DEPARTMENT OF HEALTH AND HU	EPARTMENT OF HEALTH AND HUMAN SERVICES									
CENTERS FOR MEDICARE & MEDIC	CAID SERVICES									
STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION								

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155064	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		ONSTRUCTION	(X3) DATE SURVEY COMPLETED 10/01/2024	
	PROVIDER OR SUPPLIER			3518 S	ADDRESS, CITY, STATE, ZIP COD LAFOUNTAIN ST MO, IN 46902		
(X4) ID PREFIX TAG E 0000	(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)	TE	(X5) COMPLETION DATE
Bldg	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 10/01/24 Facility Number: 000025 Provider Number: 155064 AIM Number: 100274850 At this Emergency Preparedness survey, Aprion Care Kokomo was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 105 certified beds. At the time of the survey, the census was 55. Quality Review completed on 10/08/24		E 00	E 0000			
E 0006 SS=F Bldg	Plan Based on All Based on record rev failed to maintain at Plan (EPP) that was documented, facility risk assessment, util including missing re strategies for addres identified by the risl with 42 CFR 483.73	416.54(a)(1)-(2), 418 Hazards Risk Assessment iew and interview, the facility in Emergency Preparedness (1) based on and includes a y-based and community-based izing an all-hazards approach, esidents and (2) included using emergency events assessment in accordance (a) (1) and 42 CFR 483.73(a) (2). ce could affect all occupants.	E 00	006	E006 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 of forth in the statement of deficiencies. The plan of correction is prepared and/or	t ment the	10/03/2024

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

TITLE

(X6) DATE

Deana Jordan Collins Regional Nurse Consultant 10/22/2024 Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin

other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 80N921 Facility ID: 000025 If continuation sheet Page 1 of 43

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

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155064	(X2) MULTIPLE (A. BUILDING B. WING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED 10/01/2024			
	PROVIDER OR SUPPLIER		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 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			
TAG	Based on records re Director on 10/01/2 provided regarding and community-bas all-hazards approac an interview at the t Maintenance Direct utilizing an all-haza review was left blan This finding was re Nursing, Assistant	wiew with the Maintenance 4 at 10:45 a.m., the paperwork a documented facility-based sed risk assessment utilizing an h was not filled out. Based on time of record review, the sor agreed the risk assessment ards approach provided for	TAG	executed solely because it is required by the provisions of federal and state law. 1 How the corrective action be accomplished for those residents found to be affected the deficient practice: No residents negatively affected. 2 How will the facility identification of the residents having the potential to be affected by the same deficient practice: All residents have the potential to be affected. Facilification will keep updated and complete hazard risk assessment in EO binder. 3 What measures will be pure into place or what systemic changes the facility will make the ensure the deficient practice do not recur:	ty ted P ut to oes			
				Administrator will review EOP binder monthly to make sure a assessments are accurate and filled out	ıll			
				4 How will the facility monit its performance to make sure solutions are sustained; the place is implemented, and the correct action evaluated for its	that an			

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

Event ID:

80N921

Facility ID: 000025

If continuation sheet

Page 2 of 43

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

	OF CORRECTION	IDENTIFICATION NUMBER 155064	A. BUILDING B. WING		COMPLETED 10/01/2024
	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
				effectiveness; and the plan of correction is integrated into th quality assurance system? Add it to environmental section of the monthly QAP to review 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 of greater is achieved x3 consect months. The QA Committee widentify any trends or patterns make recommendations to revithe plan of correction as indicated.	l be e of in r cutive will and vise ated.
E 0037 SS=F Bldg	Based on record rev failed to conduct an Emergency Prepare facility must do all of training in emergency procedures to all ne individuals providing and volunteers, constroles; (ii) Provide entraining at least annotation of all training; (iv) Demonstraining; (iv) Demonstraining	iew and interview, the facility nual training for the dness Program (EPP). The LTC of the following: (i) Initial cy preparedness policies and w and existing staff, ag services under arrangement, sistent with their expected mergency preparedness	E 0037	E037 This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution this plan of correction does not constitute admission or agreed by the provider of the truth of facts alleged or conclusions of forth in the statement of deficiencies. The plan of correction is prepared and/or	of ot ment the

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

Event ID:

80N921

Facility ID: 000025

If continuation sheet

Page 3 of 43

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

		T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155064	l í	LDING	INSTRUCTION	(X3) DATE COMPL 10/01/	LETED	
		ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 3518 S LAFOUNTAIN ST KOKOMO, IN 46902					
(X4) PREF TA	FIX	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION deficient practice could affect acility.	I	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) executed solely because it is required by the provisions of	те	(X5) COMPLETION DATE	
		Nursing (DON) and 10/01/24 at 10:11 a. hires was completed annual EPP training existing staff could EPP was available from the time of the	eview with the Director of I the Maintenance Director on a.m., initial EPP training for new II, but no documentation of gor documentation to show demonstrate knowledge of the For review. Based on an e of records review, the for and the DON agreed annual asting staff was not conducted wiewed with the Director of Director of Nursing, and for during the exit conference.			1 How the corrective action be accomplished for those residents found to be affected the deficient practice: No residents were negatively affected. New employees will be trained on emergency preparedness upon their orientation period. Existing employees will be trained annually. 2 How will the facility idention other residents having the potential to be affected by the same deficient practice: All residents have the potential to be affected. Training completed for current employers all new employees will receive training during orientation perionally. 3 What measures will be trained annually. 3 What measures will be printo place or what systemic changes the facility will make ensure the deficient practice contrecur: The Maintenance Direct has been delegated to lead the emergency preparedness training to the same deficient practice of the same delegated to lead the emergency preparedness training to the same delegated to lead the emergency preparedness training the same delegated to lead the emergency preparedness training to the same delegated to lead the emergency preparedness training the same delegated to lead the emergency preparedness training the same delegated to lead the emergency preparedness training the same delegated to lead the emergency preparedness training the same deficient practice of the same delegated to lead the emergency preparedness training the same deficient practice of the same delegated to lead the emergency preparedness training the same deficient practice of the same deficient practice.	by on		

PRINTED: 10/28/2024

	T OF HEALTH AND HUN R MEDICARE & MEDIC						RM APPROVED B NO. 0938-039
STATEMEN		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155064	(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR A. BUILDING COMPLETE B. WING 10/01/20:			SURVEY .ETED	
	PROVIDER OR SUPPLIER	t		3518 S	ADDRESS, CITY, STATE, ZIP COD LAFOUNTAIN ST MO, IN 46902		
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CROSS-R TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY) for new and existing employee		(X5) COMPLETION DATE		
					The Administrator will review the annually with the Maintenance Director	his	
					4 How will the facility monit its performance to make sure it solutions are sustained; the plais implemented, and the correct action evaluated for its effectiveness; and the plan of correction is integrated into the quality assurance system?	that an ctive	
					The emergency preparedness training will be added to in-service as a recurrannual task. Human Resource will be monitoring to ensure ne employees are receiving their emergency preparedness train	es ew	
					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 consecuments. The QA Committee widentify any trends or patterns make recommendations to revithe plan of correction as indicated.	e of n r utive vill and vise	

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

Event ID:

80N921

Facility ID: 000025

If continuation sheet

5 Date of compliance 10/14/24

Page 5 of 43

CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES			OMB NO. 0938-039		
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING		COMPLETED		
		155064	B. WING		10/01/2024		
NAME OF I	PROVIDER OR SUPPLIER	\ \		ADDRESS, CITY, STATE, ZIP COD			
ADEDIO	N OADE KOKOMO			S LAFOUNTAIN ST			
APERIO	N CARE KOKOMO		KOKOMO, IN 46902				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE COMPLETION		
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE		
E 0039	402 749/4\/2\ 444	S E4(4)(2), 449,442(4)(
SS=C	, , , ,	6.54(d)(2), 418.113(d)(
Bldg	EP Testing Requi	rements					
Diag	Based on record rev	view and interview, the LTC	E 0039	E039	10/18/2024		
		ze the facility's response to and	E 0039	2039	10/16/2024		
		documentation of all		This Plan of Correction is the			
	_	dness Program drills. The LTC		center's credible allegation of			
	facility must do the			compliance.			
		annual full-scale exercise that		Preparation and/or execution of	of		
	is community-based			this plan of correction does no			
		ity-based exercise is not		constitute admission or agreer			
		an annual individual,		by the provider of the truth of t			
	facility-based funct			facts alleged or conclusions se			
		y experiences an actual natural		forth in the statement of	^		
		gency that requires activation		deficiencies. The plan of			
		lan, the LTC facility is exempt		correction is prepared and/or			
		ext required full-scale in a		executed solely because it is			
		or individual, facility-based		required by the provisions of			
		l exercise for 1 year following		federal and state law.			
	the onset of the actu	-		Today and state value			
	(ii) Conduct an add	itional exercise that may					
	' '	imited to the following:		1 How the corrective action	will		
	a. A second full-sca	_		be accomplished for those			
	community-based of	or an individual, facility-based		residents found to be affected	by		
	functional exercise.	_		the deficient practice:	,		
	b. A mock disaster	drill; or		No residents affected. The	ne		
	c. A tabletop exerci	se or workshop that is led by a		facility will complete a full-scale			
		des a group discussion, using		community-based exercise an			
	a narrated, clinically	y-relevant emergency scenario,		tabletop EP exercise.			
	and a set of problen	n statements, directed		·			
	messages, or prepar	red questions designed to		2 How will the facility identi	fy		
	challenge an emerg			other residents having the			
	(iii) Analyze the LT	CC facility's response to and		potential to be affected by the			
		ation of all drills, tabletop		same deficient practice:			
	exercises, and emer	gency events, and revise the		All residents have the			
	LTC facility's emer	gency plan, as needed in		potential to be affected. The			
	accordance with 42	CFR 483.73(d)(2). This		facility has completed tabletop	EP		

deficient practice could affect all occupants.

exercise annually.

PRINTED: 10/28/2024

	R MEDICARE & MEDIC			OMB NO. 0938-039				
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155064		(X2) MULTIPLE CONSTRUCTION (X3) DATE A. BUILDING COMPI			E SURVEY PLETED 1/2024			
	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 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)	TE	(X5) COMPLETION DATE		
	Nursing (DON) and 10/01/24 at 11:11 a annual exercises co 06/28/24 was income show the scenario of facility's response was taff followed the Eleffective. Based on records review, the no documentation for response was composed to the finding was responsed to the finding was responsed.	eview with the Director of d the Maintenance Director on .m., documentation for the inducted on 06/28/24 and on inplete. Both exercises did not of the exercise and if the exast analyzed to ensure the EPP to ensure the policies were an interview at the time of Maintenance Director stated for analyzing the LTC facility's leted. Viewed with the Director of Director of Nursing, and tor during the exit conference.		3 What measures will be purinto place or what systemic changes the facility will make ensure the deficient practice do not recur: Add to in-service calenda as a recurring annual reminder complete the training. Facility will conduct EP tabletop annually. 4 How will the facility monitits performance to make sure solutions are sustained; the plis implemented, and the correction evaluated for its effectiveness; and the plan of correction is integrated into the quality assurance system? Added to in-service as a recurring annual task. The Administrator will review this annually. 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 consect months. The QA Committee widentify any trends or patterns	to loes ar er to tor that an ctive e			

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

Event ID:

80N921

Facility ID: 000025

make recommendations to revise the plan of correction as indicated.

If continuation sheet

Page 7 of 43

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA	î ´	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155064					COMPLETED 10/01/2024	
		100001		_		10/01/	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
		t.		3518 S	ADDRESS, CITY, STATE, ZIP COD LAFOUNTAIN ST AO IN 46002			
AFERIO	· CARE KOKOWO			KOKOMO, IN 46902				
(X4) ID				ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)	
PREFIX TAG				PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.TE	COMPLETION DATE	
E 0041 SS=F Bldg	482.15(e), 483.73 Hospital CAH and	(e), 485.542(e), 485.62 LTC Emergency Power			5 Date of compliance 10/18	3/24		
	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION 482.15(e), 483.73(e), 485.542(e), 485.62 Hospital CAH and LTC Emergency Power Based on records review and interview, the facility failed to implement the emergency power system requirements found in the Health Care Facilities Code, NFPA 110, and the Life Safety Code in accordance with 42 CFR 483.73(e)(2). This deficient practice could affect all occupants. Findings include: Based on records review with the Maintenance Director on 10/01/24 at 10:42 a.m., the generator lacked complete weekly inspections and the monthly load testing required by the LSC and NFPA 110. Based on interview at the time of record review, the Maintenance Director stated the generator was missing some of the required testing. This finding was reviewed with the Director of Nursing, Assistant Director of Nursing, and Maintenance Director during the exit conference.		E 00	041	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 of forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1 How the corrective action be accomplished for those residents found to be affected the deficient practice: No residents were negatively affected. 2 How will the facility idention other residents having the potential to be affected by the same deficient practice: All residents have the	of ot ment the et by	10/20/2024	
					All residents have the potential to be affected.			

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

Event ID:

80N921

Facility ID: 000025

If continuation sheet

Page 8 of 43

PRINTED: 10/28/2024

	OF HEALTH AND HUR MEDICARE & MEDIC						RM APPROVED IB NO. 0938-039
STATEMEN	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155064	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		ONSTRUCTION	(X3) DATE SURVEY COMPLETED 10/01/2024	
	ROVIDER OR SUPPLIER	2		3518 S	ADDRESS, CITY, STATE, ZIP COD 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)	TE	(X5) COMPLETION DATE
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	Maintenance Director will complete weekly inspections a monthly load testing. 3 What measures will be pure into place or what systemic changes the facility will make the ensure the deficient practice do not recur: The Maintenance Director will complete and document weekly inspections and month load testing. The Administrator review this weekly with the Maintenance Director 4 How will the facility monite its performance to make sure the solutions are sustained; the place is implemented, and the correction evaluated for its effectiveness; and the plan of correction is integrated into the quality assurance system? The weekly inspection and monthly Inspection audit will be review during monthly safety	and ut to to to to to tr ty tr will or that an ctive	DATE
					committee meeting The results of these audits will reviewed in Quality Assurance Meeting monthly. The results of these audits will be reviewed in	of	

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

Event ID:

80N921

Facility ID: 000025

Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will

If continuation sheet

Page 9 of 43

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

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING B. WING			COMPLETED 10/01/2024	
		155064	B. WI	NG		10/01/	2024
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
APERION	N CARE KOKOMO				LAFOUNTAIN ST IO, IN 46902		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA [*] DEFICIENCY)	TE	COMPLETION DATE
K 0000					identify any trends or patterns make recommendations to rev the plan of correction as indicated as a Date of compliance 10/20	rise ated.	
Bldg. 01							
Blag. U1	Licensure Survey w Department of Heal 483.90(a). Survey Date: 10/01 Facility Number: 0 Provider Number: 1002 At this Life Safety C Kokomo was found Requirements for Pa Medicare/Medicaid. Life Safety from Fin National Fire Protect Life Safety Code (L Health Care Occupa This one-story facility one-story facility in the safety from Fin Sprinklered. The factory in the corridory of the corridory detectors in all residuals.	00025 155064 274850 Code survey, Aperion Care not in compliance with	K 0	000			

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

Event ID:

80N921

Facility ID: 000025

If continuation sheet

Page 10 of 43

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155064	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 10/01/2024	
	ROVIDER OR SUPPLIER	<u> </u>	3518 S	ADDRESS, CITY, STATE, ZIP COD 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 APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE	
K 0211	55 at the time of thi All areas where the access were sprinkl Quality Review cor NFPA 101	residents have customary ered. mpleted on 10/08/24	TAU		DAIL	
SS=F Bldg. 01	failed to ensure 3 of egress were continuous obstructions. LSC 1 into the required with wheeled equipment following condition (a) The wheeled equipment (a) The wheeled equipment (b) The health care training program and wheeled equipment emergency. (c) The wheeled equipment emergency. (c) The wheeled equipment in use ii. Medical emerger iii. Patient lift and to This deficient practifacility. Findings include: Based on observation Director on 10/01/2 p.m., in all resident equipped with wheeled into the program of the progra	on and interview, the facility of 3 resident corridors means of cously maintained free of 19.2.3.4 (4) states projections dth shall be permitted for or, provided that all of the as are met: uipment does not reduce the corridor width to less than 60 occupancy fire safety plan and ddress the relocation of the during a fire or similar tipment is limited to the and carts in use acy equipment not in use	K 0211	K211 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 set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1 How the corrective action be accomplished for those residents found to be affected the deficient practice: No residents were negatively affected. Trashcans were removed from hallway. 2 How will the facility identification of the correction is prepared and state law.	t nent he et will by	

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and 317. Based on an interview at the time of

Event ID:

80N921

Facility ID: 000025

If continuation sheet

potential to be affected by the

Page 11 of 43

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

AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155064			A. BUILDING B. WING	01	COMPLETED 10/01/2024
	PROVIDER OR SUPPLIER		3518 S	ADDRESS, CITY, STATE, ZIP COD LAFOUNTAIN ST MO, IN 46902	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION	ID PREFIX TAG	(X5) COMPLETION DATE	
140	observations, the Main trashcans at the aforem	tenance Director stated the entioned locations were els and would need to be s with wheels. ewed with the DON, fursing, and the		same deficient practice: All residents have the potential to be affected. A full facility assessment has been conducted ensuring there are trashcans without wheels left hallway outside of resident roo 3. What measures will be pinto place or what systemic changes the facility will make ensure the deficient practice on trecur: The facility will conduct of full facility assessment once a month for 6 months. 4. How will the facility monifits performance to make sure solutions are sustained; the place is implemented, and the correaction evaluated for its effectiveness; and the plan of correction is integrated into the quality assurance system? Facility Administrator will review monthly. 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 greater is achieved x3 consecutions.	no in oms. ut to does a tor that dan ctive e lill be e of in

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CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA

AND PLAN	AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155064		A. BUILI B. WING		-	COMPLETED 10/01/2024	
	PROVIDER OR SUPPLIEI	₹	STREET ADDRESS, CITY, STATE, ZIP COD 3518 S LAFOUNTAIN ST KOKOMO, IN 46902				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PR	ID PROVIDER'S PLAN OF CORRIECTIVE ACTION SHE CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
				months. The QA Commidentify any trends or paramake recommendations the plan of correction as	atterns and s to revise		
				5 Date of compliance	e 10/13/24		
(0271 SS=E Bldg. 01	NFPA 101 Discharge from E	xits					
	failed to ensure 1 of provided with an usurface in accordance edition) section 7.7 affect 25 residents exit. Findings include: Based on observation of the common way. It is section of the there were patched walkway uneven. For observation, the the walkway was in provide an unobstruction. Assistant	on and interview, the facility of 8 exit discharges were nobstructed level walking one with NFPA 101 (2012 This deficient practice could that would use the southeast on with the Maintenance on with the southeast on concrete walkway leading to on with the walk and the time on with the Maintenance on with the walking apart making the on with the maintenance on on the time on with the time on	K 027	This Plan of Correction center's credible allegat compliance. Preparation and/or exect this plan of correction do constitute admission or by the provider of the trafacts alleged or conclus forth in the statement of deficiencies. The plan of correction is prepared and executed solely because required by the provision federal and state law. 1 How the corrective be accomplished for the residents found to be afthe deficient practice: No residents were negatively affected.	cution of cution of ces not agreement uth of the ions set of end/or e it is ns of action will ose fected by	11/20/2024	

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

Event ID:

80N921

Facility ID: 000025

If continuation sheet

Page 13 of 43

PRINTED: 10/28/2024

EPARTMENT OF HEALTH AND HUMAN SERVICES ENTERS FOR MEDICARE & MEDICAID SERVICES						OMB NO. 0938-039	
	NT OF DEFICIENCIES I OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155064	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 10/01/2024		
	PROVIDER OR SUPPLIE		3518 \$	ADDRESS, CITY, STATE, ZIP COD S LAFOUNTAIN ST MO, IN 46902			
AI LINO	T CARE ROROWO		T RORO	1000, 114 40302		1	
(X4) ID PREFIX TAG	(EACH DEFICIEN	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 APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE	
	3.1-19(b)	R LSC IDENTIFICATION ON MATION		2 How will the facility ident other residents having the potential to be affected by the same deficient practice: All residents have the potential to be affected. Facili has reached out to outside verto prepare uneven walkway, awaiting quote. 3 What measures will be printo place or what systemic changes the facility will make ensure the deficient practice on the recur: Maintenance director has completed fully assessment for walkway leading from or to far will complete monthly assessment and report any findings to Administrator 4 How will the facility monitis performance to make sure solutions are sustained; the pris implemented, and the correction evaluated for its effectiveness; and the plan of correction is integrated into the quality assurance system?	ty endor out to does as or cility.	DAIL	
				Maintenance Director w complete monthly assessmen and report any findings to			

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

Event ID:

80N921

Facility ID: 000025

If continuation sheet

Administrator to be corrected.

The results of these audits will be reviewed in Quality Assurance

Page 14 of 43

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

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 01			COMPLETED	
		155064	B. WING 10/01/2024			/2024	
	PROVIDER OR SUPPLIER	· · · · · · · · · · · · · · · · · · ·	STREET ADDRESS, CITY, STATE, ZIP COD 3518 S LAFOUNTAIN ST KOKOMO, IN 46902				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
K 0291 SS=E	NFPA 101 Emergency Lightin	na			Meeting monthly. The results of these audits will be reviewed it Quality Assurance Meeting monthly x6 months or until an average of 90% compliance of greater is achieved x3 consect months. The QA Committee with identify any trends or patterns make recommendations to review plan of correction as indicated. 5 Date of compliance: TBD	r utive will and vise ated.	
Bldg. 01	Based on observation interview, the facility emergency battery monthly and annual emergency lighting accordance with Se requires functional monthly, with a min maximum of 5 weethan 30 seconds, (3 conducted annually if the emergency lighting powered and (5) Winspections and test for inspection by the jurisdiction. This domaintenance staff in	on, records review, and ty failed to ensure 1 of 1 backup lights was tested lly. LSC 19.2.9.1 requires shall be provided in ction 7.9. Section 7.9.3.1.1 (1) testing shall be conducted nimum of 3 weeks and a ks between tests, for not less) Functional testing shall be for a minimum of 1 1/2 hours ghting system is battery ritten records of visual s shall be kept by the owner	K 02	291	This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution this plan of correction does not constitute admission or agreed by the provider of the truth of the facts alleged or conclusions of 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.	of ment the et	10/20/2024
	Findings include: Based on an observ	ation with the Maintenance			How the corrective action be accomplished for those residents found to be affected		

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

Event ID:

80N921

Facility ID: 000025

If continuation sheet

Page 15 of 43

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 C A. BUILDING B. WING	construction 01	(X3) DATE SURVEY COMPLETED 10/01/2024		
	PROVIDER OR SUPPLIER		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	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE	
TAG	Director on 10/01/2 battery-powered emboiler room by the trecords review at 2: available to show a 30-second monthly light in the last 12 mat the time of record Director stated it is tested monthly and like a battery power sure. The findings were resulting the record of the state of the st	4 at 12:50 p.m., there was a sergency light in the main ransfer switch. Based on 30 p.m., no documentation 90-minute annual test or a test was conducted for the nonths. Based on an interview a review, the Maintenance unknown if the light was annually and the light did look red light but did not know for eviewed with the Director of Director of Nursing, and the or at the exit conference.	TAG	the deficient practice: No residents were negatively affected. 2 How will the facility ident other residents having the potential to be affected by the same deficient practice: All residents have the potential to be affected. No additional emergency lighting need during facility wide audi 3 What measures will be pinto place or what systemic changes the facility will make ensure the deficient practice on trecur: Maintenance director and designee will conduct a 90-mitest for annual testing and more forward will do 30 second testing monthly testing for powered emergency lighting for 12 months is implemented, and the correction evaluated for its effectiveness; and the plan of correction is integrated into the quality assurance system? Maintenance Director we complete annual and/or month battery powered emergency lighting for 12 months.	tify test t. out to does nd/or inute oving t nths. itor that clan ective e	

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

Event ID:

80N921

Facility ID: 000025

If continuation sheet

Page 16 of 43

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

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER			(X2) MULTIPLE CONSTRUCTION A. BUILDING 01		onstruction 01	(X3) DATE SURVEY COMPLETED	
		155064	B. WIN	G		10/01	/2024
	PROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZIP COD 3518 S LAFOUNTAIN ST KOKOMO, IN 46902				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NOY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	P.	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas Based on observatifailed to ensure 2 of square feet and bein amounts of combusting hazardous area. The affect 30 residents Findings include: Based on observation Director and Adminational a.m., the front store contained over 20 to that 50 square feet hazardous area. The protected as a hazar corridor door to the automatic closing,		K 032		The results of these audits wil 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 of greater is achieved x3 consect months. The QA Committee widentify any trends or patterns make recommendations to result the plan of correction as indicated as a part of the plan of correction as indicated as a part of the plan of correction does not constitute admission or agree by the provider of the truth of facts alleged or conclusions as 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.	of or sutive will and vise ated. 0/24 of ot ment the et	10/20/2024

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

Event ID:

80N921

Facility ID: 000025

If continuation sheet

Page 17 of 43

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

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155064		î ´	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 10/01/2024		
		ROVIDER OR SUPPLIER	·	3518	EET ADDRESS, CITY, STATE, ZIP COD 8 S LAFOUNTAIN ST KOMO, IN 46902		
		SUMMARY (EACH DEFICIEN REGULATORY OF Based on interviews the Maintenance Di storerooms contains combustible storage feet, and the corride self-closing or did r The findings were r Nursing, Assistant	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION IS at the time of observations, irector agreed the two ed large amounts of e, was larger than 50 square or door to the rooms were not	3518	8 S LAFOUNTAIN ST COMO, IN 46902 PROVIDER'S PLAN OF CORRECTION	dents de	(X5) COMPLETION DATE
					Maintenance director will conduct monthly audits in storeroom making sure boxe supplies are store correctly a less than 50cg feet. Administration of the conduction of th	and	

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

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01		ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED		
AND FLAIN	OI CORRECTION	155064			10/01		
	PROVIDER OR SUPPLIED		STREET ADDRESS, CITY, STATE, ZIP COD 3518 S LAFOUNTAIN ST KOKOMO, IN 46902				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE SICY 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)	NTE.	(X5) COMPLETION DATE
K 0324 SS=E	NFPA 101				will review audit during month safety committee meeting. The results of these audits wil 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 of greater is achieved x3 consect months. The QA Committee widentify any trends or patterns make recommendations to review plan of correction as indicated. 5. Date of compliance 10/20/2	I be e of in reutive will and vise ated.	
Bldg. 01	facility failed to en shutoff switch for 1 gym. LSC 19.3.2.5 compartment, reside equipment that is usefewer persons shall the cooking facility following condition Section 19.3.2.5.3(through (10) and (1 Section 19.3.2.5.3) the following is proceed as the cooking facility following is proceed as the following i	ervation and interview, the sure staff had access to the of 1 cook tops in the therapy of the second or commercial cooking sed to prepare meals for 30 or the permitted, provided that the complies with all of the ones: 3) states The requirements of (3) ones of the second of the ones of the second of the ones of the order of the ones of the order of the o	K 0.	324	K324 This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution this plan of correction does not constitute admission or agree by the provider of the truth of facts alleged or conclusions s forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of	of ot ment the	10/18/2024

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

Event ID:

80N921

Facility ID: 000025

If continuation sheet

Page 19 of 43

		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155064	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 10/01/2024	
	PROVIDER OR SUPPLIER	2	STREET ADDRESS, CITY, STATE, ZIP COD 3518 S LAFOUNTAIN ST KOKOMO, IN 46902			
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION	TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATI DEFICIENCY)	DATE	
IAG	facility that deactiv (b) The switch is us or range whenever supervision. This de five residents in the (#2.) Based on obset facility failed to pre equipment protecte extinguishing syste equipment shall be NFPA 96 section 1: appliances requirin, moved, modified, or re-evaluation of the the system installer otherwise allowed I extinguishing syste are approved existin permitted to be con approved method th appliances were ret location after they I maintenance and cl cooking equipment vapors and that mig grease in the hood, shall be protected be equipment. The def the kitchen and 30 room. The findings include Based on observation Director on 10/01/2 p.m.:	ates the cooktop or range. Seed to deactivate the cooktop the kitchen is not under staff efficient practice could affect the therapy gym. Ervation and interview, the operly install and maintain d by 1 of 1 kitchen hood ms. LSC 9.2.3 states cooking in accordance with NFPA 96. 2.1.2.2 states cooking g protection shall not be or rearranged without prior fire-extinguishing system by or servicing agent, unless by the design of the fire m, unless such installations ng installations, which shall be tinued in service, and have an nat would ensure that the urned to an approved design nad been moved for eaning. Section 10.1.2 states that produces grease-laden ght be a source of ignition of grease removal device, or duct ty fire-extinguishing ficient practice affects staff in residents in the main dining	1AG	federal and state law. 1 How the corrective action be accomplished for those residents found to be affected the deficient practice: No residents negatively affected. 2 How will the facility identify other residents having the potential to be affected by the same deficient practice: All residents have the potential to be affected. Facility has reached out to outside ven to add shutoff so that staff can have access. Schedule date for vendor to come is 10/18/2024. 3 What measures will be pur into place or what systemic changes the facility will make to ensure the deficient practice do not recur: Facility has reached out to outside vendor to come install shutoff. Maintenance and/or designee will conduct monthly audit once shut off is installed to make sure working properly. 4 How will the facility monitor its performance to make sure the solutions are sustained; the plat is implemented, and the correct	will y y dor r t b bes o	
l	[("1) There was a co	oktop in the therapy gym that	1	I is implemented, and the confec	uvo	

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

was separated from the corridor, but staff were

Event ID:

80N921

Facility ID: 000025

125 If continuation sheet

action evaluated for its

Page 20 of 43

PRINTED: 10/28/2024 FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 01 COMPLETED 155064 B. WING 10/01/2024 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 unable to deactivate the cooktop from power. effectiveness; and the plan of Based on interview at the time of observation, the correction is integrated into the Maintenance Director was asked if staff were able quality assurance system? to deactivate the cooktop and lock the switch. The Maintenance director stated a shut off switch Maintenance director will was not found. conduct monthly audits monthly audit once shut off is installed to (2.) The cooking equipment in the main kitchen make sure working properly. was covered by the fire suppression system, but the kitchen was not provided with an approved method that would ensure that the appliances The results of these audits will be were returned to an approved design location reviewed in Quality Assurance after they had been moved for maintenance and Meeting monthly. The results of cleaning. Based on interviews during observation, these audits will be reviewed in the Maintenance Director and Dietary Manager **Quality Assurance Meeting** agreed the kitchen was not provided with an monthly x6 months or until an approved method that would ensure that the average of 90% compliance or appliances were returned to an approved design greater is achieved x3 consecutive location after they had been moved for months. The QA Committee will maintenance and cleaning. identify any trends or patterns and make recommendations to revise The findings were reviewed with the Director of the plan of correction as indicated. Nursing, Assistant Director of Nursing, and the Maintenance Director at the exit conference. Date of compliance 10/18/24 3.1-19(b) K 0353 **NFPA 101** SS=F Sprinkler System - Maintenance and Testing Bldg. 01 (#1.) Based on record review and interview, the K 0353 K353 10/10/2024 facility failed to maintain 1 of 1 sprinkler system in accordance with LSC 9.7.5. LSC 9.7.5 requires all This Plan of Correction is the

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

automatic sprinkler systems shall be inspected

and maintained in accordance with NFPA 25,

Maintenance of Water-Based Fire Protection

Systems. NFPA 25, 2011 edition, Table 5.1.1.2

Standard for the Inspection, Testing, and

Event ID:

80N921

Facility ID: 000025

compliance.

center's credible allegation of

Preparation and/or execution of

this plan of correction does not

constitute admission or agreement

If continuation sheet

Page 21 of 43

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 155064 B. WING 10/01/2024 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 indicates the required frequency of inspection and by the provider of the truth of the testing. NFPA 25, 5.2.4.1 states gauges on wet facts alleged or conclusions set pipe sprinkler systems shall be inspected monthly forth in the statement of and gauges on dry systems (5.2.4.2) shall be deficiencies. The plan of inspected weekly to ensure normal water or air correction is prepared and/or pressure is being maintained. NFPA 25 13.3.2.1 executed solely because it is states valves should be inspected weekly or required by the provisions of valves secured locks or supervised (13.3.2.1.1) federal and state law. shall be permitted to be inspected monthly. (#2.) Based on observation and interview, the How the corrective action will facility failed to ensure 2 of 2 sprinklers in the be accomplished for those kitchen washroom were free of corrosion. NFPA residents found to be affected by 25, 2011 edition, at 5.2.1.1.1 sprinklers shall not the deficient practice: show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and No residents were shall be installed in the correct orientation (e.g., negatively affected. up-right, pendent, or sidewall). Furthermore, at 5.2.1.1.2 any sprinkler that shows signs of any of How will the facility identify the following shall be replaced: (1) Leakage (2) other residents having the Corrosion (3) Physical Damage (4) Loss of fluid in potential to be affected by the the glass bulb heat responsive element (5) same deficient practice: Loading (6) Painting unless painted by the All residents have the sprinkler manufacturer. potential to be affected. Both deficient sprinkler head were This deficient practice could affect all occupants. replaced on 10/10/2024. Facility wide audit conduct no additional Findings include: sprinklers with corrosion identified. (#1.) Based on records review with the What measures will be put Maintenance Director on 10/01/24 at 10:13 a.m., into place or what systemic there was no monthly inspection of the wet pipe changes the facility will make to sprinkler system's gauges and valves for the ensure the deficient practice does months of October 2023 to April of 2024. During not recur: an interview at the time of record review, the Maintenance Director stated the inspection of Maintenance Director will gauges and valves were not conducted due to inspect all sprinkler heads there being no Maintenance Director during the monthly and ensure they are free aforementioned months. from corrosion.

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

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155064	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 10/01/2024
	ROVIDER OR SUPPLIER		3518 S	ADDRESS, CITY, STATE, ZIP COD LAFOUNTAIN ST MO, IN 46902	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	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
	Director on 10/01/2 heads in the kitchen showed signs of cor at the time of obserdirector agreed two washroom showed signs. The findings were resulting. Assistant I	evation with the Maintenance 4 at 1:21 p.m., the two-sprinkler 1 washroom were green and 1 rosion. Based on an interview 1 vation, the Maintenance 2 sprinkler heads in the kitchen 1 signs of corrosion. 1 eviewed with the Director of 1 Director of Nursing, and the 1 or at the exit conference.		4 How will the facility moni its performance to make sure 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? Maintenance Director w conduct monthly checks on all sprinkler heads in the facility the ensure all heads are free from corrosion. 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 greater is achieved x3 consect months. The QA Committee widentify any trends or patterns make recommendations to rethe plan of correction as indiced.	that lan ective e e ill l co n ll be e of in or cutive will s and vise ated.
K 0372 SS=E Bldg. 01	Barrie Based on observation	Iding Spaces - Smoke on and interview, the facility penetrations caused by the	K 0372	K372	10/24/2024

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

Event ID:

80N921

Facility ID: 000025

If continuation sheet

Page 23 of 43

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155064	(X2) MULTIPLE A. BUILDING B. WING	E CONSTRUCTION O1	(X3) DATE SURVEY COMPLETED 10/01/2024		
	PROVIDER OR SUPPLIER	8	STREET ADDRESS, CITY, STATE, ZIP COD 3518 S LAFOUNTAIN ST KOKOMO, 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 B CROSS-REFERENCED TO THE APPROPE	(X5) E COMPLETION DATE		
	smoke barrier walls smoke resistance of Section 8.5.6.2 requested trays, conduit and similar items to mechanical, plumbs systems that pass the floor/ceiling assembarrier, or through roof/ceiling of a small protected by a system restricting the move	lor conduit through 4 of 10 s were protected to maintain the feach smoke barrier. LSC aires penetrations for cables, s, pipes, tubes, vents, wires, o accommodate electrical, ing, and communications arough a wall, floor, or obly constructed as a smoke the ceiling membrane of the looke barrier assembly, shall be term or material capable of the ement of smoke. This deficient et staff and at least 40 residents partments.		This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution this plan of correction does in constitute admission or agree by the provider of the truth of facts alleged or conclusions forth in the statement of deficiencies. The plan of correction is prepared and/of executed solely because it is required by the provisions of federal and state law.	of n of not eement of the set		
	Findings include: Based on observations with the Maintenance Director on 10/01/24 between 1:45 p.m. and 2:15 p.m., the following unsealed penetrations were discovered: a) Above the drop ceiling of smoke wall #1 had a 3/4-inch unsealed gap around wires and black and gray caulk with unknown UL Listing. b) Above the drop ceiling of smoke wall #7 had a 3/4-inch unsealed gap around wires and black and gray caulk with unknown UL Listing. c) Above the drop ceiling of smoke wall #8 had unsealed broken pipe sleeve containing wires. d) Above the drop ceiling of smoke wall #10 had a 3/4-inch unsealed gap around wires and black and gray caulk with unknown UL Listing. e) Above the drop ceiling of smoke wall #11 had a 3/4-inch unsealed gap around wires and black and gray caulk with unknown UL Listing. Based on interview at the time of observation, the			How the corrective active accomplished for those residents found to be affected the deficient practice: No residents negatively affected.	ed by		
				2 How will the facility idea other residents having the potential to be affected by the same deficient practice: All residents have the potential to be affected. Maintenance director of designee will update smoke layout to include what doors safe smoke barriers, plan will include which resident are non smoke barriers. 3 What measures will be	or barrier are II ear		
		tor agreed the aforementioned ned unsealed penetrations or cnown UL Listing.		into place or what systemic			

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 10/28/2024 FORM APPROVED

	R MEDICARE & MEDI					B NO. 0938-039
	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155064		(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 10/01/2024	
	PROVIDER OR SUPPLIE		3518 S	ADDRESS, CITY, STATE, ZIP COD S LAFOUNTAIN ST MO, IN 46902		
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPRODEFICIENCY)	ION D BE DPRIATE	(X5) COMPLETION DATE
	The findings were Nursing, Assistant Maintenance Direct 3.1-19(b)	reviewed with the Director of Director of Nursing, and the etor at the exit conference.		ensure the deficient praction rot recur: Maintenance will cor annual inspections of all subarriers to ensure all penerare fire caulked. No addition the process of the plan of correction is integrated in Quality assurance systems. Annual smoke barries checks will be added to Temporary. The results of these audits reviewed in Quality Assurance Meeting monthly. The results will be reviewed Quality Assurance Meeting monthly x6 months or until average of 90% compliance greater is achieved x3 commonths. The QA Committed identify any trends or patternake recommendations to the plan of correction as in the plan of correction as in the plan of compliance 1	mplete moke trations onal area nonitor ure that e plan orrective n of o the er wall els s will be ance ults of eed in g l an ce or isecutive ee will erns and o revise edicated.	
K 0511	NFPA 101					

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

Utilities - Gas and Electric

SS=E

Event ID:

80N921

Facility ID: 000025

If continuation sheet

Page 25 of 43

PRINTED: 10/28/2024

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES				FORM APPROVED OMB NO. 0938-039			
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155064		JILDING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 10/01/2024	
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD S LAFOUNTAIN ST		
APERIO	N CARE KOKOMO			KOKOI	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 APPROPRIATE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)		DATE
Bldg. 01	failed to ensure 2 of 4 main power switch operating condition to comply with Secreterical wiring and NFPA 70, 2011 edit parts of service equivalents of the service of	on and interview, the facility of 2 electrical terminals and 4 of thes were maintained in safe LSC 19.5.1.1 requires utilities tion 9.1. LSC 9.1.2 requires d equipment to comply with. tion states 230.62 Energized ipment shall be enclosed as A) or guarded as specified in gized parts shall be enclosed be exposed to accidental guarded as in 230.62(B). tized parts that are not enclosed a switchboard, panelboard, or uarded in accordance with Where energized parts are d in 110.27(A)(1) and (A)(2), a for sealing doors providing parts shall be provided. This build affect staff and residents. tice could affect all residents on with the Maintenance 4 at 1:11 p.m., in the ADON ght fixture missing two bulbs or terminals. Based on an te of the observation, the tor agreed the light was talls in the ADON office with minals. eviewed with the Director of	K 0	511	This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution this plan of correction does not constitute admission or agree by the provider of the truth of facts alleged or conclusions of the factor of the plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1 How the corrective action be accomplished for those residents found to be affected the deficient practice: No residents were negatively affected. The two be missing from the light fixture exposing the copper terminals was fixed. 2 How will the facility ident other residents having the potential to be affected by the same deficient practice: All residents have the	of ot ment the et by oulbs	10/20/2024

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

3.1-19(b)

Nursing, Assistant Director of Nursing, and the

Maintenance Director at the exit conference.

Event ID:

80N921

Facility ID: 000025

potential to be affected.

Maintenance Director/designee will make checks to ensure that

there are no bulbs missing from

If continuation sheet

Page 26 of 43

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

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155064	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 10/01/2024
	ROVIDER OR SUPPLIE		3518 S	ADDRESS, CITY, STATE, ZIP CO LAFOUNTAIN ST MO, IN 46902	D
(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 CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE API DEFICIENCY)	CTION (X5) ULD BE PROPRIATE COMPLETION DATE
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	light fixtures. 3 What measures will into place or what system changes the facility will mensure the deficient praction recur: Maintenance Director/designee will mechecks to ensure that the bulbs missing from light Checks will be added to maintenance logs. 4 How will the facility its performance to make solutions are sustained; is implemented, and the action evaluated for its effectiveness; and the procorrection is integrated in the system.	I be put mic make to ctice does ake ere are no fixtures. quarterly monitor sure that the plan corrective
				Maintenance Direct bring results to QAA mo months and quarterly the 100% compliant. The results of these aud reviewed in Quality Assu Meeting monthly. The rethese audits will be revie Quality Assurance Meet monthly x6 months or ur average of 90% compliant greater is achieved x3 components. The QA Commidentify any trends or page 100.	etor will enthly for 6 ereafter if its will be arance esults of ewed in ing entil an ence or onsecutive eittee will

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

Event ID:

80N921

Facility ID: 000025

If continuation sheet

Page 27 of 43

	VT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155064	(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 10/01/2024
	PROVIDER OR SUPPLIER		3518 \$	FADDRESS, CITY, STATE, ZIP COD S LAFOUNTAIN ST DMO, 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
				make recommendations to revelope the plan of correction as indicated as a Date of compliance 10/20	ated.
K 0711 SS=F Bldg. 01	NFPA 101 Evacuation and R	elocation Plan			
	interview; the facili written Fire Safety location of the FSP (#1.) LSC 19.7.1.1 every health care of and available to all copies of a plan for the event of fire, for refuge, and for their when necessary. (#2.) LSC 19.7. stat incorporat all items 19.7.2.2. 1. Use of alarms.	riew, observation, and ty failed to provide 1 of 1 Plans (FSP) or know the according to LSC 19.7. states that the administration of ecupancy shall have, in effect supervisory personnel, written the protection of all persons in their evacuation to areas of evacuation from the building es the fire safety plan must listed in NFPA 101, Section	K 0711	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.	t ment he
	 Emergency phor Response to alar Isolation of fire. Evacuation of in Evacuation of sn Preparation of flevacuation. Extinguishment This deficient pract	nmediate area. noke compartment. oors and building for		How the corrective action be accomplished for those residents found to be affected the deficient practice: No residents were negatively affected. How will the facility idention other residents having the potential to be affected by the same deficient practice:	by

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

Event ID:

80N921

Facility ID: 000025

If continuation sheet

Page 28 of 43

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155064		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 10/01/2024	
	PROVIDER OR SUPPLIEI		3518 S	ADDRESS, CITY, STATE, ZIP COD LAFOUNTAIN ST MO, IN 46902	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION
TAG	(#1.) Based on obse Nursing (DON) on Management (included Maintenance Direct of the FSP and coulincluding at the nursing office, Maintenance Preparedness Plan. 3:30 p.m., the DON company's web site plan for the companinformation for the 12:10 p.m., the DO of the FSP was located in the DON checked the DON checked the the DON checked the DON checked the DON checked the the DON checked the DON	tor) did not know the location ld not be found in the facility se's station, Administrator's e office, nor in the Emergency Based on records review at I found a copy of the FSP on the I, but the FSP was a generic my and did not include specific facility. Based on interviews at IN was asked where the location ated, and the DON stated I am at the nurse's station. When the nurse's station the FSP was IS was not located until 3:00 mee Director also stated he did on of the FSP. Fords review with the tor and the DON on 10/01/24 at ided facility's FSP did not mg items: Fincke compartments. The facility location of the facility's or location of non-barrier cross ould be mistaken as a soors and buildings for callity did not address removing aipment from the corridors and turing a fire evacuation. Fincke the location of the smoke/fire gethe halls of wheeled	TAG	All residents have the potential to be affected. Fire Safety Plan updated. Fire safe plan will be placed EOP binded. 3 What measures will be placed into place or what systemic changes the facility will make ensure the deficient practice of not recur: Maintenance Director with monthly audit of EOP binder making sure most updated factorist fisp is in binder. 4 How will the facility monit its performance to make sure solutions are sustained; the place is implemented, and the correaction evaluated for its effectiveness; and the plan of correction is integrated into the quality assurance system? Maintenance Director/designee Continued review fire safety policies and procedures by Administrator and designee during monthly Performance Improvement meeting. The results of these audits will reviewed in Quality Assurance Meeting monthly x6 months or until and the potential and the potential and the plan of correction is integrated into the quality Assurance Meeting monthly. The results these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until and the potential and the plan of the pl	ety ers. ut to does ill do cility tor that lan ective e

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 01 COMPLETED 155064 B. WING 10/01/2024 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 DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE The findings were reviewed with the DON, average of 90% compliance or Assistant Director of Nursing, and the greater is achieved x3 consecutive Maintenance Director at the exit conference. months. The QA Committee will identify any trends or patterns and 3.1-19(b)make recommendations to revise the plan of correction as indicated. Date of compliance 10/18/24 K 0712 **NFPA 101** SS=F Fire Drills Bldg. 01 Based on record review and interview, the facility K 0712 K712 10/20/2024 failed to conduct fire drills on each shift for 3 of 4 quarters. LSC 19.7.1.6 states drills shall be This Plan of Correction is the conducted quarterly on each shift to familiarize center's credible allegation of facility personnel (nurses, interns, maintenance compliance. engineers, and administrative staff) with the Preparation and/or execution of signals and emergency action required under this plan of correction does not varied conditions. This deficient practice affects constitute admission or agreement all staff and residents. by the provider of the truth of the facts alleged or conclusions set Findings include: forth in the statement of deficiencies. The plan of Based on records review with the Maintenance correction is prepared and/or Director on 10/01/24 at 10:02 a.m., the following executed solely because it is shifts were missing documentation of completed required by the provisions of federal and state law. a) A third shift fire drill in the first quarter of 2024. b) A third shift fire drill in the second quarter of 2024. How the corrective action will c) A first, second, and third shift fire drills in the be accomplished for those fourth quarter of 2023. residents found to be affected by Based on an interview at the time of record review, the deficient practice: the Maintenance Director agreed there were five

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

drills that were not completed within the last four

Event ID:

80N921

Facility ID: 000025

If continuation sheet

No residents were

Page 30 of 43

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

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155064	B. Wl	NG		10/01/	/2024
	PROVIDER OR SUPPLIED			3518 S	ADDRESS, CITY, STATE, ZIP COD LAFOUNTAIN ST MO, IN 46902		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DECLIDED IN AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE
	_	eviewed with the Director of			negatively affected. Missing documentation for fire drills		
		Director of Nursing and the			2 How will the facility identi	fy	
	Maintenance Direc	tor at the exit conference.			other residents having the		
	21.10(1)				potential to be affected by the		
	3.1-19(b)				same deficient practice:		
	3.1-51(c)				All residents have the potential to be affected. Maintenance director will conducted quarterly drills for each shift. A fire drilling up to date 3 What measures will be printo place or what systemic changes the facility will make ensure the deficient practice of not recur: Maintenance Director all shift drill has been conducted	ut to does I and	
					the facility is on track for each		
					shift to practice a fire drill quan moving forward for compliance	-	
					4 How will the facility monit its performance to make sure solutions are sustained; the pl is implemented, and the correaction evaluated for its effectiveness; and the plan of correction is integrated into the quality assurance system? Maintenance Director/designee will provide	tor that an ctive e	
					calendar year form during Saf	-	
					Committee monthly meeting to	o	

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

Event ID:

80N921

Facility ID: 000025

If continuation sheet

Page 31 of 43

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

	OF CORRECTION	IDENTIFICATION NUMBER 155064	A. BUILDING B. WING	01	COMPLETED 10/01/2024
	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
K 0741 SS=E Bldg. 01	NFPA 101 Smoking Regulation	ons		ensure future compliance with rotating shifts. Administrator we review drill audit books. 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 of greater is achieved x3 consect months. The QA Committee widentify any trends or patterns make recommendations to review plan of correction as indicated to the plan of compliance 10/26.	vill I be e of in r cutive will and vise ated.
5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5	failed to ensure 1 of maintained by disponental or noncombus self-closing cover decould affect staff an southeast exit. Findings include: Based on records re Director on 10/01/2-12:40 p.m. outside t	on and interview, the facility 2 smoking areas were using of cigarette butts in a stible container with evices. This deficient practice d 25 residents using the view with the Maintenance 4 at 08:35 a.m. and again at the southeast exit in the staff were over 30 cigarette butts	K 0741	K741 This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution this plan of correction does not constitute admission or agree by the provider of the truth of facts alleged or conclusions s forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is	of ot ment the

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

Event ID:

80N921

Facility ID: 000025

If continuation sheet

Page 32 of 43

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

	VT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155064	(X2) MULTIPLE A. BUILDING B. WING	CONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 10/01/2024
	PROVIDER OR SUPPLIER		3518	ET ADDRESS, CITY, STATE, ZIP COD S LAFOUNTAIN ST OMO, IN 46902	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	(X5) COMPLETION DATE
	smoking area. Also, with a self-closing l	und around the exit and the provided metal container id contained both trash and ed on an interview at the time		required by the provisions of federal and state law.	r
	there were cigarette staff smoking area a	Maintenance Director agreed butts on the ground in the and the metal butt can and cigarette butts.		1 How the corrective action be accomplished for those residents found to be affected the deficient practice:	
	Nursing, Assistant I	viewed with the Director of Director of Nursing and the or at the exit conference.		No residents were negatively affected.	Nife.
	3.1-19(b)			2 How will the facility ider other residents having the potential to be affected by th same deficient practice: All residents have the potential to be affected. No additional cigarette butt iden in facility wide audit.	e
				3 What measures will be into place or what systemic changes the facility will make ensure the deficient practice not recur:	e to
				Maintenance Director removed Cigarette butts off outside in the staff smoking a on 10/01/2024. Staff educate using metal container with self-closing lid. In additional to routine outside facility cleaning. Maintenance director or desi will check all smoking area 4 weekly for 1 month, then 3 x weekly for a monthly, then 2 weekly moving forward.	area ed on ignee kx

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

Event ID:

80N921

Facility ID: 000025

If continuation sheet

Page 33 of 43

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

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155064	A. BUILDING <u>01</u> CO		COMPLETED	(3) DATE SURVEY COMPLETED 10/01/2024	
	PROVIDER OR SUPPLIE N CARE KOKOMO		3518 S	ADDRESS, CITY, STATE, ZIP COD S LAFOUNTAIN ST 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 APPROPRIA DEFICIENCY)	ATE COM	(X5) MPLETION DATE	
				4 How will the facility monitis performance to make sure solutions are sustained; the pis implemented, and the correaction evaluated for its effectiveness; and the plan of correction is integrated into the quality assurance system? Maintenance Director of designee will check all smokinarea 4x weekly for 1 month, that x weekly for a monthly, then 2 weekly moving forward. Will be audit to safety committee meaning monthly for review. The results of these audits with 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 greater is achieved x3 consection. The QA Committee identify any trends or patterns make recommendations to rethe plan of correction as indicated.	that lan ective lan ective lan ective lan ective lan ele lan ele lan ele lan ective lan ele lan ective lan ection ection ection ection ection ele lan ection		
K 0761	NFPA 101						

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

Maintenance, Inspection & Testing - Doors

SS=E

Event ID:

80N921

Facility ID: 000025

If continuation sheet

Page 34 of 43

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUI			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	01	COMPL	ETED
		155064	B. W	NG		10/01/	2024
				GENERA	A DDDDGG GITW GTATE JID GOD		
NAME OF P	ROVIDER OR SUPPLIER			l	ADDRESS, CITY, STATE, ZIP COD		
ADEDIOA	LOADE KOKOMO				LAFOUNTAIN ST		
APERION	N CARE KOKOMO			KUKU	MO, IN 46902		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
Bldg. 01							
-	Based on observation	on, records review, and	K 0	761	F761		10/14/2024
	interview:			,			
					This Plan of Correction is the		
	(#1.) The facility fai	iled to ensure 11 of 11 smoke			center's credible allegation of		
		ntinely inspected and repaired			compliance.		
		y maintenance program.			Preparation and/or execution of	of	
	F	,			this plan of correction does no		
	(#2.) The facility fai	iled to ensure annual			constitute admission or agreer		
	· · ·	ng of 1 of 1 oxygen room fire			by the provider of the truth of t		
	-	ed in accordance of LSC			facts alleged or conclusions se		
	_	nicating openings in dividing			forth in the statement of	^	
		d by 19.1.1.4.1 shall be			deficiencies. The plan of		
	-	orridors and shall be protected			correction is prepared and/or		
		osing fire door assemblies.			executed solely because it is		
		3.) LSC 8.3.3.1 Openings			required by the provisions of		
	,	re protection rating by Table			federal and state law.		
	-	ected by approved, listed,			l lederal and state law.		
	_	semblies and fire window					
		accompanying hardware,			1 How the corrective action	. will	
		, closing devices, anchorage,				WIII	
		nce with the requirements of			be accomplished for those	by.	
		for Fire Doors and Other			residents found to be affected the deficient practice:	Бу	
		s, except as otherwise			•		
		de. NFPA 80 5.2.1 states fire			No residents negatively		
	-	ll be inspected and tested not			affected.		
		and a written record of the			O Have will the facility identi	£.,	
		signed and kept for inspection			2 How will the facility identi	ıy	
	•				other residents having the		
	-	80, 5.2.4.1 states fire door			potential to be affected by the		
		visually inspected from both			same deficient practice:		
		verall condition of door			All resident has the		
		, 5.2.4.2 states as a minimum,			potential to be affected. Smok		
	the following items				door inspection was scheduled	J.	
		r breaks exist in surfaces of					
	either the door or fra				3 What measures will be pu	Jt.	
	· · · —	ight frames, and glazing beads			into place or what systemic		
		ely fastened in place, if so			changes the facility will make t		
	equipped.				ensure the deficient practice d	oes	
		, hinges, hardware, and			not recur:		
	noncombustible thre	eshold are secured, aligned,					

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

Event ID:

80N921

Facility ID: 000025

If continuation sheet Page 35 of 43

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155064	(X2) MULT A. BUILI B. WING	DING	nstruction 01	(X3) DATE SURVEY COMPLETED 10/01/2024
NAME OF PROVIDER OR SUPPLIER APERION CARE KOKOMO		3	3518 S L	DDRESS, CITY, STATE, ZIP COD LAFOUNTAIN ST O, IN 46902	
` '	TATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL		ID REFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	(X5) COMPLETION
	LSC IDENTIFYING INFORMATION	Т	ΓAG	DEFICIENCY)	DATE
damage. (4) No parts are mis (5) Door clearances listed in 4.8.4 and 6. (6) The self-closing the active door compliant from the full open p (7) If a coordinator is closes before the act (8) Latching hardward door when it is in th (9) Auxiliary hardward prohibit operation and frame. (10) No field modified have been performed inspected to verify the self-coordinate of the self-coord	do not exceed clearances 3.1.7. device is operational; that is, pletely closes when operated osition. is installed, the inactive leaftive leaf. ire operates and secures the e closed position. are items that interfere or re not installed on the door or cations to the door assembly			Maintenance added all asmoke doors for annual inspection. Will be monitored monthly by ED/designee for compliance. 4 How will the facility moni its performance to make sure 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? Inspection audits will be review annually by qapi to ensity inspection as a recurring an task. The Administrator will rethis annually.	tor that lan ective ee
there was no docum the facility's smoke inspected. Based on observatio p.m., there were 11 Based on interview Maintenance Direct smoke doors in the t documentation of ro doors. (#2.) Based on recon Maintenance Direct	or on 10/01/24 at 11:20 a.m., entation for review to show if doors were routinely n between 11:30 a.m. to 2:00 smoke doors in the facility. at the time of observation, the or stated there were eight facility and did not have utinely inspected smoke			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 greater is achieved x3 consect months. The QA Committee identify any trends or patterns make recommendations to retthe plan of correction as indicated. 5 Date of compliance 10/15	e of in or cutive will s and vise ated.

	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155064	(X2) MULTIPLE C A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 10/01/2024
	PROVIDER OR SUPPLIER		3518 S	ADDRESS, CITY, STATE, ZIP COD S LAFOUNTAIN ST MO, IN 46902	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	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
K 0914 SS=F Bldg. 01	observation during to was a one-and-a-hal trans-filling room. For records review and Maintenance Direct trans-filling door is inspected within the The findings were receptacles of the continuity of the electrical receptacles of the local polarity of the hot a each electrical receptacles receptacles of the receptacles of the continuity of the electrical receptacles of the local polarity of the hot a each electrical receptacles of the local polarity of the local polarity of the electrical receptacles of the local polarity of the local polarity of the hot a each electrical receptacle receptacles) shall be receptacles).	or stated the oxygen a rated fire door and was not	K 0914	K914 This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution this plan of correction does not constitute admission or agree by the provider of the truth of facts alleged or conclusions of forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1 How the corrective action be accomplished for those residents found to be affected the deficient practice:	of ot ment the et

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

Event ID:

80N921

Facility ID: 000025

If continuation sheet

Page 37 of 43

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

	OF CORRECTION	IDENTIFICATION NUMBER 155064	A. BUILDING B. WING	01	COMPLETED 10/01/2024
	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
TAG	Based on observation Director on 10/01/2 p.m., the facility's 4 contained four to eigelectrical receptacle 11:30 a.m., no docus show the last time the resident sleeping rowinterview at the time records review, the confirmed all the element of the resident sleeping rowand stated it is unknown testing was completed. The findings were resident, Assistant I	ons with the Maintenance 4 between 12:30 p.m. and 2:00 5 resident sleeping rooms ght non-hospital-grade s. Based on records review at mentation was available to ne electrical receptacles in oms were tested. Based on the of the observation and Maintenance Director tectrical receptacles in the oms were not hospital-grade own the last time the annual	TAG	No residents were negatively affected. 2 How will the facility idention other residents having the potential to be affected by the same deficient practice: All residents have the potential to be affected. 3 What measures will be pinto place or what systemic changes the facility will make ensure the deficient practice contrecur: Maintenance Director scheduled for outside electrication company come do testing to pracility in compliance on 10/24/2024 and will schedule yearly testing. 4 How will the facility monifits performance to make sure solutions are sustained; the plies implemented, and the correaction evaluated for its effectiveness; and the plan of correction is integrated into the quality assurance system? Maintenance Director will monitor and keep track on whannual testing is needed and schedule for outside vendor to come in. Will bring to safety committee meeting and qapi quarterly.	ify ut to does al out tor that an ctive e Il en

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

CENTERS FOR	MEDICARE & MEDIC	AID SERVICES			OMB NO. 0938-039		
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
		A. BUILDING	<u>01</u>	COMPLETED			
		155064	B. WING		10/01/2024		
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 3518 S LAFOUNTAIN ST KOKOMO, IN 46902				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		(X5)		
PREFIX		CY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE		
K 0918 SS=F Bldg. 01	Based on record rev	s - Essential Electric Syste riew and interviews, the facility	K 0918	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 of greater is achieved x3 consect months. The QA Committee widentify any trends or patterns make recommendations to revithe plan of correction as indicated. 5 Date of compliance 10/24	e of in reutive will and vise ated.		
		iel and conducted required		This Plan of Correction is the			
		accordance with the		center's credible allegation of			
	_	PA 101-2012 edition section		compliance.			
		2 edition, and NFPA 110-2010		Preparation and/or execution			
	Edition.			this plan of correction does no			
	(#1) NFPA 99 sect	ion 6.4.4.1.1.4(a) requires		constitute admission or agree by the provider of the truth of the trut			
		he generator serving the		facts alleged or conclusions s			
		il system to be in accordance		forth in the statement of			
		e Standard for Emergency and		deficiencies. The plan of			
		stems, Chapter 8. NFPA 110		correction is prepared and/or			
		generator sets in service to be		executed solely because it is			
		nce monthly, for a minimum of		required by the provisions of			
	30 minutes. Section	8.4.1 requires an Emergency		federal and state law.			

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

Power Supply System (EPSS) including all

Event ID:

80N921

Facility ID: 000025

If continuation sheet

Page 39 of 43

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BU	a. Building <u>01</u>		COMPLETED		
155064		155064	B. WING 10/01/202		2024			
				STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>		
NAME OF PROVIDER OR SUPPLIER					LAFOUNTAIN ST			
APERION CARE KOKOMO				KOKOMO, IN 46902				
					,	1		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID PROVIDER'S PLAN OF CORRECTION (FACH CORRECTIVE ACTION SHOULD BE			(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	DEFICIENC!)		DATE	
		nents, shall be inspected			4			
	-	ed monthly. Chapter 6.4.4.2 of		1 How the corrective action		ı Will		
	_	a written record of inspection,			be accomplished for those			
	_	ising period, and repairs for the			residents found to be affected by			
	for inspection by th	alarly maintained and available			the deficient practice:			
	jurisdiction.	e authority having			No regidente were			
	Jurisaiction.				No residents were			
	(#2) NFDA 110 sad	ction 5.1.1 states the following			negatively affected.			
		(#2.) NFPA 110 section 5.1.1 states the following energy sources shall be permitted to be used for			2 How will the facility identi	fı,		
		-			other residents having the	iy		
	the emergency power supply (EPS): (1) Liquid petroleum products at atmospheric				potential to be affected by the			
	pressure				same deficient practice:			
	(2) Liquefied petroleum gas (liquid or vapor				All residents have the			
	withdrawal)				potential to be affected. No			
	(3) Natural or synthetic gas				additional required testing			
	Exception: For Level 1 installations in locations				identified.			
	where the probability of interruption of off-site							
	fuel supplies is high, on-site storage of an				3 What measures will be p	_{ut}		
		arce sufficient to allow full			into place or what systemic			
	output of the EPSS to be delivered for the class				changes the facility will make to			
	specified shall be required, with the provision for				ensure the deficient practice does			
	automatic transfer from the primary energy source				not recur:			
	to the alternate ener	rgy source. A.5.1.1 states						
	examples of probab	oility of interruption could			Maintenance Director an	ıd/or		
	include the following: earthquake, flood damage,				designee will conduct weekly			
	or a demonstrated utility unreliability.				inspection and exercise once			
					monthly under load for minimum of			
	This deficient practice affects all staff, visitors,				30 minutes.			
	and residents.				Natural gas letter will be			
					placed in EOP binder.			
	Findings include:							
					4 How will the facility monit			
	Based on records review with the Maintenance				its performance to make sure that			
	Director on 10/02/24 at 11:55 a.m.:				solutions are sustained; the plan			
					is implemented, and the corre	ctive		
	` '	ation was available to show the			action evaluated for its			
	generator set in service was inspected weekly and				effectiveness; and the plan of			
	exercised once monthly under load for a minimum				correction is integrated into the	e		
	of 30 minutes between the months of October				quality assurance system?			

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>01</u>		COMPLETED			
155064		B. WING 10/01/2024				/2024		
				STREET A	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	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	*	ICY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		TE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCE		DATE	
	2023 to April 2024.				Maintananaa Diraatar wi			
	(#2) No letter of re	liability for the facility's natural			Maintenance Director wi			
	(#2.) No letter of reliability for the facility's natural gas generator was provided for review.				monitor and keep track on who			
	gas generator was p	orovided for review.			weekly inspections and month under load for minimum of 30			
	Based on interview	s during records review, the						
		tor stated the missing load		minutes. Will bring to safety committee meeting and qapi				
		ests were not conducted due to			quarterly for review.			
	_	rector during that time and the			quarterly for review.			
		ty letter could not be found.			The results of these audits wil	l be		
	C	•			reviewed in Quality Assurance			
	This finding was re	viewed with the Director of			Meeting monthly. The results			
		Director of Nursing and the			these audits will be reviewed i			
	Maintenance Direct	tor at the exit conference.			Quality Assurance Meeting			
					monthly x6 months or until an			
	3.1-19(b)				average of 90% compliance o	r		
					greater is achieved x3 consec	utive		
					months. The QA Committee v			
					identify any trends or patterns			
					make recommendations to rev			
					the plan of correction as indica	ated.		
					5 Date of compliance 10/20	0/24		
K 0920	NFPA 101							
SS=E		ent - Power Cords and						
Bldg. 01	Extens							
		on and interview, the facility	K 0	920	K920		10/04/2024	
		f 1 power strips were not used						
		ixed wiring to provide power			This Plan of Correction is the			
	equipment with a h	_			center's credible allegation of			
		0.8 state unless specifically			compliance.			
	_	flexible cords and cables shall			Preparation and/or execution			
		as a substitute for fixed wiring.			this plan of correction does no			
	_	ice could affect up to 5			constitute admission or agree			
	residents outside of	the housekeeping office.			by the provider of the truth of	the		

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

Event ID:

80N921

Facility ID: 000025

If continuation sheet Page 41 of 43

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

		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155064	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 10/01/2024	
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	SUMMARY: (EACH DEFICIEN REGULATORY OR Findings include: Based on observation Director on 10/01/2 (high power draw eand supplied power housekeeping office time of observation agreed a power strip power draw equipm The findings were r Nursing, Assistant I	ons with the Maintenance 4 at 2:05 p.m., a refrigerator quipment) was plugged into by a power strip in the 2. Based on an interview at the 3, the Maintenance Director 5 was supplying power to high ment. eviewed with the Director of Director of Nursing, and the or at the exit conference.				et will by ify ut to does ad/or on ty.	(X5) COMPLETION DATE
					power strips to ensure not bei used in facility.	119	

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

Event ID:

80N921

Facility ID: 000025

If continuation sheet

Page 42 of 43

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

CT A TEN CEN	IT OF DEFICIENCIES	NATURE OF THE POST OF THE	(VA) 1 (II II II II II II	ONGTRUGTION	OVA) DATE CLIDATES
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u>		COMPLETED
155064		B. WING		10/01/2024	
			0777	ADDRESS CITY OF THE TIP CO.	
NAME OF P	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD	
				LAFOUNTAIN ST	
APERION	N CARE KOKOMO		KOKO	MO, IN 46902	
(X4) ID	SHIMMADV	STATEMENT OF DEFICIENCIE	ID		(X5)
PREFIX	SUMMARY STATEMENT OF DEFICIENCIE			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	
	`	ENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROXIMATION OF THE PROPERTY OF THE APPROXIMATION OF THE PROPERTY		CROSS-REFERENCED TO THE APPROPRIADEFICIENCY)	
TAG	KEGULATURY OR	LSC IDENTIFYING INFORMATION	TAG		DATE
				4 How will the facility monit	I
				its performance to make sure t	
				solutions are sustained; the pla	I
				is implemented, and the correct	ctive
				action evaluated for its	
				effectiveness; and the plan of	
				correction is integrated into the	e
				quality assurance system?	
				Maintenance Director wil	I
				monitor and keep track of audi	ts
				on power strips to ensure not	
				being used in facility. Will brir	ng
				to safety committee meeting a	•
				qapi quarterly.	
				ا المحاد	
				The results of these audits will	be
				reviewed in Quality Assurance	
				Meeting monthly. The results of	I
				these audits will be reviewed in	
				Quality Assurance Meeting	
				monthly x6 months or until an	
				average of 90% compliance or	
				greater is achieved x3 consecu	
				months. The QA Committee v	
				identify any trends or patterns	
				make recommendations to rev	
				the plan of correction as indica	ilea.
				5 Date of compliance 10/04	1/24

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 80N921 Facility ID: 000025 If continuation sheet Page 43 of 43