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

PRINTED: 04/07/2022 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '		ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		155064	B. WING			R-C	
155064			B. WIIVO			03/	31/2022
NAME OF PI	ROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP CODE		
APERION	CARE KOKOMO			3518	8 S LAFOUNTAIN ST		
7				KOI	KOMO, IN 46902		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFI		(EACH CORRECTIVE ACTION SHOULD BE		COMPLETION DATE
TAG			TAG		CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(IE	5/112
					,		
{F 000}	INITIAL COMMENTS		{F 0	00}			
	This visit was for a P						
	the Investigation of C	the Investigation of Complaint IN00372373					
	completed on Februa						
	This visit was in conju	unction with the PSR to the					
	Investigation of Comp	plaint IN00370095					
	completed on January 10, 2022.						
	This visit was in conjunction with the PSR to the						
Investigation of Compla							
	IN00371731 complete	ed on February 2, 2022.					
	This visit was in conjunction with the PSR to the						
		plaints IN00373762 and					
	IN00373364 complete	ed on March 4, 2022					
	Complaint INIO02722	72 Carrested					
Complaint IN0037		73 - Corrected.					
	Complaint IN00370095 - Corrected.						
	Complaint intocorocc	oo concessa.					
	Complaint IN0037092	23 - Corrected.					
	•						
	Complaint IN0037173	31 - Corrected.					
	Complaint IN0037376	62 - Corrected.					
	Complaint IN00373364 - Corrected.						
	Comes data Manak 1	24 2022					
	Survey date: March 3	31, 2022					
	Facility number: 0000	125					
	Facility number: 000025 Provider number: 155064						
	AIM number: 100274						
	7 divi nullibel. 1002/4	000					
	Census Bed Type:						
	SNF/NF: 60						
	Total: 60						
	15.01. 00						
_ABORATORY	LECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATU	RE		TITLE		(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 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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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
						R-C	
NAME OF D		155064	B. WING _	CTDEET ADDRESS SITV STATE 7	VID CODE	03/31/2022	
NAME OF PROVIDER OR SUPPLIER APERION CARE KOKOMO				STREET ADDRESS, CITY, STATE, Z 3518 S LAFOUNTAIN ST KOKOMO, IN 46902	IP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFII TAG		ACTION SHOULD BI TO THE APPROPRIA		
{F 000}	Continued From page	÷ 1	{F 0	00}			
	Census Payor Type: Medicare: 9 Medicaid: 35 Other: 16 Total: 60						
		FR Part 483 Subpart B and egard to the Investigation of					
	Quality review was co	ompleted on April 6, 2022.					