STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155064	A. BUILDING -- B. WING	12/02/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	A Post Survey Revisit (PSR) to the Emergency Preparedness Survey conducted on 10/01/24 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.475. Survey Date: 12/02/24 Facility Number: 000025 Provider Number: 155064 AIM Number: 100274850 At this PSR survey, Aprion Care Kokomo was found in substantial 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 12/06/24	E 0000		
E 0037 SS=C Bldg. --	403.748(d)(1), 416.54(d)(1), 418.113(d)(EP Training Program Based on record review and interview, the facility failed to ensure staff were trained in emergency preparedness policies and procedures (EPP). The ICF/IID facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles; (ii) Provide emergency preparedness training at least every two years; (iii) Maintain documentation of all emergency preparedness training; (iv) Demonstrate staff knowledge of	E 0037	**E037** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of*	12/16/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Markia Baker	Administrator	12/20/2024

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.

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	emergency procedures; (v) If the emergency preparedness policies and procedures are significantly updated, the facility must conduct training on the updated policies and procedures in accordance with 42 CFR 483.475(d) (1). This deficient practice could affect all occupants. Findings include: Based on records review with the Administrator and the Maintenance Director on 12/02/24 at 11:59 a.m., there was documentation of a sign sheet for EPP training dated 10/14/24, but there was no documentation to show if staff could demonstrate knowledge of the EPP. Based on an interview at the time of records review, the Administrator and the Maintenance Director stated staff were asked questions about the EPP but did not document the demonstration knowledge. The finding was reviewed with the Administrator and the Maintenance Director during the exit conference. This deficiency was cited on 10/01/24. The facility failed to implement a systemic plan of correction to prevent recurrence.		*correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* 1 How the corrective action will be accomplished for those residents found to be affected by 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. Documentation with staff demonstrating knowledge of emergency procedures will be kept annually. 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. Training completed for current employees; all new employees will receive training during orientation period. All employees will be trained annually. Documentation with staff demonstrating knowledge of emergency procedures will be kept annually. 3 What measures will be put	

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			into place or what systemic changes the facility will make to ensure the deficient practice does not recur: The Maintenance Director has been delegated to lead the emergency preparedness training for new and existing employees. Documentation with staff demonstrating knowledge of emergency procedures will be kept and logged. The Administrator will review this annually with the Maintenance Director 4 How will the facility monitor its performance to make sure that solutions are sustained; the plan is implemented, and the corrective action evaluated for its effectiveness; and the plan of correction is integrated into the quality assurance system? The emergency preparedness training will be added to in-service as a recurring annual task. Human Resources will be monitoring to ensure new employees are receiving their emergency preparedness training and document knowledge. The results of these audits will be reviewed in Quality Assurance Meeting monthly. The results of these audits will be reviewed in	

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			Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 5 Date of compliance 12/16/24	
K 0000 Bldg. 01	A Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted on 10/01/24 was conducted by the Indiana Department of Health in accordance 42 CFR Subpart 483.90(a). Survey Date: 12/02/24 Facility Number: 000025 Provider Number: 155064 AIM Number: 100274850 At this Life Safety Code survey, Aperion Care-Kokomo was found in substantial compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire, and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type II (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces	K 0000		

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	open to the corridors and battery operated detectors in all resident sleeping rooms. The facility has a capacity of 105 and had a census of 55 at the time of this survey. All areas where the residents have customary access were sprinklered. Quality Review completed on 12/06/24			
K 0711 SS=C Bldg. 01	NFPA 101 Evacuation and Relocation Plan Based on record review, observation, and interview; the facility failed to provide 1 of 1 written Fire Safety Plans (FSP) according to LSC 19.7 which states the fire safety plan must incorporate all items listed in NFPA 101, Section 19.7.2.2. 1. Use of alarms. 2. Transmission of alarms to fire department. 3. Emergency phone call to fire department 4. Response to alarms. 5. Isolation of fire. 6. Evacuation of immediate area. 7. Evacuation of smoke compartment. 8. Preparation of floors and building for evacuation. 9. Extinguishment of fire. This deficient practice affects all residents, staff, and visitors in the event of a fire emergency. Findings include: Based on records review with the Maintenance Director and the administrator on 12/02/24 at 1:30 p.m. The facility's FSP from the two nurses' station did not address the following items: a) Evacuation of smoke compartments. The two copies of the FSP did not address the location of	K 0711	**K711** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* 1 How the corrective action will be accomplished for those residents found to be affected by the deficient practice: No residents were negatively affected. 2 How will the facility identify	12/16/2024

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	the facility's smoke/fire barriers or location of non-barrier cross corridor door that could be mistaken as a smoke/fire barrier. b) Preparation of floors and buildings for evacuation. The facility's FSP from the two nurses' station did not address removing wheeled patient equipment from the corridors and evacuation routes during a fire evacuation. Based on an interview during records review, the Maintenance Director stated two new fire safety plans were kept at the nurses' stations but the FSPs still to address the location of the smoke/fire barriers nor clearing the halls of wheeled equipment during a fire evacuation. The finding was reviewed with the Administrator and the Maintenance Director during the exit conference. This deficiency was cited on 10/01/24. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-19(b)		other residents having the potential to be affected by the same deficient practice: All residents have the potential to be affected. Fire Safety Plan updated. Fire safety plan will be placed EOP binders and nurse station. FSP will include location of the facility smoke/fire barriers or location of non-barrier cross corridor that can be mistaken as a smoke/fire door. FSP will address removing wheeled patient equipment from the corridors and evacuation routes during fire evacuation. 3 What measures will be put into place or what systemic changes the facility will make to ensure the deficient practice does not recur: Maintenance Director will do monthly audit of EOP binder making sure most updated facility fsp is in binder. 4 How will the facility monitor its performance to make sure that solutions are sustained; the plan is implemented, and the corrective action evaluated for its effectiveness; and the plan of correction is integrated into the quality assurance system?	

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			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 be 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 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 5 Date of compliance 12/16/24	