PRINTED: 12/31/2024 FORM APPROVED OMB NO. 0938-039

		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155064	A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 12/02/2024	
	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	1	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	тЕ	(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.		E 00	E 0000				
E 0037 SS=C Bldg	Quality Review completed on 12/06/24 403.748(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 00		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 a facts alleged or conclusions so forth in the statement of deficiencies. The plan of	of ot ment the	12/16/2024 (X6) DATE	

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

(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.

Event ID: 80N922 Facility ID: 000025 If continuation sheet Page 1 of 7

PRINTED: 12/31/2024 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 B. WING			COMPLETED 12/02/2024	
155064			B. WI	ING		12/02/	2024
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
A DEDION	N CARE KOKOMO				LAFOUNTAIN ST		
APERIUI	N CARE NUNUIVIU			NUNUN	MO, IN 46902 		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION
TAG		res; (v) If the emergency		TAG			DATE
		es and procedures are			correction is prepared and/or executed solely because it is		
		ed, the facility must conduct			required by the provisions of		
		ated policies and procedures in			federal and state law.		
		CFR 483.475(d) (1). This			Todorai and state law.		
		ould affect all occupants.					
					1 How the corrective action	n will	
	Findings include:				be accomplished for those		
					residents found to be affected	by	
		eview with the Administrator			the deficient practice:		
		e Director on 12/02/24 at 11:59			No vacidante viene		
		umentation of a sign sheet for 10/14/24, but there was no			No residents were negatively affected. New		
		now if staff could demonstrate			employees will be trained on		
		PP. Based on an interview at			emergency preparedness upo	n	
	-	review, the Administrator and			their orientation period. Existing		
		rector stated staff were asked			employees will be trained	.9	
	questions about the	EPP but did not document			annually. Documentation with	staff	
	the demonstration k	nowledge.			demonstrating knowledge of		
					emergency procedures will be)	
	-	viewed with the Administrator e Director during the exit			kept annually.		
	conference.				2 How will the facility identi	ify	
					other residents having the		
		s cited on 10/01/24. The facility			potential to be affected by the		
	_	a systemic plan of correction			same deficient practice:		
	to prevent recurrence	ce.			All regidents have the		
					All residents have the potential to be affected. Traini	na	
					completed for current employe	-	
					all new employees will receive		
					training during orientation peri		
					All employees will be trained		
					annually. Documentation with	1	
					staff demonstrating knowledge		
					emergency procedures will be	;	
					kept annually.		
					3 What measures will be p	ut	

12/31/2024 PRINTED:

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES							FORM APPROVED OMB NO. 0938-039	
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 12/02/2024	
NAME OF PROVIDER OR SUPPLIER APERION CARE KOKOMO			STREET ADDRESS, CITY, STATE, ZIP COD 3518 S LAFOUNTAIN ST KOKOMO, IN 46902					
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIATE OF THE APPROPRIATE O			ATE	(X5) COMPLETION DATE	
					into place or what systemic changes the facility will make ensure the deficient practice of not recur:			
					The Maintenance Direct has been delegated to lead the emergency preparedness traifor new and existing employe Documentation with staff demonstrating knowledge of emergency procedures will be kept and logged. The Administrator will review this annually with the Maintenance Director	ne ning es.		
					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?	that lan ective		
					The emergency preparedness training will be added to in-service as a recurannual task. Human Resource will be monitoring to ensure nemployees are receiving their	es ew		

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

Event ID:

80N922

Facility ID: 000025

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

If continuation sheet

Page 3 of 7

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

PRINTED: 12/31/2024 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155064		A. BUILDING B. WING		COMP	LETED 2/2024			
NAME OF PROVIDER OR SUPPLIER APERION CARE KOKOMO			STREET ADDRESS, CITY, STATE, ZIP COD 3518 S LAFOUNTAIN ST KOKOMO, IN 46902					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AF DEFICIENCY)	OUI D BE	(X5) COMPLETION DATE		
K 0000 Bldg. 01	A Post Survey Revis Code Recertification conducted on 10/01/ Indiana Department CFR Subpart 483.90 Survey Date: 12/02 Facility Number: 00 Provider Number: 11 AIM Number: 1002 At this Life Safety C Care-Kokomo was for compliance with Re Medicare/Medicaid, Life Safety from Fir National Fire Protect Life Safety Code (L Health Care Occupation This one story facility Type II (111) constributions Sprinklered. The factorial	sit (PSR) to the Life Safety n and State Licensure Survey /24 was conducted by the of Health in accordance 42 0(a). //24 00025 155064 274850 Code survey, Aperion	K 0000	Quality Assurance Mee monthly x6 months or u average of 90% complia greater is achieved x3 c months. The QA Comn identify any trends or parake recommendations the plan of correction as 5 Date of compliance	ntil an ance or consecutive nittee will atterns and s to revise s indicated.			

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

Event ID:

80N922

Facility ID: 000025

If continuation sheet

Page 4 of 7

PRINTED: 12/31/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DA		(X3) DATE	DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>01</u>			COMPLETED	
15500		155064	B. W	B. WING		12/02/2024		
				STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF PROVIDER OR SUPPLIER					LAFOUNTAIN ST			
APERION	N CARE KOKOMO			KOKON	MO, IN 46902			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION	AN OF CORRECTION		
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION	-	TAG	DEFICIENCY		DATE	
	_	s and battery operated lent sleeping rooms. The						
		ty of 105 and had a census of						
	55 at the time of this	-						
	All areas where the	residents have customary						
	access were sprinkle	ered.						
	Quality Review con	npleted on 12/06/24						
K 0711	NFPA 101							
SS=C	SS=C Evacuation and Relocation Plan							
Bldg. 01								
Ŭ	Based on record review, observation, and		K 0	711	K711		12/16/2024	
	interview; the facility failed to provide 1 of 1							
	written Fire Safety Plans (FSP) according to LSC				This Plan of Correction is the			
		e fire safety plan must			center's credible allegation of			
	-	s listed in NFPA 101, Section			compliance.			
	19.7.2.2.				Preparation and/or execution of			
	1. Use of alarms.	1			this plan of correction does no			
		alarms to fire department.			constitute admission or agreer			
	Emergency phon Response to alar.	e call to fire department			by the provider of the truth of t facts alleged or conclusions se			
	5. Isolation of fire.	ms.			forth in the statement of	;L		
	6. Evacuation of in	nmediate area.			deficiencies. The plan of			
	7. Evacuation of sn				correction is prepared and/or			
		oors and building for			executed solely because it is			
	evacuation.				required by the provisions of			
	9. Extinguishment	of fire.			federal and state law.			
	•	ice affects all residents, staff,						
	and visitors in the e	vent of a fire emergency.						
	E' 1' ' 1 1				1 How the corrective action	will		
	Findings include:				be accomplished for those	b		
	Rosed on records re	view with the Maintenance			residents found to be affected	ру		
		ninistrator on 12/02/24 at 1:30			the deficient practice:			
		'SP from the two nurses' station			No residents were			
	did not address the				negatively affected.			
		oke compartments. The two						
		id not address the location of			2 How will the facility identi	fv		

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

Event ID:

80N922

Facility ID: 000025

If continuation sheet Page 5 of 7

PRINTED: 12/31/2024 FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 01 COMPLETED 155064 B. WING 12/02/2024 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 3518 S LAFOUNTAIN ST

APERION CARE KOKOMO			KOKOMO, IN 46902			
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PEGLIL ATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIO		
TAG	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.	TAG	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.	DATE		
	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)		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			

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

Event ID:

80N922

Facility ID: 000025

If continuation sheet

Page 6 of 7

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 12/31/2024 FORM APPROVED OMB NO. 0938-039

CENTERSTOR	MEDICARE & MEDIC	AID SERVICES				ON	ID NO. 0938-039		
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 01		01	COMPL	LETED		
		155064	B. WI	NG		12/02	/2024		
NAME OF P	ROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD				
			3518 S LAFOUNTAIN ST						
APERION CARE KOKOMO				KOKOMO, IN 46902					
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID PREFIX		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)			
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL				\TC	COMPLETION		
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE			
					Maintenance				
					Director/designee Continued				
					review fire safety policies and				
					procedures by Administrator a	and			
					designee during monthly				
					Performance Improvement				
					meeting.				
					The results of these audits wi	ll be			
					reviewed in Quality Assurance	е			
					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 consec				
					months. The QA Committee				
					identify any trends or patterns				
					make recommendations to re				
					the plan of correction as indic	ated.			
						0/04			
					5 Date of compliance 12/1	6/24			
							Ī		

Event ID: 80N922 Facility ID: 000025 Page 7 of 7 If continuation sheet