	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CO	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED		
		155064	B. WING		09/23/2024		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 3518 S LAFOUNTAIN ST KOKOMO, IN 46902				
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	(X5) COMPLETION		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE		
F 0000 Bldg. 00		Recertification and State	F 0000				
	Investigation of Con	This visit included the mplaint IN00443390.					
	the allegations are o						
	2024.	mber 16, 17, 18, 19, 20 and 23,					
	Facility number: 00						
	Provider number: 1 AIM number: 1002						
	Census Bed Type: SNF/NF: 52						
	Total: 52						
	Census Payor Type Medicare: 2 Medicaid: 36 Other: 14 Total: 52	:					
	These deficiencies i	reflect State Findings cited in 0 IAC 16.2-3.1.					
	Quality review was	completed on October 2, 2024.					
F 0567 SS=D Bldg. 00	483.10(f)(10(i)(ii) Protection/Manag	ement of Personal Funds					
J	failed to ensure a re personal funds when	and record review, the facility sident was able to receive n requested for 1 of 1 resident all funds. (Resident 36)	F 0567	F567 This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of			
LABORATOR	RY DIRECTOR'S OR PRO	VIDER/SUPPLIER REPRESENTATIVE'S S	GNATURE	TITLE	(X6) DATE		
Markia Bal	ker		Administ	rator	10/17/2024		

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 80N911 Facility ID: 000025 If continuation sheet Page 1 of 19

CENTERS FOI	R MEDICARE & MEDIC				OMB NO. 0938-039
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED
		155064	B. WING		09/23/2024
	PROVIDER OR SUPPLIER	8	3518 S	ADDRESS, CITY, STATE, ZIP COD LAFOUNTAIN ST MO, IN 46902	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	BROWDERIC DLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTION SHOULD BE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	REGULATORY OF Finding includes: During an interview Resident 36 indicat get money from her to get money out of An email, dated 9/1 Business Office Madeposited the reside instead of her RFM Service) account. During an interview Administrator indic business office mar Office Manager was During an interview Administrator indic discharged to anoth Resident 36's funds readmitted, her fund resident's funds couget resolved. During an interview Corporate Business RFMS (Resident Funds Check was deposite rejected. The facilit took a while. They and the Corporate Eguand to the control of the corporate Eguand the Corpor	A LSC IDENTIFYING INFORMATION IV, on 9/16/24 at 11:17 a.m., ed she asked several times to account and she was not able Ther account. 7/24, from the Corporate mager indicated she had ent's check into the AR side S (Resident Fund Management IV, on 9/23/24 at 9:27 a.m., the mated the facility did not have a mager. The Corporate Business is covering multiple facilities. IV, on 9/23/24 at 10:00 a.m., the mated when the resident was mer facility they cancelled IV, when the resident was dis were messed up. The mild take more than 30 days to IV, on 9/23/24 at 12:07 p.m., the Office Manager indicated the mid Management Service) The resident's social security dinto her account, and it was y had to reapply for her, and it received a check for \$333.00, Business Office Manager had		this plan of correction does not constitute admission or agreed by the provider of the truth of the facts alleged or conclusions so 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. This facility request a desk review for this alleged allegation. 1 What corrective action will accomplished for those reside found to have been affected be alleged deficient practice? Resident 36 was provided with personal funds on 9/24/2024. 2 How other residents havin potential to be affected by the same deficient practice will be identified and what corrective action will be taken? All residents have the potential be affected by the alleged defipractice. 3 What measures will be put into place and what systematic changes will be made to ensurthat the deficient practice does recur? Administrator/designee will train	be ents y the ent of t
	liability billing account			the BOM on the policy "Reside Rights" to include ensuring a resident has access to their personal funds.	
		y, on 9/23/24 at 3:02 p.m., the atted if the resident wanted the		4 How the corrective action be monitored to ensure the	Will

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED 155064 B. WING 09/23/2024 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 3518 S LAFOUNTAIN ST APERION CARE KOKOMO KOKOMO. IN 46902 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE funds today, she would take the money out of the deficient practice will not recur, Administrator's personal funds to give to the what quality assurance program resident. The Administrator's funds would be will be put into place? reimbursed from the corporate office. Administrator/designee will audit residents personal fund accounts A current policy, titled "Resident Funds," dated to ensure they have access to as revised 4/29/19 and received from the their funds. Audits will be Administrator on 9/23/24 at 2:00 p.m., indicated completed on 10 resident "...This facility manages the personal funds of accounts a day x 4 weeks, then 5 residents when such request is made by the resident accounts a week x 4 resident...The resident may choose to have the weeks, then 1 resident account facility hold, safeguard, and manage his/her weekly x 4 months. personal funds...Resident funds are deposited into an interest bearing resident trust fund The results of these audits will be account...Residents should have access to petty reviewed in Quality Assurance cash on an ongoing basis and be able to arrange Meeting monthly. The results of for access for larger funds...Resident requests for these audits will be reviewed in access to their funds should be honored by **Quality Assurance Meeting** facility staff as soon as possible but no later monthly x6 months or until an than...Three banking days for amounts of \$100.00 average of 90% compliance or (\$50.00 for Medicaid residents)...." greater is achieved x3 consecutive months. The QA Committee will A current policy, titled "Resident Rights," dated identify any trends or patterns and 8/23/17 and received from the Administrator on make recommendations to revise 9/23/24 at 9:00 p.m., indicated "...To promote the the plan of correction as indicated. exercise of rights for each resident...These rights include the resident's right to: Exercise his or her rights...If he or she wishes, have the facility Date of Compliance 10/4/2024 manage his personal funds...." 3.1-6(e) 3.1-6(f)(1)F 0657 483.21(b)(2)(i)-(iii) SS=D Care Plan Timing and Revision Bldg. 00 Based on observation, interview and record F 0657 F727 10/04/2024 review, the facility failed to ensure a care plan was reviewed and revised as appropriate for 1 of 4 This Plan of Correction is the residents reviewed for accidents. (Resident 23)

center's credible allegation of

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED 155064 B. WING 09/23/2024 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 3518 S LAFOUNTAIN ST APERION CARE KOKOMO **KOKOMO, IN 46902** (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE compliance. Finding includes: Preparation and/or execution of this plan of correction does not During daily observations, on 9/16/24, 9/17/24, constitute admission or agreement 9/18/24, 9/19/24 and 9/20/24, a mattress was noted by the provider of the truth of the on the floor on the right side of Resident 23's bed facts alleged or conclusions set forth in the statement of with the left side of the bed positioned against the half wall in the room. deficiencies. The plan of correction is prepared and/or The clinical record for Resident 23 was reviewed executed solely because it is on 9/17/24 at 3:22 p.m. The diagnoses included, required by the provisions of but were not limited to, seizures, schizoaffective federal and state law. disorder, depression, pseudobulbar affect, This facility request a desk dementia- moderate with behavioral disturbance, review for this alleged cerebellar ataxia, bipolar disorder, chronic kidney allegation. disease-stage 3, intellectual disabilities, and atrial flutter. 1 How the corrective action will be accomplished for those A Minimum Data Set (MDS) assessment, dated residents found to be affected by 3/26/24, indicated Resident 23 was discharged to the deficient practice: an inpatient psychiatric facility and was expected Resident 23 care plan was to return to the facility. The resident was reviewed and updated. readmitted to the facility on 4/4/24. 2 How will the facility identify A care plan, dated 6/10/24, indicated interventions other residents having the included, but were not limited to, the resident was potential to be affected by the to be "1:1 with staff member at all times" and same deficient practice: "Mattress against wall between wall and bed for All residents currently residing in resident safety." Both interventions were initiated the facility have the potential to be on 3/22/24 with no revision date. affected. Thus, this plan of correction applies to all residents. The resident was not observed to be on 1:1 with a staff member or to have a mattress between the 3 What measures will be put resident's bed and the wall. into place or what systemic changes the facility will make to During an interview, on 9/20/24, the Director of ensure the deficient practice does Nursing (DON) indicated the care plan had not not recur: been updated to indicate the resident no longer The interdisciplinary team will be

needed to be 1:1 with a staff member and no

longer needed a mattress against the wall beside

educated on, but not limited to,

care plan revisions.

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/28/2024 FORM APPROVED OMB NO. 0938-039

	OF CORRECTION	IDENTIFICATION NUMBER 155064	A. BUILDING B. WING	00	COMPLETED 09/23/2024
	PROVIDER OR SUPPLIER		3518 S	ADDRESS, CITY, STATE, ZIP COD B LAFOUNTAIN ST MO, IN 46902	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R 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
	REGULATORY OF her bed, following to inpatient psychiatric. A current policy, tit Plan," dated as revised by the interest assessment, including and quarterly review should be revised of	the resident's stay at an c facility. the d'Comprehensive Care sed 11/17/17, indicated " A e plan must bereviewed and disciplinary team after eaching both the comprehensive w assessmentsThe care plan in an ongoing basis to reflect lent and the care that the		4 How will the facility monitor performance to make sure that solutions are sustained; the plicition is implemented, and the correlation evaluated for its effectiveness; and the plan of correction is integrated into the quality assurance system? The interdisciplinary to will meet once a week to discovered the correlation of the scheduled residnts during that week. MD or Social Service will review individual care plans during the actual meeting weekly and manecessary changes at that time This audit will occur weekly a weeks, then monthly thereafted. The results of these audits will reviewed in Quality Assurance Meeting monthly. The results these audits will be reviewed in Quality Assurance Meeting monthly assurance Meeting monthly to months or until an average of 90% compliance of greater is achieved x3 consecution. The QA Committee widentify any trends or patterns make recommendations to result the plan of correction as indicated.	or its at an an active e e e e e e e e e e e e e e e e e e
				5 Date of compliance 10/04/2024	

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

Event ID:

80N911

Facility ID: 000025

If continuation sheet

Page 5 of 19

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		09/23/	/2024
				CTREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIER				LAFOUNTAIN ST		
∆DEDI∩!	N CARE KOKOMO				MO, IN 46902		
AI LINIOI				KOKO			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	.TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
F 0695	483.25(i)						
SS=D	l ','	eostomy Care and					
Bldg. 00	Suctioning	•					
	Based on observation	on, interview and record	F 0	595	F695	ļ	10/04/2024
	review, the facility	failed to administer oxygen at					
	the correct flow rate	e as ordered by the physician			This Plan of Correction is the		
	for 2 of 3 residents	reviewed for respiratory care.			center's credible allegation of		
	(Residents 32 and 4	3)			compliance.		
					Preparation and/or execution	of	
	Findings include:				this plan of correction does no		
					constitute admission or agree		
	1. During an observ	ation, on 9/16/24 at 4:03 p.m.,			by the provider of the truth of the	the	
	Resident 32 was rec	eiving oxygen at a flow rate of			facts alleged or conclusions se	et	
	2 liters per minute (LPM) via a nasal canula.			forth in the statement of		
					deficiencies. The plan of		
	During an observati	on, on 9/17/24 at 9:15 a.m.,			correction is prepared and/or		
	Resident 32 was rec	eiving oxygen at a flow rate of			executed solely because it is		
	2 LPM via a nasal c	anula.			required by the provisions of		
					federal and state law.		
	_	on, on 9/18/24 at 11:35 a.m.,			This facility request a desk		
		eiving oxygen at a flow rate of			review for this alleged		
	2 LPM via a nasal c	anula.			allegation.		
	_	on, on 9/19/24 at 1:29 p.m.,					
		eiving oxygen at a flow rate of			1 How the corrective action	will	
	2 LPM via a nasal c	anula.			be accomplished for those		
					residents found to be affected	by	
		for Resident 32 was reviewed			the deficient practice:		
		p.m. The diagnoses included,			Resident 32 oxygen was set a	ıt	
		to, chronic obstructive			the correct liter flow.		
		(COPD), chronic respiratory					
		n (not enough oxygen in the			2 How will the facility identify	/	
		l fibrillation, dependence on			other residents having the	ļ	
	supplemental oxyge	en, and anxiety disorder.			potential to be affected by the		
		17.1 25271 1 2 3			same deficient practice:		
	_	dated as initiated and revised			All residents who receive oxyg	-	
		ted to use oxygen therapy for			therapy are at risk for respirate	•	
		tatus related to COPD, anxiety			care related to oxygen use ha		
		failure with hypoxia, and			the potential to be affected by	tne	
	asthma. Intervention	ns included, but were not			alleged deficient practice. A		

CENTERS FOR MEDICARE & MEDICAID SERVICES

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155064	JILDING	ONSTRUCTION 00	(X3) DATE SU COMPLE 09/23/2	TED
	PROVIDER OR SUPPLIER	1	3518 S	ADDRESS, CITY, STATE, ZIP COD LAFOUNTAIN ST MO, IN 46902		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R 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
		ering oxygen via nasal canula		facility wide audit on all reside with oxygen use to ensure oxy is set to correct flow rate.		J.N.D
	administer oxygen a continuously every A physician's progrindicated the reside oxygen with a plan oxygen at 3 LPM co	ess note, dated 9/16/24, indicated to at 3 LPM via nasal canula day and night shift for COPD. ess note, dated 9/16/24, int was dependent on 3 LPM of to continue the supplemental continuously for the resident's despiratory failure with		3 What measures will be purinto place or what systemic changes the facility will make ensure the deficient practice of not recur: DON, or designee, will re-edurursing staff on, but not limited oxygen use and ordered liter frate. Oxygen orders were revifor accuracy.	to loes cate d to,	
	dated 9/1/24 throug resident was admin continuously. During an observate at 1:40 p.m., the As (ADON) indicated oxygen rather than ADON indicated th ordered by the physobservation, on 9/1	inistration Record (MAR), h 9/30/24, indicated the istered 3 LPM of oxygen ion and interview, on 9/19/24 sistant Director of Nursing the resident was on 2 LPM of the ordered 3 LPM. The e oxygen should be at the rate sician.2. During an 7/24 at 11:29 a.m., Resident 43 en at a flow rate of 4 LPM via a		4 How will the facility monitor performance to make sure that solutions are sustained; the plies implemented, and the correction evaluated for its effectiveness; and the plan of correction is integrated into the quality assurance system? DON, or designee, will check 5 oxygen flow rates dai (M-F) X 4 weeks, then 5 oxygen	at an ctive e	
	nasal canula. During an observative resident was received. LPM via a nasal canon buring an observative resident was received between 3 and 3.5 In the clinical record on 9/17/24 at 4:24 In the clini	ion, on 9/19/24 at 2:38 p.m., the ing oxygen at a flow rate of 4		flow rates three times a week weeks, then 5 oxygen flow rat twice a week X 2 weeks. Any discrepancies will be corrected and MD/NP notified. The results of these audits will reviewed in Quality Assurance Meeting monthly. The results these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or	X 4 es d I be e of	

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155064	(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 09/23/2024
	PROVIDER OR SUPPLIER		3518 S	ADDRESS, CITY, STATE, ZIP COD S LAFOUNTAIN ST MO, IN 46902	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)	(X5) COMPLETION DATE
F 0727	with hypoxia, chror disease (COPD), and (CKD), and arterios A care plan, dated 6 was at risk for alterbreathing related to congestive heart fai embolism and thror but were not limited per MD order. A physician's order 3 LPM every day and A MAR, dated 9/1/2 resident received Onight shift. During an interview 6 indicated the oxyg LPM per the physic A current policy, tit and received from t 9/20/24 at 3:24 p.m prescribed drug and which outlineslite	nic obstructive pulmonary xiety, chronic kidney disease sclerotic heart disease. 6/20/23, indicated the resident ed respiratory status/difficulty morbid obesity, COPD, lure (CHF), and a history of inbosis. Approaches included, d to, O2 via NC (nasal cannula) 6, dated 6/20/24, indicated O2 at ind night shift. 124 to 9/30/24, indicated the 2 at 3 LPM every day and 17, on 9/23/24 at 10:20 a.m., LPN gen should have been at 3 ian's order. 18 de "Oxygen Safety," undated the Director of Nursing on, indicated "Oxygen is a lamust have a Physician's order or flowAll changes in an order of verified by physician	IAG	greater is achieved x3 consect months. The QA Committee identify any trends or patterns make recommendations to rethe plan of correction as indicated as a pattern of the plan of compliance 10/4/2	cutive will s and vise ated.
SS=D Bldg. 00	RN 8 Hrs/7 days/N Based on interview	Nk, Full Time DON and record review, the facility	F 0727	F727	10/17/2024
	the facility at least 8	egistered Nurse (RN) was in 3 consecutive hours a day, 7 f the days reviewed during the		This Plan of Correction is the center's credible allegation of	

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

Event ID:

80N911

Facility ID: 000025

If continuation sheet

Page 8 of 19

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 155064 B. WING 09/23/2024 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 3518 S LAFOUNTAIN ST APERION CARE KOKOMO **KOKOMO, IN 46902** (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE third quarter for RN coverage. (8/10, 8/11, 8/31, 9/1 compliance. and 9/14/24) Preparation and/or execution of this plan of correction does not Finding includes: constitute admission or agreement by the provider of the truth of the A Payroll-Based Journal (PBJ) staffing report, for facts alleged or conclusions set forth in the statement of the third quarter of 2024, indicated the facility had failed to have licensed nursing coverage for 24 deficiencies. The plan of hour/day. correction is prepared and/or executed solely because it is During a record review, on 9/23/24 at 11:20 a.m., required by the provisions of the actual worked staffing schedule indicated federal and state law. there was no RN coverage for 8/10, 8/11, 8/31, 9/1 This facility request a desk and 9/14/24. review for this alleged allegation. During an interview, on 9/19/24 at 11:18 a.m., the Director of Nursing (DON) indicated RN 2 was on 1 How the corrective action will call for 8/10, 8/11, 8/31, 9/1 and 9/14/24. The nurse be accomplished for those was not in the building on those days. residents found to be affected by the deficient practice: During an interview, on 9/23/24 at 2:20 p.m., the No residents were affected. Scheduler indicated other than management staff, the facility had one RN who worked every other 2 How will the facility identify weekend. other residents having the potential to be affected by the The facility followed the state regulations and same deficient practice: guidelines and did not have a policy for staffing. No residents will be affected. 3.1-17(b)(3)3 What measures will be put into place or what systemic changes the facility will make to ensure the deficient practice does not recur: On 9/23/24, the Director of Nursing and the Executive Director met with the scheduler to ensure education on, but not limited to, scheduling of RN hours (8 hours a

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

Event ID:

80N911

Facility ID: 000025

day, seven days a week).
Reeducation was completed on

If continuation sheet

Page 9 of 19

PRINTED: 10/28/2024

	T OF HEALTH AND HU R MEDICARE & MEDIC					RM APPROVED B NO. 0938-039
STATEMEN	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155064	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE : COMPL 09/23/	SURVEY ETED
	PROVIDER OR SUPPLIER		3518 S	ADDRESS, CITY, STATE, ZIP COD B LAFOUNTAIN ST MO, IN 46902		
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) 9/23/24.	ATE	(X5) COMPLETION DATE
				4 How will the facility monitor performance to make sure the solutions are sustained; the pris implemented, and the corresponding of correction is integrated into the quality assurance system? Beginning 9/25/24, the Director of Nursing, or design will audit the daily staffing to ensure adequate RN coverages chedule if applicable. This are will be M-F X 8 weeks, then do (M-F) going forward. The Executive Director designee, will meet with Hum Resource Director, Director or Nursing and the scheduler were to monitor applicants and staff needs. The results of these audits wireviewed in Quality Assurance Meeting monthly. The results these audits will be reviewed Quality Assurance Meeting monthly x6 months or until an average of 90% compliance of greater is achieved x3 consect months. The QA Committee identify any trends or patterns make recommendations to rethe plan of correction as indices.	at at altan active acti	

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

Event ID:

80N911

Facility ID: 000025

If continuation sheet

5 Date of compliance: ongoing

Page 10 of 19

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	JLTIPLE C	ONSTRUCTION	(X3) DATE S	URVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPLE	ETED
		155064	B. WI	NG		09/23/2	2024
				CTREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF	PROVIDER OR SUPPLIE	R			S LAFOUNTAIN ST		
\ \DEDI∩	N CARE KOKOMO				MO, IN 46902		
AFERIO	N CARE ROROWO			KOKO			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		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	ATE .	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
F 0755	483.45(a)(b)(1)-(3	3)					
SS=D	Pharmacy						
Bldg. 00		s/Pharmacist/Records					
		view and interview, the facility	F 07	755	F755		10/04/2024
		edications were available and a					
		er scheduled medication as			This Plan of Correction is the		
		resident reviewed for pharmacy			center's credible allegation of		
	services. (Resident	(4)			compliance.		
					Preparation and/or execution		
	Finding includes:				this plan of correction does no	ot	
					constitute admission or agree	ment	
	_	w, on 9/16/24 at 11:42 a.m.,			by the provider of the truth of	I .	
		ed she had missed 2 days of her			facts alleged or conclusions s	et	
		for overactive bladder) and she			forth in the statement of		
		nent episodes. She was told by			deficiencies. The plan of		
		was slow and had not			correction is prepared and/or		
	delivered the medi	cation.			executed solely because it is		
					required by the provisions of		
	_	w, on 9/18/24 at 11:29 a.m.,			federal and state law.		
		ed she did not receive her			This facility request a desk		
		xybutynin. The staff told her			review for this alleged		
		not delivered it yet. The			allegation.		
		she had not received her					
	1 ' '	lays and had increased			1 How the corrective action	will	
	incontinence episo	des.			be accomplished for those		
	TEL 1: 1 1	C D 11 (4) 1			residents found to be affected	by	
		for Resident 4 was reviewed on			the deficient practice:		
		n. The diagnoses included, but			On 9/21/24, Resident 4		
		o, overactive bladder,			medications were audited to		
		s, emphysema, and			ensure all medications were		
	hypertension.				available per physician orders		
	A agraphan datal	12/24/22 indicated Desident 4			Any identified discrepancies w		
	_	12/24/22, indicated Resident 4			corrected immediately, and th	e	
		n urinary elimination.			MD notified.		
		ded, but were not limited to,			0	.	
		ts completed upon admission,			2 How will the facility identify	y	
I	quarterly and when	n needed and to monitor for			other residents having the		

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

Event ID:

80N911

Facility ID: 000025

If continuation sheet

Page 11 of 19

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	ľ	ULTIPLE CO	ONSTRUCTION 00	(X3) DATE S	
		155064	B. W			09/23/	
NAME OF	PROVIDER OR SUPPLIEI	R			ADDRESS, CITY, STATE, ZIP COD LAFOUNTAIN ST		
APERIO	N CARE KOKOMO			KOKON	MO, IN 46902		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		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' DEFICIENCY)	TE	COMPLETION
TAG	_	R LSC IDENTIFYING INFORMATION		TAG			DATE
	incontinence and cl	hange as needed.			potential to be affected by the		
					same deficient practice:		
	_	12/24/22, indicated Resident 4			On 9/23/24, a full house audit		
	was incontinent of				completed to ensure medication		
		ded, but were not limited to,			were available for all residents		
		le causes of bladder			Any discrepancies were correct	cted,	
	incontinence.				and the MD was notified.		
	A physician's order	, dated 6/20/24, indicated to			3 What measures will be put	t	
	give 1 tablet of Oxy	ybutynin Chloride ER (Extended			into place or what systemic		
	Release) 10 mg (m	illigrams) daily.			changes the facility will make t	to	
					ensure the deficient practice d	oes	
		delivery invoice indicated the			not recur:		
		4 tablets of Oxybutynin 10 mg			On 9/23/24, the DON and AD0	NC	
		e pharmacy on 8/24/24, and did			provided education to the floor	•	
	not receive addition	nal tablets until 9/18/24.			nurses and Qualified Medication	on	
					Assistants (QMA's) on the		
	_	v, on 9/18/24 at 11:32 a.m.,			process of reordering medicati		
	`	he resident did not have the			with emphasis on the use of the	ne	
		tablets in the drawer with the			EDK and notification to the		
	_	ls. The medication was not			pharmacy to request and		
		ergency Drug Kit (EDK). QMA			determine delivery time of		
		tom of the medication cart and			medications and if back up		
		ybutynin 10 mg ER containing			pharmacy is needed, and		
	14 tabs which were	received on 9/18/24.			notification to provider and		
		0/10/04 + 1.04			responsible party if applicable.		
	1	v, on 9/19/24 at 1:24 p.m., the			Reeducation was completed o	n	
	_	g (DON) indicated the pharmacy			9/25/24.		
		cated the resident went 7 days			Beginning 9/25/24, the DON o	r	
		tion. The staff should have			ADON will pull the eMAR		
		edication was unavailable and			administration compliance rep		
	contacted the pharm	nacy.			each day in clinical whiteboard		
	During on interni-	y on 0/10/24 at 2:20 the			meeting to review for medicati		
	_	v, on 9/19/24 at 2:20 p.m., the			documented not administered	uue	
		the received her medication, on 4, and her incontinent episodes			to unavailability. The DON or		
	9/18/24 and 9/19/24 were a lot less.	+, and her incontinent episodes			ADON will audit the report to		
	were a fot less.				ensure all medications are	ıŧ	
	A aumont maliar 4	tlad "Madigation			available per physician orders		
	A current policy, ti				medications are not available,		
	Administration Ger	neral Guidelines," undated and	I		medication will be retrieved fro	om	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF CORRECTION	IDENTIFICATION NUMBER 155064	A. BUILDING B. WING	00	COMPLETED 09/23/2024
	PROVIDER OR SUPPLIER		3518 S	ADDRESS, CITY, STATE, ZIP COD LAFOUNTAIN ST MO, IN 46902	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE 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
	indicated "If a me order cannot be loca cart/drawer, other an medication room, an searched, if possible located after further contacted, or medica emergency kitIf a medication isnot a	ON on 9/18/24 at 4:27 p.m., dication with a current active ated in the medication reas of the medication cart, and facility (e.g., other units) are examples. If the medication cannot be investigation, the pharmacy is ation removed from the dose of regularly scheduled availablethe space provided MAR for that dosage tialed and circled.		the Ekit (if applicable) and the pharmacy and provider will be notified. This audit will be M-F weeks, then daily (M-F) going forward. 4 How will the facility monito performance to make sure the solutions are sustained; the p is implemented, and the correaction evaluated for its effectiveness; and the plan of correction is integrated into the quality assurance system? Beginning 9/25/24, the DON ADON will pull the eMAR administration compliance repeach day in clinical whiteboar meeting to review for medicate documented not administered to unavailability. The DON or ADON will audit the report to ensure all medications are available per physician orders medications are not available, medication will be retrieved from the Ekit (if applicable) and the pharmacy and provider will be notified. This audit will be M-F weeks, then daily (M-F) going forward. The results of these audits will reviewed in Quality Assurance Meeting monthly. The results these audits will be reviewed Quality Assurance Meeting monthly x6 months or until an average of 90% compliance of	or its at lan active e or port disons due i. If the pom i. X 8

DEPARTMENT OF HEALTH AND HU	MAN SERVICES		I
CENTERS FOR MEDICARE & MEDIC	AID SERVICES		(
STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION	(X3) DA
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 00	COM

AND PLAN	NT OF DEFICIENCIES OF CORRECTION PROVIDER OR SUPPLIE		3518 S	ADDRESS, CITY, STATE, ZIP COD	(X3) DATE SURVEY COMPLETED 09/23/2024	
APERIO	N CARE KOKOMO		KOKO	MO, IN 46902		
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) greater is achieved x3 consect	DATE	
				months. The QA Committee widentify any trends or patterns make recommendations to revithe plan of correction as indicated by the plan of compliance - 10/4/2024	vill and ise	
F 0761 SS=D Bldg. 00	facility failed to en when opened and r loose unidentified medication carts re (walnut hall) Findings include: During an observat bottles of eye drop and in the top draw open dates were or containing the bott medication cart had green, 2 round whi round yellow pill. A physician's order administer 1 drop of ophthalmic suspen eyes.	•	F 0761	F761 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 agreed by the provider of the truth of the facts alleged or conclusions seforth 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. This facility request a desk review for this alleged allegation. 1 What corrective action will accomplished for those resider found to have been affected by alleged deficient practice? Residents eye drops were	t nent he et	

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

Event ID:

80N911

Facility ID: 000025

If continuation sheet Page 14 of 19

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTR		ONSTRUCTION	(X3) DATE SURVEY	
		IDENTIFICATION NUMBER	A. B	a. Building <u>00</u>		COMPLETED	
155064		B. W	B. WING 09/23/2024			24	
NAME OF F	DROVIDED OF GUIDNIED			STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF PROVIDER OR SUPPLIER				3518 S	LAFOUNTAIN ST		
APERIO	N CARE KOKOMO			KOKON	MO, IN 46902		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE C	OMPLETION
TAG		LISC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		drops should have had open			discarded and new eye drops		
		e or bottle and the loose			ordered. Any loose pills were		
		have been removed and			removed from the cart.		
	destroyed.				2 How other residents havin	·	
		1 1 1 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2			potential to be affected by the		
		led "Storage of Medications,"			same deficient practice will be		
		ved from the Administrator on			identified and what corrective		
	_	., indicated "certain			action will be taken?		
		tage types, such as I.V.			All residents have the		
	_	dose, injectable vials,			potential to be affected by the		
		ycerin tablets, once opened,			alleged deficient practice.		
	required an expiration date shorter that the				All medications that are		
	manufacturer's expiration date to insure				stored in separate packages v		
	medication and potencywhen the original seal of				checked on 9/23/24 by the DC		
	a manufacturer's container or vial is initially				and ADON to all med carts we	ere	
broken, the container or vial will be datedthe				audited to ensure medications			
nurse shall place a "date opened" sticker on the				required date opened were lal			
	medication and enter the date opened"				with such, and the carts were	free	
					from loose pills.		
	3.1-25(m) 3.1-25(o)				3 What measures will be pur	t	
					into place and what systemati	С	
				changes will be made to ensu	re		
					that the deficient practice does	s not	
					recur?		
					On 9/23/24, the DON began		
					re-educating licensed nurses	and	
					Qualified Medication Assistan		
					on proper medication storage	to	
					include dating medications an	d	
					removing any loose pills in me	ed	
					carts. and loose pills in		
					medication carts.		
					How the corrective action will	be	
					monitored to ensure the defici	ent	
					practice will not recur, what qu	ıality	
					assurance program will be put	tinto	
					place? DON/designee will aud	lit	
					med carts to ensure meds are		
					dated (when applicable) and t	here	
					are not loose pills in carts.		

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/28/2024 FORM APPROVED OMB NO. 0938-039

i i i i i i i i i i i i i i i i i i i		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFIC		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>			COMPLETED		
155064		B. WING			09/23/2024			
NAME OF PROVIDER OR SUPPLIER APERION CARE KOKOMO			3	STREET ADDRESS, CITY, STATE, ZIP COD 3518 S LAFOUNTAIN ST KOKOMO, IN 46902				
(X4) ID PREFIX				ID EFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5) COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	Т	ΓAG	DEFICIENCY		DATE	
					Beginning 9/24/24, the DON of ADON will verify proper labeling medications in separate packar and assessment of the medications are also and assessment of the medications week X 4 weeks, then 2 times week X 4 weeks, then weekly weeks. The results of these audits will reviewed in Quality Assurance Meeting monthly. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consectments. The QA Committee widentify any trends or patterns make recommendations to revithe plan of correction as indications. Date of Compliance 10/4/2024	ng of ages ation s a a X 4 I be e of n utive will and vise ated.		
F 0804 SS=D Bldg. 00	Temp Based on observation review, the facility served at the proper followed, or resident of nutritional value puree recipes were received nutritional	pear, Palatable/Prefer on, interview and record failed to ensure food was temperature, menus were tts were offered a substitution of their choice, and to ensure followed to ensure residents adequacy for 1 of 1 resident viewed for food and diet.	F 0804	4	F804 This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does no constitute admission or agreed by the provider of the truth of the constitute.	nt ment	10/04/2024	

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

Event ID:

80N911

Facility ID: 000025

If continuation sheet

Page 16 of 19

AND PLAN OF CREATER ON CARE KOKOMO NAME OF PROVIDER OR SUPPLIER APERION CARE KOKOMO SOMMARY STATEMENT OF DEFICIENCE PREETS TAG (Resident 32, Cook 4 and Cook 5) (Resident 32, Cook 4 and Cook 5) Findings include: 1. During an interview, on 9/17/24 at 10:07 a.m., Resident 32 indicated the food tasted terrible because they kept decreasing the hadget and the food was often served cold. During an interview, on 9/18/24 at 12:05 p.m., Resident 32 indicated the fish was served very cold last evening, be was not sure if it was cooked all the way because it still seemed a little frozen in the middle, and the colesiaw was served at room temperature. During an interview, on 9/20/24 at 10:07 a.m., Resident 32 indicated according to the menu last evening he was to be served a hazon, lettruce, tomato (BLT) wrap with a salad but instead he received a grilled cheese sandwich with mashed potatoes and gravy. Resident 32 indicated this menu substitution happened routinely without them ever asking him what he would like as a substitute for his selection when they not or the menu items or had to serve something different because they did not have the correct ingredients. During an observation, on 9/20/24 at 12:36 p.m., the room tray cart with the 300 hall noom tray were being passed out and a test tray was received at 12:51 p.m., the liberary Manager (DM) tested the temperature of the items on the food tray. The temperature of the items on the food tray. The temperature for the lish should be 145 degrees.	STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY							SIIDAEA	
NAME OF PROVIDER OR SUPPLIER APERION CARE KOKOMO NAME OF PROVIDER OR SUPPLIER APERION CARE KOKOMO STREET ADDRESS, CITY, STATE, ZIP COD 3518 S LAFOUNTAIN ST KOKOMO, IN 46902 ID PROVIDER TAN OF CORRECTION TAG (Resident 32, Cook 4 and Cook 5) Findings include: During an interview, on 9/17/24 at 10:07 a.m., Resident 32 indicated the food ussed terrible because they kept decreasing the budget and the food was often served cold. During an interview, on 9/18/24 at 12:05 p.m., Resident 32 indicated the fish was sure if it was cooked all the way because it still seemed a little frozen in the middle, and the coleslaw was served at room temperature. During an interview, on 9/20/24 at 10:07 a.m., Resident 32 indicated according to the menu last evening he was to be served a bacon, lettuce, tomato (BLT) ways with a salad but instead he received a grilled cheese sandwich with mashed potatoes and gravy. Resident 32 indicated this menu substitution happened routinely without them ever asking him what he would like as a substitute for his selection when they run out of the menu items or had to serve something different because they did not have the correct ingredients. During an observation, on 9/20/24 at 12:36 p.m., the room tray cart with the 300 hall room trays were being passed out and a test tray was received at 12:51 p.m. the Dictury Manager (DM) tested the temperature of the items on the food tray. The temperature of the items on the food tray. The temperature of the fish was 118.9. She indicated the temperature of the fish was 118.9. She indicated the temperature of the fish she will be 145				r í			f '		
APERION CARE KOKOMO (X4) ID PRIEFIX TAG (Resident 32, indicated the food tasted terrible because they kept decreasing the budget at 12:05 p.m., Resident 32 indicated the fish was the servering, he was not sure if it was cooked all the way because it still secure a troin temperature. During an interview, on 9/20/24 at 10:07 a.m., Resident 32 indicated coording to the menu last evening he was not sure if it was cooked all the way because it still secure at room temperature. During an interview, on 9/20/24 at 10:07 a.m., Resident 32 indicated according to the menu last evening he was not sure if it was cooked all the way because it still secure at room temperature. During an interview, on 9/20/24 at 10:07 a.m., Resident 32 indicated according to the menu last evening he was to be served a bacon. Lettuce, tomato (BLT) wrap with a salad but instead he received a grilled cheese anadvich with mashed potatoes and gravy. Resident 32 indicated this menu substitution happened routinely without them ever asking him what he would like as a substitute for his selection when they without them ever asking him what he would like as a substitute for his selection when they without them ever something different because they did not have the correct ingredients. During an observation, on 9/20/24 at 12:36 p.m., the room tray cart with the 300 hall room trays were being passed out and a test tray was received at 12:51 p.m. the Dictary Manager (DM) tested the temperature of the items on the food tray. The temperature of the items on the food tray. The temperature of the items on the food tray. The temperature of the items on the food tray. The temperature of the items on the food tray. The temperature of the items on the food tray. The temperature of the fish should be 145	AND PLAN OF CORRECTION			_		<u>UU </u>			
APERION CARE KOKOMO (X9) ID SUMMARY STATEMENT OF DEPICIENCE PREFIX TAG (Resident 32, Cook 4 and Cook 5) Findings include: 1. During an interview, on 9/17/24 at 10:07 a.m., Resident 32 indicated the food tasted terrible because they kept decreasing the budget and the food was often served cold. During an interview, on 9/18/24 at 12:05 p.m., Resident 32 indicated the fish was served very cold last evening, he was not sure if it was cooked all the way because it still seemed a little frozen in the middle, and the coleslaw was served at room temperature. During an interview, on 9/20/24 at 10:07 a.m., Resident 32 indicated according to the menu last evening he was to be served a baseon, lettuce, tomato (BLT) wary with a sallab turi instead he received a grilled cheese sandwich with mashed polatose and gravy. Resident 37 indicated this menu substitution happened routinely without them ever asking him what he would like as a substitute for his selection when they ran out of the menu items or had to serve something different because they did not have the correct ingredients. During an observation, on 9/20/24 at 12:35 p.m., the room tray cart with the 300 hall room trays were being passed out and a test tray was received at 12:51 p.m. During an observation and interview, on 9/20/24 at 12:51 p.m., the bitany Manager (DM) tested the temperature of the ifish was 118.9. She indicated the the temperature of the fish should be 145 TAG Facts alleged or conclusions set forth in the statement of deficiences. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. This facility request a desk review for this alleged allegation. 1 What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice. 2 How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? All residents have the potential to be affected	155064			B. W	B. WING 09/23/2024				
APERION CARE KOKOMO (X4) ID PREFIX (RACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (Resident 32, Cook 4 and Cook 5) Findings include: (Resident 32 indicated the food tasted terrible because they kept decreasing the budget and the food was often served cold. During an interview, on 9/18/24 at 12:05 p.m., Resident 32 indicated the food tasted terrible because they kept decreasing the budget and the food was often served cold. During an interview, on 9/18/24 at 12:05 p.m., Resident 32 indicated the fish was served very cold last evening, be was not sure if it was cooked all the way because it still seemed a little frozen in the middle, and the coleslaw was served at room temperature. During an interview, on 9/20/24 at 10:07 a.m., Resident 32 indicated according to the menu last evening he was to be served a bacon, lettuce, tomato (BLT) wrap with a salad but instead he received a grilled cheese sandwich with mashed potatoses and gravy. Resident 32 indicated this menu substitution happened routinely without them ever asking him what he would like as a substitute for his selection when they run out of the menu items or had to serve something different because they did not have the correct ingredients. During an observation, on 9/20/24 at 12:35 p.m., the room tray cart with the 300 hall room trays were being passed out and a test tray was received at 12:51 p.m. beliancy Manager (DM) tested the temperature of the tish was 118.9. She indicated the temperature of the tish was 118.9. She indicated the temperature of the tish was 118.9. She indicated the temperature of the tish was 118.9. She indicated the temperature of the tish should be 145	NAME OF PROVIDER OR SUPPLIER								
INTERPRETARY STATEMENT OF DEFICIENCE TAG TROUBLEST PLAN OF CORRECTION TROUBEST PLAN OF CORRECTION TROUBEST PLAN OF CORRECTION TROUBLEST PLAN OF CORRECTION TROUBLEST PLAN OF CORRECTION TROUBLEST PLAN OF CORRECTION									
REGIL ATORY OR LSC IDENTIFYING INFORMATION (Resident 32, Cook 4 and Cook 5) Findings include: 1. During an interview, on 9/17/24 at 10:07 a.m., Resident 32 indicated the food tasted terrible because they kept decreasing the budget and the food was often served cold. During an interview, on 9/18/24 at 12:05 p.m., Resident 32 indicated the fish was served very cold last evening, he was not sure if it was cooked all the way because it still seemed a little frozen in the middle, and the coleslaw was served at room temperature. During an interview, on 9/20/24 at 10:07 a.m., Resident 32 indicated according to the menu last evening he was to be served a bacon, lettuce, tomato (BLT) wrap with a salad but instead he received a grilled cheese anadyvie with mashed potatoes and gravy. Resident 32 indicated this menu substitution happened routinely without them ever asking him what he would like as a substitute for his selection when they ran out of the menu items or had to serve something different because they did not have the correct ingredients. During an observation, on 9/20/24 at 12:36 p.m., the room tray cart with the 300 hall room trays were being passed out and a test tray was received at 12:51 p.m., the Dictary Manager (DM) tested the temperature of the fish should be 145 TAG Resident 32 indicated mode of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. This facility request a desk review for this alleged allogation. 1 What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice? Resident 32 has no adverse outcomes related to the alleged deficient practice will be identified and what corrective action will be taken? All residents have the potential to be affected by the alleged deficient practice. Cook #4 and dook #5 were educated on following recipes. The province of the fish was linear the fish should be 145 Tag Tag Tag Tag Tag Tag Tag Ta	APERION	N CARE KOKOMO			KOKON	MO, IN 46902			
TAG (Resident 32, Cook 4 and Cook 5) Findings include: 1. During an interview, on 9/17/24 at 10:07 a.m., Resident 32 indicated the food tasted terrible because they kept decreasing the budget and the food was often served cold. During an interview, on 9/18/24 at 12:05 p.m., Resident 32 indicated the fish was served very cold last evening, he was not sure if it was cooked all the way because it still secende all the food in the middle, and the coleslaw was served at room temperature. During an interview, on 9/20/24 at 10:07 a.m., Resident 32 indicated the fish was land but instead he received a grilled these sandwich with mashed potatoes and gravy. Resident 32 indicated this menu substitute for his selection when they ran out of the menu items or had to serve something different because they did not have the correct ingredients. During an observation, on 9/20/24 at 12:35 p.m., the room tray cart with the 300 hall room trays were being passed out and a test tray was received at 12:51 p.m., the Dictary Manager (DM) tested the temperature of the fish should be 145 PRESENT TAG Tag Resident 32 andicated fook 5) facts alleged or conclusions set forth in the statement of deficienies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. This facility request a desk review for this alleged allegation. 1. What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice? Resident 32 indicated the fish should be 145 1. What corrective action will be accomplished for those residents for this allegad allegation. 2. How other residents having the potential to be affected by the alleged deficient practice will be identified and what corrective action will be taken? All residents have the potential to be affected by the alleged deficient	(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE				PROVIDER'S PLAN OF CORRECTION		(X5)	
(Resident 32, Cook 4 and Cook 5) Findings include: 1. During an interview, on 9/17/24 at 10:07 a.m., Resident 32 indicated the food tasted terrible because they kept decreasing the budget and the food was often served cold. During an interview, on 9/18/24 at 12:05 p.m., Resident 32 indicated the fish was served very cold last evening, he was not sure if it was cooked all the way because it still seemed a little frozen in the middle, and the coleslaw was served at room temperature. During an interview, on 9/20/24 at 10:07 a.m., Resident 32 indicated according to the menu last evening he was to be served a bacon, lettuce, tomato (BLT) warp with a salad but instead he received a grilled cheese sandwich with mashed potatoes and gravy. Resident 32 indicated the potatoes and gravy. Resident 32 indicated this menu substitution happened routinely without them ever asking him what he would like as a substitute for his selection when they ran out of the menu items or had to serve something different because they did not have the correct ingredients. During an observation, on 9/20/24 at 12:36 p.m., the room tray cart with the 300 hall room trays were being passed out and a test tray was received at 12:51 p.m. During an observation and interview, on 9/20/24 at 12:51 p.m., the Dictary Manager (DM) (ested the temperature of the items on the food dray. The temperature of the fish should be 145	PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE		COMPLETION	
Findings include: 1. During an interview, on 9/17/24 at 10:07 a.m., Resident 32 indicated the food tasted terrible because they kept decreasing the budget and the food was often served cold. During an interview, on 9/18/24 at 12:05 p.m., Resident 32 indicated the fish was served very cold last evening, he was not sure if it was cooked all the way because it still seemed a little frozen in the middle, and the coleslaw was served at room temperature. During an interview, on 9/20/24 at 10:07 a.m., Resident 32 indicated according to the menu last evening he was to be served a bacon, lettuce, tomato (BLT) wrap with a salad but instead he received a grilled cheese sandwich with mashed potatoes and gravy. Resident 32 indicated this menu substitution happened routinely without them ever asking him what he would like as a substitute for his selection when they ran out of the menu items or had to serve something different because they did not have the correct ingredients. During an observation, on 9/20/24 at 12:36 p.m., the room tray cart with the 300 hall room trays were being passed out and a test tray was received at 12:51 p.m. During an observation and interview, on 9/20/24 at 12:51 p.m., the Dietary Manager (DM) tested the temperature of the items on the food tray. The temperature of the fish was 118.9. She indicated the temperature of the fish should be 145 forth in the statement of deficientes. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. This facility because it is required by the provisions of federal and state law. This facility because it is required by the provisions of federal and state law. This facility because it is required by the provisions of federal and state law. This facility by the saleged allogation. 1. What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice? Resident 32 has no adverse outcomes related the same deficient practice. 2. How other	TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG DEFICIENCY)			DATE	
Findings include: 1. During an interview, on 9/17/24 at 10:07 a.m., Resident 32 indicated the food tasted terrible because they kept decreasing the budget and the food was often served cold. During an interview, on 9/18/24 at 12:05 p.m., Resident 32 indicated the fish was served very cold last evening, he was not sure if it was cooked all the way because it still seemed a little frozen in the middle, and the coleslaw was served at room temperature. During an interview, on 9/20/24 at 10:07 a.m., Resident 32 indicated according to the menu last evening he was to be served a bacon, lettuce, tomato (BLT) wrap with a salad but instead he received a grilled cheese sandwich with mashed potatoes and gravy. Resident 32 indicated this menu substitution happened routinely without them ever asking him what he would like as a substitute for his selection when they ran out of the menu items or had to serve something different because they did not have the correct ingredients. During an observation, on 9/20/24 at 12:36 p.m., the room tray cart with the 300 hall room trays were being passed out and a test tray was received at 12:51 p.m. During an observation and interview, on 9/20/24 at 12:51 p.m., the Dietary Manager (DM) tested the temperature of the items on the food tray. The temperature of the fish should be 145 deficient is prepared and/or executed solely be easeast it is required by the provisions of federal and state law. This facility request a desk review for this alleged allegation. 1 What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice? Resident 32 indicated according to the menu last evering he was to be served a bacon, lettuce, outcomes related to the alleged deficient practice and and a test tray was received at 12:30 p.m., the redicated and state law. This facility request a desk review for this alleged allegation. 1 What corrective action will be excentive and according to the menu last for the seminate and according to the menu l		(Resident 32, Cook	4 and Cook 5)			_	et		
correction is prepared and/or executed solely because it is required by the provisions of federal and state law. This facility request a desk review for this alleged allegation. Resident 32 indicated the fish was served very cold last evening, he was not sure if it was cooked all the way because it still seemed a little frozen in the middle, and the coleslaw was served at room temperature. During an interview, on 9/20/24 at 10:07 a.m., Resident 32 indicated according to the menu last evening he was to be served a bacon, lettuce, tomato (BLT) wrap with a salad but instead he received a grilled cheese sandwich with mashed potatoes and gray. Resident 32 indicated this menu substitute for his selection when they ran out of the menu items or had to serve something different because they did not have the correct ingredients. During an observation, on 9/20/24 at 12:36 p.m., the room tray cart with the 300 hall room trays were being passed out and a test tray was received at 12:51 p.m. During an observation and interview, on 9/20/24 at 12:51 p.m., the Dictary Manager (DM) tested the temperature of the fish was 118.9. She indicated in the temperature of the fish should be 145 correction is prepared and/or executed solely be executed by the provisions of federal and state law. This facility request a desk review for this alleged allegation. 1 What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice. 2 How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? All residents have the potential to be affected by the alleged deficient practice. Cook #4 and cook #5 were educated on following recipes. 3 How the corrective action will be manager/designee to educate all cooks on the policy "Pureed Food Preparation" to include following the correct pureed recipe, ensuring food is at the correct energe the interview.									
I. During an interview, on 9/17/24 at 10:07 a.m., Resident 32 indicated the food tasted terrible because they kept decreasing the budget and the food was often served cold. During an interview, on 9/18/24 at 12:05 p.m., Resident 32 indicated the fish was served very cold last evening, he was not sure if it was cooked all the way because it still seemed a little frozen in the middle, and the coleslaw was served at room temperature. During an interview, on 9/20/24 at 10:07 a.m., Resident 32 indicated according to the menu last evening he was to be served a bacon, lettuce, tomato (BLT) wrap with a salad but instead he received a grilled cheese sandwich with mashed potatoes and gravy. Resident 32 indicated this menu substitution happened routinely without them ever asking him what he would like as a substitute for his selection when they ran out of the menu items or had to serve something different because they did not have the correct ingredients. During an observation and interview, on 9/20/24 at 12:51 p.m., the Dietary Manager (DM) tested the temperature of the fish was 118.9. She indicated the temperature of the fish should be 145 executed solely because it is required by the provisions of federal and state law. This facility request a desk review for this alleged allegation. 1 What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice. 2 How other residents having the potential to be affected by the same deficient practice. 2 How other residents having the potential to be affected by the same deficient practice. 3 How the corrective action will be identified and what corrective action will be taken? All residents have the potential to be affected by the alleged deficient practice. Cook #4 and cook #5 were educated on following recipes. 3 How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place? Dietary manager/designee to educate all cooks on the po		Findings include:				deficiencies. The plan of			
Resident 32 indicated the food tasted terrible because they kept decreasing the budget and the food was often served cold. During an interview, on 9/18/24 at 12:05 p.m., Resident 32 indicated the fish was served very cold last evening, he was not sure if it was cooked all the way because it still seemed a little frozen in the middle, and the coleslaw was served at room temperature. During an interview, on 9/20/24 at 10:07 a.m., Resident 32 indicated according to the menu last evening he was to be served a bacon, lettuce, tomato (BLT) wrap with a salad but instead he received a grilled cheese sandwich with mashed potatoes and gravy. Resident 32 indicated this menu substitution happened routnefy without them ever asking him what he would like as a substitute for his selection when they ran out of the menu items or had to serve something different because they did not have the correct ingredients. During an observation, on 9/20/24 at 12:36 p.m., the room tray cart with the 300 hall room trays were being passed out and a test tray was received at 12:51 p.m. the Dictary Manager (DM) tested the temperature of the items on the food tray. The temperature of the fish was 118.9. She indicated the federal and state law. This facility request a desk review for this alleged allegation. 1 What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice? Resident 32 has no adverse outcomes residents found to have been affected by the alleged deficient practice. 2 How other residents having the potential to be affected by the same deficient practice. 3 How the corrective action will be monitored to ensure the deficient practice. Cook #4 and cook #5 were educated on following recipes. 3 How the corrective action will be monitored to ensure the deficient practice. Cook #4 and cook #5 were educated on following recipes. 3 How the corrective action will be monitored to ensure the deficient practice. Octo #4 and cook #5 were educated on following recipes. 3 How						1 -	d and/or		
because they kept decreasing the budget and the food was often served cold. During an interview, on 9/18/24 at 12:05 p.m., Resident 32 indicated the fish was served very cold last evening, he was not sure if it was cooked all the way because it still seemed a little frozen in the middle, and the coleslaw was served at room temperature. During an interview, on 9/20/24 at 10:07 a.m., Resident 32 indicated according to the menu last evening he was to be served a bacon, lettuce, tomato (BLT) wrap with a salad but instead he received a grilled cheese sandwich with mashed potatoes and gray. Resident 32 indicated this menu substitution happened routinely without them ever asking him what he would like as a substitute for his selection when they ran out of the menu items or had to serve something different because they did not have the correct ingredients. During an observation, on 9/20/24 at 12:36 p.m., the room tray cart with the 300 hall room trays were being passed out and a test tray was received at 12:51 p.m. During an observation and interview, on 9/20/24 at 12:51 p.m., the Dietary Manager (DM) tested the temperature of the fish was 118.9. She indicated the temperature of the fish was 118.9. She indicated the temperature of the fish was 118.9. She indicated the temperature of the fish was 118.9. She indicated the temperature of the fish was 118.9. She indicated the temperature of the temperature of the fish was 118.9. She indicated the temperature of the fish was 118.9. She indicated the temperature of the fish was 118.9. She indicated the temperature of the fish was 118.9. She indicated the temperature, and		_				executed solely because it is	cause it is		
During an interview, on 9/18/24 at 12:05 p.m., Resident 32 indicated the fish was served very cold last evening, he was not sure if it was cooked all the way because it still seemed a little frozen in the middle, and the coleslaw was served at room temperature. During an interview, on 9/20/24 at 10:07 a.m., Resident 32 indicated according to the menu last evening he was to be served a bacen, lettuce, tomato (BLT) wrap with a salad but instead he received a grilled cheese sandwich with mashed potatoes and gravy. Resident 32 indicated this menu substitution happened routinely without them ever asking him what he would like as a substitute for his selection when they ran out of the menu items or had to serve something different because they did not have the correct ingredients. During an observation, on 9/20/24 at 12:36 p.m., the room tray cart with the 300 hall room trays were being passed out and a test tray was received at 12:51 p.m. During an observation and interview, on 9/20/24 at 12:51 p.m., the Dietary Manager (DM) tested the temperature of the fish was 118.9. She indicated the temperature of the fish should be 145 This facility request a desk review for this alleged allegation. 1 What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice. 2 How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? All residents have the potential to be affected by the alleged deficient practice. Cook #4 and cook #5 were educated on following recipes. 3 How the corrective action will be monitored to ensure the deficient practice. Cook #4 and cook #5 were educated in following recipes. During an observation, on 9/20/24 at 12:36 p.m., the room tray cart with the 300 hall room trays were being passed out and a test tray was received at 12:51 p.m., the Dietary Manager (DM) tested the temperature of the fish was 118.9. She indicated the temperature of the fish was						required by the provisions of			
During an interview, on 9/18/24 at 12:05 p.m., Resident 32 indicated the fish was served very cold last evening, he was not sure if it was cooked all the way because it still seemed a little frozen in the middle, and the coleslaw was served at room temperature. During an interview, on 9/20/24 at 10:07 a.m., Resident 32 indicated according to the menu last evening he was to be served a bacon, lettuce, tomato (BLT) wrap with a salad but instead he received a grilled cheese sandwich with mashed potatoes and gravy. Resident 32 indicated this menu substitution happened routinely without them ever asking him what he would like as a substitute for his selection when they ran out of the menu items or had to serve something different because they did not have the correct ingredients. During an observation, on 9/20/24 at 12:36 p.m., the room tray cart with the 300 hall room trays were being passed out and a test tray was received at 12:51 p.m. During an observation and interview, on 9/20/24 at 12:51 p.m., the Dietary Manager (DM) tested the temperature of the items on the food tray. The temperature of the fish was 118.9. She indicated the temperature of the fish was 118.9. She indicated the temperature of the fish was 118.9. She indicated the temperature of the fish should be 145						federal and state law.			
During an interview, on 9/18/24 at 12:05 p.m., Resident 32 indicated the fish was served very cold last evening, he was not sure if it was cooked all the way because it still seemed a little frozen in the middle, and the coleslaw was served at room temperature. During an interview, on 9/20/24 at 10:07 a.m., Resident 32 indicated according to the menu last evening he was to be served a bacon, lettuce, tomato (BLT) wrap with a salad but instead he received a grilled cheese sandwich with mashed potatoes and gravy. Resident 32 indicated this menu substitution happened routinely without them ever asking him what he would like as a substitute for his selection when they ran out of the menu items or had to serve something different because they did not have the correct ingredients. During an observation, on 9/20/24 at 12:36 p.m., the room tray cart with the 300 hall room trays were being passed out and a test tray was received at 12:51 p.m., the Dietary Manager (DM) tested the temperature of the items on the food tray. The temperature of the fish was 118.9. She indicated the temperature of the fish was 118.9. She indicated in the middle, and the colesslaw was served at room temperature, and 1 What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice. 2 How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? All residents have the potential to be affected by the alleged deficient practice. Cook #4 and cook #5 were educated on following recipes. 3 How the corrective action will be monitored to ensure the deficient practice. 2 How other residents having the potential to be affected by the same deficient practice. 3 How the corrective action will be monitored to ensure the deficient practice. 5 How there or the fash was linear the		food was often serv	red cold.			This facility request a desk			
Resident 32 indicated the fish was served very cold last evening, he was not sure if it was cooked all the way because it still seemed a little frozen in the middle, and the coleslaw was served at room temperature. During an interview, on 9/20/24 at 10:07 a.m., Resident 32 indicated according to the menu last evening he was to be served a bacon, lettuce, tomato (BLT) wrap with a salad but instead he received a grilled cheese sandwich with mashed potatoes and gravy. Resident 32 indicated this menu substitution happened routinely without them ever asking him what he would like as a substitute for his selection when they ran out of the menu items or had to serve something different because they did not have the correct ingredients. During an observation, on 9/20/24 at 12:36 p.m., the the room tray cart with the 300 hall room trays were being passed out and a test tray was received at 12:51 p.m., the Dietary Manager (DM) tested the temperature of the items on the food tray. The temperature of the items on the food tray. The temperature of the fish was 118.9. She indicated the temperature of the fish was 118.9. She indicated the temperature of the fish was 118.9. She indicated the temperature of the fish was 118.9. She indicated the temperature of the fish was 118.9. She indicated the temperature of the fish was 118.9. She indicated the temperature of the fish was 118.9. She indicated the temperature of the fish was 118.9. She indicated the temperature of the fish was 118.9. She indicated the temperature of the fish was 118.9. She indicated the temperature of the fish was 118.9. She indicated the temperature of the fish was 118.9. She indicated the temperature of the fish was 118.9. She indicated the temperature of the fish was 118.9. She indicated the temperature of the fish was 118.9. She indicated the temperature of the fish was 118.9. She indicated the temperature of the fish was 118.9. She indicated the temperature of the fish was 118.9. She indicated the temperature of the fish was 118.9. She indicated the t						review for this alleged			
cold last evening, he was not sure if it was sooked all the way because it still seemed a little frozen in the middle, and the coleslaw was served at room temperature. During an interview, on 9/20/24 at 10:07 a.m., Resident 32 indicated according to the menu last evening he was to be served a bacon, lettuce, tomato (BLT) wrap with a salad but instead he received a grilled cheese sandwich with mashed potatoes and gravy. Resident 32 indicated this menu substitution happened routinely without them ever asking him what he would like as a substitute for his selection when they ran out of the menu items or had to serve something different because they did not have the correct ingredients. During an observation, on 9/20/24 at 12:36 p.m., the Dietary Manager (DM) tested the temperature of the items on the food tray. The temperature of the fish was 118.9. She indicated the temperature for the fish should be 145		_	_			allegation.			
all the way because it still seemed a little frozen in the middle, and the coleslaw was served at room temperature. During an interview, on 9/20/24 at 10:07 a.m., Resident 32 indicated according to the menu last evening he was to be served a bacon, lettuce, tomato (BLT) wrap with a salad but instead he received a grilled cheese sandwich with mashed potatoes and gravy. Resident 32 indicated this menu substitution happened routinely without the menu items or had to serve something different because they did not have the correct ingredients. During an observation, on 9/20/24 at 12:36 p.m., the promoting an observation and interview, on 9/20/24 at 12:51 p.m., the Dictary Manager (DM) tested the temperature of the fish should be 145 accomplished for those residents found to have been affected by the alleged deficient practice? Resident 32 has no adverse outcomes related to the alleged deficient practice. 2 How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be affected by the alleged deficient practice. 2 How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be affected by the alleged deficient practice. 2 How other residents having the potential to be affected by the same deficient practice will be affected by the alleged deficient practice. 2 How other residents having the potential to be affected by the same deficient practice will be action will be affected by the alleged deficient practice. 3 How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place? Dietary manager/designee to educate all cooks on the policy "Pureed Food Preparation" to include following the correct pureed recipe, ensuring food is at the temperature for the fish should be 145		cold last evening, he was not sure if it was cooked							
the middle, and the coleslaw was served at room temperature. During an interview, on 9/20/24 at 10:07 a.m., Resident 32 indicated according to the menu last evening he was to be served a bacon, lettuce, tomato (BLT) wrap with a salad but instead he received a grilled cheese sandwich with mashed potatoes and gravy. Resident 32 indicated this menu substitution happened routinely without them ever asking him what he would like as a substitute for his selection when they ran out of the menu items or had to serve something different because they did not have the correct ingredients. During an observation, on 9/20/24 at 12:36 p.m., the room tray cart with the 300 hall room trays were being passed out and a test tray was received at 12:51 p.m. During an observation and interview, on 9/20/24 at 12:35 p.m., the Dietary Manager (DM) tested the temperature of the fish was 118.9. She indicated the alleged deficient practice. 2 How other residents having the potential to be affected by the asame deficient practice will be identified and what corrective action will be taken? All residents have the potential to be affected by the alleged deficient practice. 3 How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place? Dietary manager/designee to educate all cooks on the policy "Pureed Food Preparation" to include following the correct pureed recipe, ensuring food is at the correct temperature, and						What corrective action will	l be		
alleged deficient practice? Resident 32 has no adverse outcomes related to the alleged deficient practice. 2 How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? All residents have the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? All residents have the potential to be affected by the alleged deficient practice. 2 How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? All residents have the potential to be affected by the alleged deficient practice. Cook #4 and cook #5 were educated on following recipes. 3 How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place? During an observation and interview, on 9/20/24 at 12:31 p.m., the Dictary Manager (DM) tested the temperature of the fish was 118.9. She indicated the temperature, and						accomplished for those reside	ents		
During an interview, on 9/20/24 at 10:07 a.m., Resident 32 indicated according to the menu last evening he was to be served a bacon, lettuce, tomato (BLT) wrap with a salad but instead he received a grilled cheese sandwich with mashed potatoes and gravy. Resident 32 indicated this menu substitution happened routinely without them ever asking him what he would like as a substitute for his selection when they ran out of the menu items or had to serve something different because they did not have the correct ingredients. During an observation, on 9/20/24 at 12:36 p.m., the room tray cart with the 300 hall room trays were being passed out and a test tray was received at 12:51 p.m. During an observation and interview, on 9/20/24 at 12:51 p.m., the Dietary Manager (DM) tested the temperature of the items on the food tray. The temperature for the fish was 118.9. She indicated the temperature for the fish should be 145 Resident 32 has no adverse outcomes related to the alleged deficient practice. 2 How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? All residents 32 has no adverse outcomes related to the alleged deficient practice. 2 How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? All residents ave the potential to be affected by the alleged deficient practice. Cook #4 and cook #5 were educated on following recipes. 3 How the corrective action will be monitored to ensure the deficient practice will to be affected by the same deficient practice will be identified and what corrective action will be taken? All residents ave the potential to be affected by the same deficient practice will be identified and what corrective action will be affected by the same deficient practice will be identified and what corrective action will be taken? All residents ave the potential to be affected by the same deficient practice will be	the middle, and the coleslaw was served at room				found to have been affected b	y the			
During an interview, on 9/20/24 at 10:07 a.m., Resident 32 indicated according to the menu last evening he was to be served a bacon, lettuce, tomato (BLT) wrap with a salad but instead he received a grilled cheese sandwich with mashed potatoes and gravy. Resident 32 indicated this menu substitution happened routinely without them ever asking him what he would like as a substitute for his selection when they ran out of the menu items or had to serve something different because they did not have the correct ingredients. During an observation, on 9/20/24 at 12:36 p.m., the room tray cart with the 300 hall room trays were being passed out and a test tray was received at 12:51 p.m., the Dietary Manager (DM) tested the temperature of the fish was 118.9. She indicated the temperature for the fish should be 145 outcomes related to the alleged deficient practice. 2 How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? All residents have the potential to be affected by the alleged deficient practice. Cook #4 and cook #5 were educated on following recipes. 3 How the corrective action will be monitored to ensure the deficient practice. All residents have the potential to be affected by the same deficient practice will not be affected by the same deficient practice will be action will be taken? All residents have the potential to be affected by the alleged deficient practice. Cook #4 and cook #5 were educated on following recipes. 3 How the corrective action will be monitored to ensure the deficient practice. action will be taken? All residents have the potential to be affected by the alleged deficient practice. Cook #4 and cook #5 were educated on following recipes. 3 How the corrective action will be monitored to ensure the deficient practice. action will be put into place? Dietary manager/designee to educate all cooks on the policy "Pureed Food Preparation" to include following the correct pure deficient practice. a		temperature.				alleged deficient practice?			
Resident 32 indicated according to the menu last evening he was to be served a bacon, lettuce, tomato (BLT) wrap with a salad but instead he received a grilled cheese sandwich with mashed potatoes and gravy. Resident 32 indicated this menu substitution happened routinely without them ever asking him what he would like as a substitute for his selection when they ran out of the menu items or had to serve something different because they did not have the correct ingredients. During an observation, on 9/20/24 at 12:36 p.m., the room tray cart with the 300 hall room trays were being passed out and a test tray was received at 12:51 p.m., the Dictary Manager (DM) tested the temperature of the fish was 118.9. She indicated the temperature for the fish should be 145 deficient practice. 2 How other residents having the potential to be affected by the alleged deficient practice will be identified and what corrective action will be affected by the alleged deficient practice. Cook #4 and cook #5 were educated on following recipes. 3 How the corrective action will be monitored to ensure the deficient practice. 4 How other residents having the potential to be affected by the alleged and what corrective action will be affected by the alleged deficient practice. Cook #4 and cook #5 were educated on following recipes. 3 How the corrective action will be monitored to ensure the deficient practice. 4 If residents have the potential to be affected by the alleged deficient practice. Cook #4 and cook #5 were educated on following recipes. 3 How the corrective action will be monitored to ensure the deficient practice. 4 If residents have the potential to be affected by the alleged deficient practice. 5 Were educated on following recipes. 3 How the corrective action will be monitored to ensure the deficient practice. 5 Ook #4 and cook #5 were educated on following recipes. 5 How the corrective action will be monitored to ensure the deficient practice. 6 Ook #4 and cook #5 were educated on following recipes. 6 How the rec		_				Resident 32 has no adverse			
evening he was to be served a bacon, lettuce, tomato (BLT) wrap with a salad but instead he received a grilled cheese sandwich with mashed potatoes and gravy. Resident 32 indicated this menu substitution happened routinely without them ever asking him what he would like as a substitute for his selection when they ran out of the menu items or had to serve something different because they did not have the correct ingredients. During an observation, on 9/20/24 at 12:36 p.m., the room tray cart with the 300 hall room trays were being passed out and a test tray was received at 12:51 p.m. the Dietary Manager (DM) tested the temperature of the fish was 118.9. She indicated the temperature for the fish should be 145 2 How other residents having the potential to be affected by the alfected by the alfected by the alternative of the fish should be 145 2 How other residents having the potential to be affected by the asame deficient practice will be identified and what corrective action will be affected by the asame deficient practice will be identified and what corrective action will be affected by the same deficient practice will be identified and what corrective action will be affected by the asame deficient practice will be identified and what corrective action will be affected by the alternation will be affected by the alternation will be affected by the alternation will be affected by the action will be affected by the alternation will be affected by the action will be affected by the alternation will be affected by the action will be affected by the alternation will be affected by the alternation will be affected by the action will be action will be affected by the alternation will be affected by the action will be affected by the alternation will be affected by the action will be affected by the alternation will be action will be affected by the alternation will be action will be affected by the alternation						outcomes related to the allege	ed		
tomato (BLT) wrap with a salad but instead he received a grilled cheese sandwich with mashed potatoes and gravy. Resident 32 indicated this menu substitution happened routinely without them ever asking him what he would like as a substitute for his selection when they ran out of the menu items or had to serve something different because they did not have the correct ingredients. During an observation, on 9/20/24 at 12:36 p.m., the room tray cart with the 300 hall room trays were being passed out and a test tray was received at 12:51 p.m. During an observation and interview, on 9/20/24 at 12:35 p.m., the Dietary Manager (DM) tested the temperature of the items on the food tray. The temperature for the fish was 118.9. She indicated the temperature for the fish should be 145 Dourne an observation and interview, on 9/20/24 at 12:35 p.m., the Dietary Manager (DM) tested the temperature for the fish should be 145 Dourne an observation and interview, on 9/20/24 at 12:35 p.m., the Dietary Manager (DM) tested the temperature of the fish was 118.9. She indicated the temperature for the fish should be 145 Dourne an observation and interview, on 9/20/24 at 12:51 p.m., the Dietary Manager (DM) tested the temperature of the fish should be 145 Dourne an observation and interview, on 9/20/24 at 12:51 p.m., the Dietary Manager (DM) tested the temperature of the fish should be 145						deficient practice.			
received a grilled cheese sandwich with mashed potatoes and gravy. Resident 32 indicated this menu substitution happened routinely without them ever asking him what he would like as a substitute for his selection when they ran out of the menu items or had to serve something different because they did not have the correct ingredients. During an observation, on 9/20/24 at 12:36 p.m., the room tray cart with the 300 hall room trays were being passed out and a test tray was received at 12:51 p.m. During an observation and interview, on 9/20/24 at 12:35 p.m., the Dietary Manager (DM) tested the temperature of the fish was 118.9. She indicated the temperature for the fish should be 145 same deficient practice will be identified and what corrective action will be affected by the alleged deficient practice. Cook #4 and cook #5 were educated on following recipes. 3 How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place? Dietary manager/designee to educate all cooks on the policy "Pureed Food Preparation" to include following the correct pureed recipe, ensuring food is at the correct temperature, and		evening he was to b	e served a bacon, lettuce,			2 How other residents havin	g the		
potatoes and gravy. Resident 32 indicated this menu substitution happened routinely without them ever asking him what he would like as a substitute for his selection when they ran out of the menu items or had to serve something different because they did not have the correct ingredients. During an observation, on 9/20/24 at 12:36 p.m., the room tray cart with the 300 hall room trays were being passed out and a test tray was received at 12:51 p.m. During an observation and interview, on 9/20/24 at 12:35 p.m., the Dietary Manager (DM) tested the temperature of the fish was 118.9. She indicated the temperature for the fish should be 145 identified and what corrective action will be affected by the alleged deficient practice. Cook #4 and cook #5 were educated on following recipes. 3 How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place? Dietary manager/designee to educate all cooks on the policy "Pureed Food Preparation" to include following the correct pureed recipe, ensuring food is at the correct temperature, and		tomato (BLT) wrap	with a salad but instead he			potential to be affected by the			
menu substitution happened routinely without them ever asking him what he would like as a substitute for his selection when they ran out of the menu items or had to serve something different because they did not have the correct ingredients. During an observation, on 9/20/24 at 12:36 p.m., the room tray cart with the 300 hall room trays were being passed out and a test tray was received at 12:51 p.m. During an observation and interview, on 9/20/24 at 12:35 p.m., the Dietary Manager (DM) tested the temperature of the items on the food tray. The temperature for the fish was 118.9. She indicated the temperature for the fish should be 145 All residents have the potential to be affected by the alleged deficient practice. Cook #4 and cook #5 were educated on following recipes. 3 How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place? Dietary manager/designee to educate all cooks on the policy "Pureed Food Preparation" to include following the correct pureed recipe, ensuring food is at the correct temperature, and		received a grilled cl	heese sandwich with mashed			same deficient practice will be)		
them ever asking him what he would like as a substitute for his selection when they ran out of the menu items or had to serve something different because they did not have the correct ingredients. During an observation, on 9/20/24 at 12:36 p.m., the room tray cart with the 300 hall room trays were being passed out and a test tray was received at 12:51 p.m. During an observation and interview, on 9/20/24 at 12:36 p.m., the Dietary Manager (DM) tested the temperature of the fish was 118.9. She indicated the temperature for the fish should be 145 All residents have the potential to be affected by the alleged deficient practice. Cook #4 and cook #5 were educated on following recipes. 3 How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place? Dietary manager/designee to educate all cooks on the policy "Pureed Food Preparation" to include following the correct pureed recipe, ensuring food is at the correct temperature, and		potatoes and gravy.	Resident 32 indicated this			identified and what corrective			
substitute for his selection when they ran out of the menu items or had to serve something different because they did not have the correct ingredients. During an observation, on 9/20/24 at 12:36 p.m., the room tray cart with the 300 hall room trays were being passed out and a test tray was received at 12:51 p.m. During an observation and interview, on 9/20/24 at 12:35 p.m., the Dietary Manager (DM) tested the temperature of the fish was 118.9. She indicated the temperature for the fish should be 145 be affected by the alleged deficient practice. Cook #4 and cook #5 were educated on following recipes. 3 How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place? Dietary manager/designee to educate all cooks on the policy "Pureed Food Preparation" to include following the correct pureed recipe, ensuring food is at the correct temperature, and		menu substitution h	appened routinely without			action will be taken?			
the menu items or had to serve something different because they did not have the correct ingredients. During an observation, on 9/20/24 at 12:36 p.m., the room tray cart with the 300 hall room trays were being passed out and a test tray was received at 12:51 p.m. During an observation and interview, on 9/20/24 at 12:51 p.m., the Dietary Manager (DM) tested the temperature of the items on the food tray. The temperature for the fish was 118.9. She indicated the temperature for the fish should be 145 practice. Cook #4 and cook #5 were educated on following recipes. 3 How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place? Dietary manager/designee to educate all cooks on the policy "Pureed Food Preparation" to include following the correct pureed recipe, ensuring food is at the correct temperature, and		them ever asking hi	m what he would like as a			All residents have the potenti	al to		
different because they did not have the correct ingredients. Were educated on following recipes. 3 How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place? During an observation and interview, on 9/20/24 at 12:51 p.m., the Dietary Manager (DM) tested the temperature of the fish was 118.9. She indicated the temperature for the fish should be 145 Were educated on following recipes. 3 How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place? Dietary manager/designee to educate all cooks on the policy "Pureed Food Preparation" to include following the correct pureed recipe, ensuring food is at the correct temperature, and		substitute for his se	lection when they ran out of			be affected by the alleged def	icient		
ingredients. Tecipes. 3 How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place? During an observation and interview, on 9/20/24 at 12:51 p.m. During an observation and interview, on 9/20/24 at 12:51 p.m., the Dietary Manager (DM) tested the temperature of the items on the food tray. The temperature of the fish was 118.9. She indicated the temperature for the fish should be 145 Tecipes. 3 How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place? Dietary manager/designee to educate all cooks on the policy "Pureed Food Preparation" to include following the correct pureed recipe, ensuring food is at the correct temperature, and		the menu items or h	ad to serve something			practice. Cook #4 and cook #	! 5		
During an observation, on 9/20/24 at 12:36 p.m., the room tray cart with the 300 hall room trays were being passed out and a test tray was received at 12:51 p.m. During an observation and interview, on 9/20/24 at 12:51 p.m., the Dietary Manager (DM) tested the temperature of the fish was 118.9. She indicated the temperature for the fish should be 145 A How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place? Dietary manager/designee to educate all cooks on the policy "Pureed Food Preparation" to include following the correct pureed recipe, ensuring food is at the correct temperature, and		different because th	ey did not have the correct			were educated on following			
During an observation, on 9/20/24 at 12:36 p.m., the room tray cart with the 300 hall room trays were being passed out and a test tray was received at 12:51 p.m. During an observation and interview, on 9/20/24 at 12:51 p.m., the Dietary Manager (DM) tested the temperature of the fish was 118.9. She indicated the temperature for the fish should be 145 be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place? Dietary manager/designee to educate all cooks on the policy "Pureed Food Preparation" to include following the correct pureed recipe, ensuring food is at the correct temperature, and		ingredients.				recipes.			
the room tray cart with the 300 hall room trays were being passed out and a test tray was received at 12:51 p.m. During an observation and interview, on 9/20/24 at 12:51 p.m., the Dietary Manager (DM) tested the temperature of the items on the food tray. The temperature of the fish was 118.9. She indicated the temperature for the fish should be 145 deficient practice will not recur, what quality assurance program will be put into place? Dietary manager/designee to educate all cooks on the policy "Pureed Food Preparation" to include following the correct pureed recipe, ensuring food is at the correct temperature, and						3 How the corrective action	will		
were being passed out and a test tray was received at 12:51 p.m. What quality assurance program will be put into place? Dietary manager/designee to educate all cooks on the policy at 12:51 p.m., the Dietary Manager (DM) tested the temperature of the items on the food tray. The temperature of the fish was 118.9. She indicated the temperature for the fish should be 145 what quality assurance program will be put into place? Dietary manager/designee to educate all cooks on the policy "Pureed Food Preparation" to include following the correct pureed recipe, ensuring food is at the correct temperature, and		During an observat	ion, on 9/20/24 at 12:36 p.m.,			be monitored to ensure the			
received at 12:51 p.m. will be put into place? Dietary manager/designee to educate all cooks on the policy at 12:51 p.m., the Dietary Manager (DM) tested the temperature of the items on the food tray. The temperature of the fish was 118.9. She indicated the temperature for the fish should be 145 will be put into place? Dietary manager/designee to educate all cooks on the policy "Pureed Food Preparation" to include following the correct pureed recipe, ensuring food is at the correct temperature, and			with the 300 hall room trays			deficient practice will not recu	r,		
Dietary manager/designee to educate all cooks on the policy at 12:51 p.m., the Dietary Manager (DM) tested the temperature of the items on the food tray. The temperature of the fish was 118.9. She indicated the temperature for the fish should be 145 Dietary manager/designee to educate all cooks on the policy "Pureed Food Preparation" to include following the correct pureed recipe, ensuring food is at the correct temperature, and			out and a test tray was						
During an observation and interview, on 9/20/24 at 12:51 p.m., the Dietary Manager (DM) tested the temperature of the fish was 118.9. She indicated the temperature for the fish should be 145 educate all cooks on the policy "Pureed Food Preparation" to include following the correct pureed recipe, ensuring food is at the correct temperature, and		received at 12:51 p.m.				will be put into place?			
During an observation and interview, on 9/20/24 at 12:51 p.m., the Dietary Manager (DM) tested the temperature of the fish was 118.9. She indicated the temperature for the fish should be 145 educate all cooks on the policy "Pureed Food Preparation" to include following the correct pureed recipe, ensuring food is at the correct temperature, and		at 12:51 p.m., the Dietary Manager (DM) tested the temperature of the items on the food tray. The				Dietary manager/designee to			
at 12:51 p.m., the Dietary Manager (DM) tested the temperature of the items on the food tray. The temperature of the fish was 118.9. She indicated the temperature for the fish should be 145 "Pureed Food Preparation" to include following the correct pureed recipe, ensuring food is at the correct temperature, and							у		
temperature of the fish was 118.9. She indicated the temperature for the fish should be 145 pureed recipe, ensuring food is at the correct temperature, and						•	-		
temperature of the fish was 118.9. She indicated the temperature for the fish should be 145 pureed recipe, ensuring food is at the correct temperature, and						· ·			
the temperature for the fish should be 145 the correct temperature, and						_	is at		
		-				-	ice.		

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>			COMPLETED	
		155064	B. WING			09/23/2024	
				CTDEET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIE	R			LAFOUNTAIN ST		
∧DEDI∩I	N CARE KOKOMO				MO, IN 46902		
AFERIO	N CARE ROROWO			KOKOK	WO, IN 40902		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	PROVIDER'S PLAN OF CORRECTION	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	DEFICIENCY)		DATE
					4 How the corrective actio	n(s)	
		for Resident 32 was reviewed			will be monitored to ensure the	е	
		p.m. The diagnoses included,			deficient practice will not recu	r	
		d to, chronic obstructive			i.e., what quality assurance		
		chronic respiratory failure			program will be put into place		
		asthma, bipolar disorder			Dietary manager/designee wil	I	
		oomanic, recurrent major			audit cooks preparing pureed		
	-	, atrial fibrillation, and anxiety			foods to ensure they are follow	•	
	disorder.				recipe. Dietary manager/desig		
					will perform food temps to ens		
		Set (MDS) assessment, dated			they are in the correct temp ra	ınge.	
		e resident had a Brief Interview			Audits will be completed on 3		
	for Mental Status (BIMS) score of 14, which				pureed recipes and 3 trays a		
	indicated he was cognitively intact.				x 4 weeks, then 1 pureed reci	ре	
					and 1 tray temp a week x 5		
	A current care plan, dated as initiated and revised				months. Dietary		
	on 11/27/23, included the problem of having the				manager/designee will conduc	ct	
	potential for a nutritional problem.2. During an				random tray audits to ensure		
	observation, on 9/17/24 at 11:12 a.m., the facility				residents were given the corre	ect	
	menu indicated garlic bread was to be served for				food choice. Audits will be		
	lunch. Cook 4 indicated the facility had one				completed on 3 residents a w		
	resident on a puree diet. The cook retrieved two				x 4 weeks, then 1 resident a v	veek	
	slices of garlic bread from a metal pan and placed				x 5 months.		
	the garlic bread in the robot coupe (blender). She						
	then added two Tablespoons of melted butter.						
	The cook then added two and half cups of milk				The results of these audits wil		
	and started the blender. She looked inside the				reviewed in Quality Assurance		
	blender and stated the bread was too runny. The				Meeting monthly. The results		
	cook then added two slices of white bread. The				these audits will be reviewed	n	
	Dietary Manager (DM) asked Cook 4 if she			Quality Assurance Meeting			
	followed the recipe and had noticed Cook 4 used a				monthly x6 months or until an		
	four-cup measuring cup instead of a one cup measuring cup to measure the milk. The DM told				average of 90% compliance of		
	Cook 4 the recipe called for 3/4 cup of milk, and			greater is achieved x3 consecutive months. The QA Committee will			
	she measured two and half cups instead. The extra						
	milk made the bread too runny.				identify any trends or patterns make recommendations to rev		
	mink made the oread too fulfily.						
	3. During an observation, on 9/17/24 at 11:05 a.m.,				the plan of correction as indicate	at C U.	
	_	wation, on 9/17/24 at 11:03 a.m., will of unmeasured cake into the					
	_				Date of Compliance 40/4/202	1	
robot coupe. She then took a gallon of milk and					Date of Compliance 10/4/2024	t	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/28/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155064		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 09/23/2024			
NAME OF PROVIDER OR SUPPLIER APERION CARE KOKOMO			STREET ADDRESS, CITY, STATE, ZIP COD 3518 S LAFOUNTAIN ST KOKOMO, IN 46902					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	F	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE	
	blender. She blende indicated it was still another unmeasured into the robot coupe scrapped the edges of coupe. She indicated added more milk. Consider the interest of the in							

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 80N911 Facility ID: 000025 If continuation sheet Page 19 of 19