery powered light in the Mechanical room was tested and the one adjacent to the generator was neglected. Based on an interview at the time of record review, the MS indicated the battery powered light in the Mechanical room was inspected and tested monthly and annually, but said he forgot to check the one next to the generator. This was reviewed with the Administrator during the exit conference. 3.1-19(b)		testing. Additionally, the maintenance director completed the emergency light test on July 9, 2021.4. How the corrective actions will be monitored: Maintenance director shall log all of his activities daily in Tels. Administrator/designee shall check Tels weekly to ensure maintenance director's tasks are completed timely. This audit will be conducted weekly and reported in the QAA meeting for 6 months and quarterly thereafter. ="" p="">	
K 0293 SS=E Bldg. 01	NFPA 101 Exit Signage Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) Based on record review and interview; the facility	K 0293	K 293	07/23/2021

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	failed to install exit signage in 1 of 5 corridors in accordance with LSC 7.10. LSC 7.10.1.2.1 exits, other than main exterior exit doors that obviously and clearly are identifiable as exits, shall be marked by an approved sign that is readily visible from any direction of exit access. LSC 7.10.1.2.2 states horizontal components of the egress path within an exit enclosure shall be marked by approved exit or directional exit signs where the continuation of the egress path is not obvious. This deficient practice could affect at least 25 residents, visitors and staff. Findings include: Based on observation on 07/01/21 at 1:50 p.m. with the Maintenance Supervisor (MS), outside exit next to the O2 transfilling room on Harmony hall, the path to the public way was not obvious. To the left leads to an entrance back into the facility, and to the right leads to the public way and without signage showing direction the path of travel to the public way would not be known. Based on interview at the time of observation, the MS agreed an exit sign showing direction was needed. This finding was discussed with the Interim Administrator and MS during the exit conference. 3.1-19(b)		1. Immediate actions taken for those residents identified: No residents were directly affected. 2. All residents, visitors and staff could be affected. However, no one was affected. 3. Measures put into place / system changes: Maintenance director / designee will begin using the Tels log system to log exit sign inspections. Additionally, the maintenance director hung an exit sign that was needed on 7/9/21. 4. How the corrective actions will be monitored: Maintenance director shall log all of his activities daily in Tels. Administrator/designee shall check Tels weekly to ensure maintenance director's tasks are completed timely. This audit will be conducted weekly and reported in the QAA meeting for 6 months and quarterly thereafter. Date of Compliance: 7/23/21	
K 0324 SS=E Bldg. 01	NFPA 101 Cooking Facilities Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates,			

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	toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2			
	1. Based on observation and interview, the facility failed to ensure staff were instructed in the use of the UL 300 hood system in 1 of 1 Kitchens. NFPA 96, 11.1.4 states instructions for manually operating the fire extinguishing system shall be posted conspicuously in the kitchen and shall be reviewed with employees by management. This deficient practice could affect all kitchen staff. Findings include: Based on observation on 06/21/21 at 1:07 p.m. with the Maintenance Supervisor (MS), the Kitchen was provided with an UL 300 hood system above the gas stove. Based on interview, the Kitchen cook standing next to the gas stove was asked "what is the first and second thing to do if there was a grease fire on the gas stove underneath the UL 300 hood system". The Kitchen cook replied "I would turn off the gas and then grab the K cylinder." The Kitchen cook did not know about first pulling the ring to activate the UL 300 hood system to extinguish the fire and subsequently the "K" class fire extinguisher if the	K 0324	K 324 1. Immediate actions taken for those residents identified: No residents were directly affected. 2. All residents, visitors and staff could be affected. However, no one was affected. 3. Measures put into place / system changes: All kitchen staff educated on fire plan for kitchen on or before July 23, 2021. Maintenance director / designee will begin using the Tels log system to log fire pump inspections and drip tray audit. A drip tray will be added to the overhead hood. 4. How the corrective actions will be monitored: Maintenance director shall log all of his activities daily in Tels including a audit of the drip tray. Administrator/designee shall check Tels weekly to ensure	08/31/2021

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	UL 300 system did not put out the fire. She further stated "I did not know about pulling the ring to activate the UL 300 hood system. This finding was reviewed with the Administrator and MS during the exit conference 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 1 kitchen range hood systems was equipped with a drip tray in accordance with the requirements of LSC 9.2.3. Section 9.2.3 states commercial cooking equipment shall be installed in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations. NFPA 96, 2011 edition, Section 6.2.4.1 states kitchen range hood system filters shall be equipped with a drip tray beneath their lower edges. The tray shall be kept to the minimum size needed to collect grease and shall be pitched to drain into an enclosed metal container having a capacity not exceeding 1 gal (3.785 L). This deficient practice could affect at least 40 residents who use the main dining room located adjacent to the kitchen and staff who work in the kitchen. Findings include: Based on observation with the Maintenance Supervisor (MS) on 07/01/21 at 2:04 p.m., the overhead hood in the kitchen was missing an enclosed metal container for grease to drain into. Based on interview at the time of observation, the MS could identify the location of the drip tray and stated he would contact Nelbud to explain in further detail if the hood system has a drip tray or perhaps an alternate method to collect and discard the grease. This was discussed with the Administrator and MS during the exit conference.		maintenance director's tasks are completed timely. This audit will be conducted weekly and reported in the QAA meeting for 6 months and quarterly thereafter.	

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	3.1-19(b)			
K 0325 SS=E Bldg. 01	NFPA 101 Alcohol Based Hand Rub Dispenser (ABHR) Alcohol Based Hand Rub Dispenser (ABHR) ABHRs are protected in accordance with 8.7.3.1, unless all conditions are met: * Corridor is at least 6 feet wide * Maximum individual dispenser capacity is 0.32 gallons (0.53 gallons in suites) of fluid and 18 ounces of Level 1 aerosols * Dispensers shall have a minimum of 4-foot horizontal spacing * Not more than an aggregate of 10 gallons of fluid or 135 ounces aerosol are used in a single smoke compartment outside a storage cabinet, excluding one individual dispenser per room * Storage in a single smoke compartment greater than 5 gallons complies with NFPA 30 * Dispensers are not installed within 1 inch of an ignition source * Dispensers over carpeted floors are in sprinklered smoke compartments * ABHR does not exceed 95 percent alcohol * Operation of the dispenser shall comply with Section 18.3.2.6(11) or 19.3.2.6(11) * ABHR is protected against inappropriate access 18.3.2.6, 19.3.2.6, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Based on observation and interview, the facility failed to ensure 4 of over 40 alcohol-based hand sanitizer dispensers were not installed over an ignition source. NFPA 101, Section 19.3.2.6(8) states dispensers shall not be installed in the following locations: (a) Above an ignition source within a 1 inch	K 0325	K 325 1. Immediate actions taken for those residents identified: No residents were directly affected.2. All residents, visitors and staff could be affected. However, no one was affected.3. Measures put	07/23/2021

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	horizontal distance from each side of the ignition source (b) To the side of an ignition source within a 1 inch horizontal distance from the ignition source (c) Beneath an ignition source within a 1 inch vertical distance from the ignition source This deficient practice could affect 6 residents on 100 hall and anyone in the vicinity of the Front entry/exit. Findings include: Based on observation on 07/01/21 during the tour between 12;00 p.m. to 2;12 p.m. with the Maintenance Supervisor (MS), an alcohol-based hand sanitizer dispenser was installed on the wall directly above an electrical light switch in the following areas: a. The Front entry/exit. b. Resident rooms 111, 101 and 102 Based on interview at the time of observation, the MS confirmed the alcohol based hand sanitizer dispensers were installed on the wall directly above the light switch and was unaware this was not allowed and also stated a large portion of the hand sanitizer dispensers in resident rooms were done the same way and would all have to be changed. This finding was reviewed with the Administrator and MS during the exit conference. 3.1-19(b)		into place / system changes: Maintenance director / designee will begin using the Tels log system to log alcohol dispenser inspections. Additionally, the maintenance director removed the deficient dispensers on 7/9/21 and relocated them on 7/9/21 not above outlets. 4. How the corrective actions will be monitored: Maintenance director shall log all of his activities daily in Tels. Administrator/designee shall check Tels weekly to ensure maintenance director's tasks are completed timely. This audit will be conducted weekly and reported in the QAA meeting for 6 months and quarterly thereafter.Date of Compliance: 7/23/21	
K 0341 SS=F Bldg. 01	NFPA 101 Fire Alarm System - Installation Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any			

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	part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 Based on observation and interview, the facility failed to ensure 1 of 1 Fire Alarm Control Panel (FACP) was protected from unauthorized use. NFPA 72, National Fire Alarm and Signaling Code Section 10.10.1 states a means for turning off activated alarm notification appliance(s) shall be permitted only if it complies with 10.10.3 through 10.10.7. Section 10.10.3 states the means shall be key-operated or located within a locked cabinet, or arranged to provide equivalent protection against unauthorized use. This deficient practice could affect all occupants. Findings include: Based on observation on 07/01/21 at 2:20 p.m. with the Maintenance Supervisor (MS), the door to the Fire Alarm Control Panel (FACP) located in Nursing station on Main St was missing it's lock cylinder so it was unlocked and could be accessible to unauthorized personnel. Based on interview at the time of observation, the MS agreed this needed to be changed and would need to install another lock cylinder in the panel door. This was discussed with the Administrator and the MS during the exit conference. 3.1-19(b)	K 0341	K 341 1. Immediate actions taken for those residents identified: No residents were directly affected. 2. All residents, visitors and staff could be affected. However, no one was affected. 3. Measures put into place / system changes: Maintenance director / designee will begin using the Tels log system to log fire panel inspections. Additionally, the maintenance director replaced the fire panel lock cylinder on 7/9/21. 4. How the corrective actions will be monitored: Maintenance director shall log all of his activities daily in Tels. Administrator/designee shall check Tels weekly to ensure maintenance director's tasks are completed timely. This audit will be conducted weekly and reported in the QAA meeting for 6 months and quarterly thereafter. Date of Compliance: 7/23/21	07/23/2021

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K 0351 SS=E Bldg. 01	NFPA 101 Sprinkler System - Installation Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) 1. Based on observation and interview, the facility failed to ensure the spray pattern for sprinkler heads was not obstructed in 4 of 4 areas observed in accordance with 19.3.5.1. NFPA 13, 2010 edition, Section 8.5.5.1 states sprinklers shall be located so as to minimize obstructions to discharge as defined in 8.5.5.2 and 8.5.5.3 or additional sprinklers shall be provided to ensure adequate coverage of the hazard. Sections 8.5.5.2 and 8.5.5.3 do not permit continuous or noncontinuous obstructions less than or equal to 18 inches below the sprinkler deflector or in a horizontal plane more than 18 inches below the sprinkler deflector that prevent the spray pattern from fully developing. This deficient practice could affect 15 residents, visitors and staff.	K 0351	K 351 1. Immediate actions taken for those residents identified: No residents were directly affected. 2. All residents, visitors and staff could be affected. However, no one was affected. 3. Measures put into place / system changes: Maintenance director / designee will begin using the Tels log system to log sprinkler head inspections. Additionally, the maintenance director cleared medical records storage closet on Main hall, cleared	08/11/2021

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	Findings include: Based on observations on 07/01/21 during the tour between at 12:13 p.m. to 2:24 p.m. with the Maintenance Supervisor (MS), the following rooms stored items within 18 inches below the sprinkler deflector:\ a. Medical records storage closet on Main hall stored boxes up to the ceiling. b. Supply room on Red Bud hall stored 22 boxes less than 18 inches from the sprinkler deflector. c. Activities Director's office on Harmony hall was full of items stored up to the ceiling. d. Communications room on Main St. stored nine boxes on shelves level with the sprinkler head. Based on interview at the time of observations, the MS acknowledged the proximity of the stored items to the sprinkler head described could obstruct the spray pattern of the sprinkler head. This was discussed with the Administrator and MS during the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure a 1 of 1 complete automatic sprinkler system was installed in accordance with 19.3.5.1. NFPA 13, 2010 Edition, Standard for the Installation of Sprinkler Systems, Section 9.1.1.7, Support of Non-System Components, requires sprinkler piping or hangers shall not be used to support non-system components. This deficient practice could affect 12 residents, staff and visitors. Findings include: Based on observation on 07/01/21 at 12:58 p.m. with the Maintenance Supervisor (MS), in the		supply room on Red Bud hall, cleared Activities Director's office on Harmony hall, and cleared communications room on Main St. on 7/9/21. Maintenance director also removed the strap from the sprinkler pipe on 7/9/21. The outdoor canopy will be removed. Maintenance director received spare parts for sidewall sprinklers on 7/9/21. 4. How the corrective actions will be monitored: Maintenance director shall log all of his activities daily in Tels. Administrator/designee shall check Tels weekly to ensure maintenance director's tasks are completed timely. This audit will be conducted weekly and reported in the QAA meeting for 6 months and quarterly thereafter.	

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	Mechanical room on Red Bud hall there was an electrical metal conduit strapped the sprinkler pipe above the boilers. Based on interview after the observation, the MS acknowledged the metal conduit strapped to the sprinkler pipe and stated he would remove the strap. This was discussed with the Administrator and MS during the exit conference. 3.1-19(b) 3. Based on observation and interview, the facility failed to ensure 1 of 1 outside porch overhangs was provided with sprinkler coverage in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. NFPA 13, 2010 edition, Section 8.15.7.1 states unless the requirements of 8.15.7.2, 8.15.7.3, or 8.15.7.4 are met, sprinklers shall be installed under exterior roofs, canopies, Porte-cocheres, balconies, decks, or similar projections exceeding 4 ft (1.2 m) in width. This deficient practice could affect residents, visitors and staff using the Front entrance/exit. Findings include: Based on observation with the Maintenance Supervisor (MS) on 07/01/21 at 3:36 p.m. the Main entrance was provided with a badly torn and tattered cloth canopy measuring ten feet in width and lacked sprinkler coverage. Based on interview concurrent with observation with the MS the canopy was made of cloth with an aluminum frame and was unsprinklered. Furthermore, the MS could not produce documentation as to the flame spread rating of the cloth canopy. This was discussed with the MS when exiting the facility.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155064	A. BUILDING 01 B. WING	07/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	3.1-19(b) 4. Based on observation and interview, the facility failed to ensure 1 of 1 sprinkler systems were provided with spare sprinklers, a spare sprinkler cabinet and a sprinkler wrench on the premises. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.4.1.4 states a supply of spare sprinklers (never fewer than six) shall be maintained on the premises so that any sprinklers that have been operated or damaged in any way can be promptly replaced. The sprinklers shall correspond to the types and temperature ratings of the sprinklers on the property. The sprinklers shall be kept in a cabinet located where the temperature in which they are subjected will at no time exceed 100 degrees Fahrenheit. A special sprinkler wrench shall be provided and kept in the cabinet to be used in the removal and installation of sprinklers. This deficient practice could affect all residents and staff in the facility. Findings include: Based on observation on 07/01/21 at 1:49 p.m. with the Maintenance Supervisor (MS) there was a spare sprinkler cabinet with more than six sprinkler heads located in the riser room on Harmony hall, but the contents did not represent any sidewall sprinkler heads present throughout the facility. Based on interview at the time of the observation, the MS acknowledged there were sidewall sprinkler heads in the facility and was disappointed there were none in the sprinkler cabinet. This was discussed with the Administrator and MS during the exit conference. 3.1-19(b)			

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	155064	A. BUILDING 01 B. WING	07/01/2021

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K 0353 SS=E Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 1. Based on observation and interview, the facility did not ensure 1 of 1 fire department connections was in accordance with NFPA 25, 2011 Edition, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. Section 13.7.1 requires fire department connections to be inspected quarterly to verify the following: (1) The fire department connections are visible and accessible. (2) Couplings or swivels are not damaged and rotate smoothly. (3) Plugs or caps are in place and undamaged. (4) Gaskets are in place and in good condition. (5) Identification signs are in place. (6) The check valve is not leaking. (7) The automatic drain valve is in place and operating properly. (8) The fire department connection clapper(s) is in	K 0353	K 353 1. Immediate actions taken for those residents identified: No residents were directly affected. 2. All residents, visitors and staff could be affected. However, no one was affected. 3. Measures put into place / system changes: Maintenance director / designee will begin using the Tels log system to log fire pump inspections. Additionally, the maintenance director fixed all ceiling tiles and penetrations on 7/9/21. Koorsen lubricated the hose connect . The parts now move freely. Sprinkler heads were a immediately cleaned, the sprinkler gauge was replaced by	07/23/2021

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	155064	A. BUILDING 01 B. WING	07/01/2021

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

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	place and operating properly. This deficient practice could affect all occupants. Findings include: Based on observation on 07/01/21 with the Maintenance Supervisor at 12:26 p.m., outside the Red Bud exit there was a Fire Department Connection (FDC) with two couplings and the left one could not be rotated by hand. The MS also tried to rotate the coupling and acknowledged it was too tight. This finding was reviewed with the Administrator and MS during the exit conference. 3.1-19(b) 2. Based on observation, and interview; the facility failed to ensure 2 of 2 sprinkler heads observed covered with grease and lint dust was replaced or cleaned in accordance with NFPA 25. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.2.1.1.1 states sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., up-right, pendent, or sidewall). Furthermore, at 5.2.1.1.2 any sprinkler that shows signs of any of the following shall be replaced: (1) Leakage (2) Corrosion (3) Physical Damage (4) Loss of fluid in the glass bulb heat responsive element (5) Loading (6) Painting unless painted by the sprinkler manufacturer. In lieu of replacing sprinklers that are loaded with dust, it is permitted to clean sprinklers with		koorsen and spare side wall sprinkler heads were delivered by koorsen. 4. How the corrective actions will be monitored: Maintenance director shall log all of his activities daily in Tels. Administrator/designee shall check Tels weekly to ensure maintenance director's tasks are completed timely. This audit will be conducted weekly and reported in the QAA meeting for 6 months and quarterly thereafter. Date of Compliance: 7/23/21	

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	155064	A. BUILDING 01 B. WING	07/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	compressed air or by a vacuum provided that the equipment does not touch the sprinkler. In lieu of replacing sprinklers that are loaded with dust, it is permitted to clean sprinklers with compressed air or by a vacuum provided that the equipment does not touch the sprinkler. This deficient practice affects five staff in the Kitchen. Findings include: Based on observation on 07/01/21 at 1:40 p.m. with the Maintenance Supervisor (MS), there were two sprinkler head in the Employee breakroom on Harmony hall which were loaded with lint dust. Based on interview at the time of observation, the MS acknowledged the automatic sprinkler heads were loaded with lint dust and was unaware of this condition. 3.1-19(b) 3. Based on observation and interview, the facility failed to ensure 1 of 3 sprinkler system gauges was replaced every 5 years or documented as tested every 5 years by comparison with a calibrated gauge. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.3.2.1 states gauges shall be replaced every 5 years or tested every 5 years by comparison with a calibrated gauge. Gauges not accurate to within 3 percent of the full scale shall be recalibrated or replaced. This deficient practice could affect all residents, staff, and visitors in the facility. Findings include: Based on observation with the Maintenance Supervisor (MS) on 07/01/21 at 1:49 p.m., the			

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	155064	A. BUILDING 01 B. WING	07/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	Sprinkler riser room on Harmony hall had one sprinkler gauge with a manufacturer's date of 2015, which is a period over the five year testing or replacement requirement. Based on interview with the MS this was confirmed at the time of observation. This was discussed with the Administrator and MS during the exit conference. 3.1-19(b) 4. Based on observation and interview, the facility failed to maintain the ceiling construction in 1 of 5 corridors. The ceiling tiles trap hot air and gases around the sprinkler and cause the sprinkler to operate at a specified temperature. NFPA 13, 2010 edition, 8.5.4.11 states the distance between the sprinkler deflector and the ceiling above shall be selected based on the type of sprinkler and the type of construction. This deficient practice could affect 14 residents, staff and visitors on 100 hall Zone 5. Findings include: Based on observation with the on 07/01/21 at 12:43 p.m. with the Maintenance Supervisor (MS), there were ceiling tiles missing in the Communication closet in Therapy which could inhibit the response time of the sprinkler head. Based on interview at the time of the observation, the MS acknowledged the missing ceiling tiles, but did not realize the correlation between the missing tiles and sprinkler response time. This was discussed with the Administrator and MS during the exit conference. 3.1-19(b)			
K 0355 SS=B	NFPA 101 Portable Fire Extinguishers			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155064	A. BUILDING 01 B. WING	07/01/2021

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Bldg. 01	Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 Based on observation and interview, the facility failed to ensure 1 of 1 portable fire extinguishers were properly secured from falling. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 11.6.2.3(11) states freestanding cylinders shall be properly chained or supported in a proper cylinder stand or cart. This deficient practice could possible affect 6 staff. Findings include: Based on observation on 07/01/21 at 12:10 p.m. with the Maintenance Supervisor (MS) there was a full fire extinguisher freestanding on the floor in the Marketing office on Main hall. It was removed by the MS and set on the floor in the adjacent Reception desk where it remained unsupported for the duration of the survey. Based on interview concurrent with the observation it was confirmed by the MS the ABC portable fire extinguisher was full and not secured properly to prevent the cylinder from falling. This was discussed with the Administrator and MS during the exit conference. 3.1-19(b)	K 0355	K 355 1. Immediate actions taken for those residents identified: No residents were directly affected. 2. All residents, visitors and staff could be affected. However, no one was affected. 3. Measures put into place / system changes: Maintenance director / designee will begin using the Tels log system to log fire extinguisher inspections. Additionally, the maintenance director ensured all fire extinguishers were properly tagged and secured on 7/9/21. 4. How the corrective actions will be monitored: Maintenance director shall log all of his activities daily in Tels. Administrator/designee shall check Tels weekly to ensure maintenance director's tasks are completed timely. This audit will be conducted weekly and reported in the QAA meeting for 6 months and quarterly thereafter. Date of Compliance: 7/23/21	07/23/2021
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other			

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	155064	A. BUILDING 01 B. WING	07/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. Based on observation and interview, the facility	K 0363	**K 363**	07/23/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155064	A. BUILDING 01 B. WING	07/01/2021

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

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	failed to ensure 2 of 2 corridor doors observed would close completely and latch into their door frames. This deficient practice could affect at least 4 residents, visitors and staff. Findings include: Based on observations on 07/01/21 during the tour between 12:46 p.m. to 1:24 p.m. with the Maintenance Supervisor (MS) the door leading into the resident room # 307 would not close and latch into the door frame. In addition, the door leading into resident foom # 303 would not close and latch into the door frame. Based on interview concurrent with the observations with the MS it was agreed the corridor doors needed to be adjusted. This finding was reviewed with the Administrator and MS during the exit conference. 3.1-19(b)		**1. Immediate actions taken for those residents identified: No residents were directly affected.** **2. All residents, visitors and staff could be affected. However, no one was affected.** **3. Measures put into place / system changes: Maintenance director / designee will begin using the Tels log system to log door inspections. Additionally, the maintenance director removed the trash cans and repaired the door hinges on July 9, 2021.** **4. How the corrective actions will be monitored: Maintenance director shall log all of his activities daily in Tels. Administrator/designee shall check Tels weekly to ensure maintenance director's tasks are completed timely. This audit will be conducted weekly and reported in the QAA meeting for 6 months and quarterly thereafter.** **Date of Compliance: 7/23/21**	
K 0511 SS=E Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2			

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	155064	A. BUILDING 01 B. WING	07/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	1. Based on observation and interview, the facility failed to ensure 5 of 5 electrical receptacles observed was protected accordance with NFPA 70, National Electrical Code. NFPA 70, 2011 Edition, Article 406.6, Receptacle Faceplates (Cover Plates), requires receptacle faceplates shall be installed so as to completely cover the opening and seat against the mounting surface. This deficient practice could affect only staff. Findings include: Based on observations on 07/01/21 during the tour 12:40 p.m. to 1:16 p.m. with the Maintenance Supervisor (MS), the following light switch and outlets were missing a protective plate cover. a. Therapy on Red Bud hall has two wall outlets missing plate covers. b. Environmental office on S. Magnolia hall has two wall outlets and a wall light switch without plate covers. Based on interview at the time of observations, the MS confirmed the receptacle cover plates were missing and said they would be corrected. This was discussed with the Administrator and MS during the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 5 corridors with electrical circuit panels were secured from non-authorized personnel per LSC 19.5.1.1. LSC 19.5.1.1 states utilities shall comply with the provisions of Section 9.1. LSC 9.1.2 states electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code. NFPA 70 Section 110.27(A) states live parts of electrical equipment over 50 volts or more shall be guarded against accidental contact by	K 0511	K 511 1. Immediate actions taken for those residents identified: No residents were directly affected. 2. All residents, visitors and staff could be affected. However, no one was affected. 3. Measures put into place / system changes: Maintenance director / designee will begin using the Tels log system to log faceplate inspections and electrical panel locks/security. Additionally, the maintenance director repaired all deficient outlet covers and faceplates on 7/9/21. The maint director checked and locked the electrical circuit panel. Maintenance director also secured the fire panel and replaced the lock on 7/9/21. 4. How the corrective actions will be monitored: Maintenance director shall log all of his activities daily in Tels. Administrator/designee shall check Tels weekly to ensure maintenance director's tasks are completed timely. This audit will be conducted weekly and reported in the QAA meeting for 6 months and quarterly thereafter. Date of Compliance: 7/23/21	07/23/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155064	A. BUILDING 01 B. WING	07/01/2021

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

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	approved closures or by any of the following means: (1) by location in a room, vault, or similar enclosure that is accessible only to qualified persons. This deficient practice could affect 20 residents, visitors and staff on Red Bud hall. Findings include: Based on observation on 07/01/21 at 12:28 p.m. with the Maintenance Supervisor (MS), there was one of two electrical circuit panels installed in the corridor wall on Red Bud hall which was left unlocked and not secured against non-authorized personnel. Based on interview during the observation, the MS confirmed the electrical panel was unlocked and could be opened by anyone and further acknowledged he did not have a key to lock the panel door. This was discussed with the Administrator and the MS during the exit conference. 3.1-19(b)			
K 0741 SS=E Bldg. 01	NFPA 101 Smoking Regulations Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155064	A. BUILDING 01 B. WING	07/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 Based on record review, observation and interview, the facility failed to ensure extinguished cigarette butts were properly disposed of in 1 of 1 outdoor areas where evidence of smoking occurred. This deficient practice could affect mainly staff who use the outside smoking location. Findings include: Based on review of the facility's written smoking policy on 07/01/21 at 11:30 a.m. with the Maintenance Supervisor (MS), staff and resident smoking is permitted on the premises. Based on observation with the MS on 07/01/21 at 12:30 p.m., the smoking area for staff and residents was available in the enclosed courtyard outside Red Bud hall exit. During the inspection at least 50 cigarette butts were observed on the gravel next to exit door. Based on interview concurrent with the observation the MS was disappointed cigarette butts had been disposed of improperly. This was discussed with the Administrator and MS during the exit conference.	K 0741	**K 741** **1. Immediate actions taken for those residents identified: No residents were directly affected.** **2. All residents, visitors and staff could be affected. However, no one was affected.** **3. Measures put into place / system changes: Maintenance director / designee will begin using the Tels log system to log grounds inspections. Additionally, the maintenance director will check facility grounds daily Monday-Friday and remove cigarette butts. All butts were removed 7/9/21 and no smoking signs were posted.** **4. How the corrective actions will be monitored: Maintenance director shall log all of his activities daily in Tels. Administrator/designee**	07/23/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155064	A. BUILDING 01 B. WING	07/01/2021

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

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	3.1-19(b)		**shall check Tels weekly to ensure maintenance director's tasks are completed timely. This audit will be conducted weekly and reported in the QAA meeting for 6 months and quarterly thereafter.**	
K 0918 SS=C Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable,			

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	155064	A. BUILDING 01 B. WING	07/01/2021

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

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	and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)			
	Based on interview, the facility failed to ensure the fuel source for 1 of 1 emergency generator was from a reliable source. NFPA 110, 2010 Edition, Standard for Emergency and Standby Power Systems, Chapter 3, Emergency Power Supply (EPS), 5.1.1, Energy Sources states the following energy sources shall be permitted for use for the emergency power supply (EPS): a) Liquid Petroleum products at atmospheric pressure b) Liquefied petroleum gas (liquid or vapor withdrawal) c) Natural or synthetic gas Exception: For Level 1 installations in locations where the probability of interruption of offsite fuel supplies is high, on-site storage of an alternate energy source sufficient to allow full output of the emergency power supply system (EPSS) to be delivered for the class specified shall be required, with the provision for automatic transfer from the primary energy source to the alternate energy source. This deficient practice could affect all residents, staff and visitors. Findings include: Based on interview and record review on 07/01/21 at 10:50 a.m. with the Maintenance Supervisor (MS), the fuel source for the emergency generator was natural gas with no other back up fuel source. Based on interview, the MS stated the facility did not have a letter from their natural gas provider indicating the natural gas was from a reliable source and learned recently this was a	K 0918	K 918 1. Immediate actions taken for those residents identified: No residents were directly affected. 2. All residents, visitors and staff could be affected. However, no one was affected. 3. Measures put into place / system changes: Maintenance director / designee will begin using the Tels log system to log fuel inspections. Additionally, the maintenance director obtained a letter from gas company stating compliance on 7/9/21. 4. How the corrective actions will be monitored: Maintenance director shall log all of his activities daily in Tels. Administrator/designee shall check Tels weekly to ensure maintenance director's tasks are completed timely. This audit will be conducted weekly and reported in the QAA meeting for 6 months and quarterly thereafter. Date of Compliance: 7/23/21	07/23/2021

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	requirement. This was discussed with the Administrator and MS during the exit conference. 3.1-19(b)			
K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 Based on observation and interview, the facility failed to ensure proper use of power strips. extension cords and a multiplug in 5 of 5 areas observed. This deficient practice could affect up to 12 residents, visitors and staff. Findings include:	K 0920	K 920 1. Immediate actions taken for those residents identified: No residents were directly affected. 2. All residents, visitors and staff could be affected. However, no one was affected.	07/23/2021

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	Based on observations on 07/01/21 during the tour between 12:16 p.m. to 3:24 p.m. with the Maintenance Supervisor (MS), a power strip, extension cord and multiplug was used in the following areas: a. Medical Records office on Main hall used a power strip to power a mini refrigerator. b. Therapy room uses a power strip next to the weight machine in a patient care area. c. Power strip plugged into power strip in Conference room on S. Magnolia. d. Extension cord connected to power strip in Maintenance office on S. Magnolia. e. A multiplug was used to run various electric appliances in the Administrator's office on Main hall. Based on interview concurrent with the observations with the MS, it was acknowledged the power strips, extension cord and multiplug were improperly used and would be removed. This finding was discussed with the Administrator and MS during the exit conference. 3.1-19(b)		3. Measures put into place / system changes: Maintenance director / designee will begin using the Tels log system to log power strip inspections. Additionally, the maintenance director removed all power strips on 7/9/21. 4. How the corrective actions will be monitored: Maintenance director shall log all of his activities daily in Tels. Administrator/designee shall check Tels weekly to ensure maintenance director's tasks are completed timely. This audit will be conducted weekly and reported in the QAA meeting for 6 months and quarterly thereafter. Date of Compliance: 7/23/21	