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	09/25/2023

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 08/16/23 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 09/25/23 Facility Number: 000025 Provider Number: 155064 AIM Number: 100274850 At this PSR Survey, Aperion Care Kokomo, was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.475. The facility has 105 certified beds. At the time of the survey, the census was 48. Quality Review completed on 10/02/23	E 0000		
E 0037 SS=F Bldg. --	403.748(d)(1), 416.54(d)(1), 418.113(d)(1), 441.184(d)(1), 482.15(d)(1), 483.475(d)(1), 483.73(d)(1), 484.102(d)(1), 485.625(d)(1), 485.68(d)(1), 485.727(d)(1), 485.920(d)(1), 486.360(d)(1), 491.12(d)(1) EP Training Program §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1). *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475,			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jeff Attinger	RVP of Operations	10/16/2023

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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	HHAs at §484.102, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [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 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. (v) Maintain documentation of all emergency preparedness training.			

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	(vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF 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) After initial training, provide emergency preparedness training every 2 years. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. (v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures. *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training.			

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	(v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures. *[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC 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 role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide 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 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. (v) If the emergency preparedness policies			

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	and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, 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 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide 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, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years. Based on record review and interview, the facility	E 0037	What corrective action(s)	09/26/2023

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	failed to conduct annual training for the Emergency Preparedness Program (EPP). The LTC 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 annually; (iii) Maintain documentation of all emergency preparedness training; (iv) Demonstrate staff knowledge of emergency procedures in accordance with 42 CFR 483.73(d) (1). This deficient practice could affect all residents in the facility. Findings include: Based on record review with the Director of Nursing (DON) and Maintenance Director (MD) on 09/25/23 at 04:30 p.m., there was documentation of a sign-in sheet for EPP training; but it was incomplete. There were 63 employees listed on the Emergency Preparedness Plan (EPP) in-service sign in sheet but only 29 employees had signed it. The completion date on the plan of correction was 09/15/23. Based on an interview at the time of records review, the DON and the MD agreed that not all staff have been trained on the EEP by the completion date of 09/15/23. This finding was reviewed with the DON and MD at the exit conference.		will be accomplished for those residents found to have been affected by the deficient practice; No residents were affected by this alleged deficient practice II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents have the potential to be affected by this alleged deficient practice. All staff completed emergency preparedness training. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; All staff were trained on the updated emergency preparedness plan including the risk assessment and policies and procedures. The facility will conduct annual staff training on the emergency preparedness plan the month after the IDT completes the annual review. Emergency preparedness training was added to new employee orientation. If a significate change is made to the emergency preparedness plan a staff training will be scheduled to review the changes. The facility will ensure all health care occupancy personnel are	

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K 0000 Bldg. 01			periodically instructed in the use and response to fire alarms. Emphasis must be placed on training staff to sound the fire alarm, to rescue residents (as needed), and to close all doors IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; The administrator or designee will audit the inservice sign in sheet annually to ensure all staff have been inserviced the month after the annual IDT review. The admin or designee will review all new employee files monthly to ensure training has occurred. If significate changes are made to the plan the admin or designee will audit to ensure a training of the changes occurred. Ongoing, the Administrator or designee will monitor training documentation to ensure all employees of health care occupancies have received instruction in life safety procedures and devices to ensure continued compliance. Results of the monitoring will be reviewed during the facility's Quality Assurance meeting; monitoring will be ongoing	

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	A Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted on 08/16/23 was conducted by the Indiana Department of Health in accordance 42 CFR Subpart 483.90(a). Survey Date: 09/25/23 Facility Number: 000025 Provider Number: 155064 AIM Number: 100274850 At this Life Safety Code Survey, Aperion Care Kokomo, was found not in compliance with the Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.90(a). The facility has 105 certified beds. At the time of survey the census was 48. Quality Review completed on 10/02/23	K 0000		
K 0711 SS=F Bldg. 01	NFPA 101 Evacuation and Relocation Plan Evacuation and Relocation Plan There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. Employees are periodically instructed and kept informed with their duties under the plan, and a copy of the plan is readily available with telephone operator or with security. The plan addresses the basic response required of staff per 18/19.7.2.1.2 and provides for all of the fire safety plan components per 18/19.2.2. 18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2, 19.7.2.3			

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	Based on record review and interview, the facility failed to follow their written fire safety plan for the protection of residents to accurately address all life safety systems, plus a system addressing all items required by NFPA 101, 2012 edition, Section 19.7.2.2. LSC 4.8.2.1(3) requires evacuation procedures appropriate to the building, its occupancy, emergencies, and hazards. LSC 19.7.2.2 requires a written health care occupancy fire safety plan that shall provide for the following: (1) Use of alarms (2) Transmission of alarm 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 could affect all occupants in the event of an emergency. Findings include: Based on a review of the fire plan within the Disaster Preparedness Plan on 08/16/23 at the Annual Life Safety Code recertification survey with the Maintenance Director present, it was determined that the facility did not follow their fire plan during an actual fire. They failed to immediately contact the fire department upon finding a fire condition in the facility. As stated in their Plan of Correction, the facility said they would train all staff on the fire plan by 09/15/23. At this Post Survey Revisit (PSR) survey it was determined that the facility did not complete the all-staff training by their completion date of 09/15/23. The Fire Plan in-service sign in sheet	K 0711	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; No residents were affected by this alleged deficient practice II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents have the potential to be affected by this alleged deficient practice. The fire safety plan was updated. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; All staff were inserviced and quizzed on the fire safety plan. The updated plan was placed in all emergency preparedness binders. Fire drills we be conducted monthly. The results of the fire drill be be documented on the fire drill log The facility will ensure all health care occupancy personnel are periodically instructed in the use and response to fire alarms. Emphasis must be placed on training staff to sound the fire alarm, to rescue residents (as needed), and to close all doors.	09/26/2023

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	listed 63 employees but only 29 employees had signed it on 09/25/23. This was acknowledged by the Director of Nursing (DON) and Maintenance Director (MD) at the time of review. This finding was reviewed with the DON and MD at the exit conference. 3.1-19(b)		IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; The fire drill log will be audited monthly to ensure the fire safety policy is followed. The emergency preparedness binders will be reviewed annually to ensure the most up to date policy is in all binders. Ongoing, the Administrator or designee will monitor training documentation to ensure all employees of health care occupancies have received instruction in life safety procedures and devices to ensure continued compliance. Results of the monitoring will be reviewed during the facility's Quality Assurance meeting; monitoring will be ongoing	
K 0927 SS=E Bldg. 01	NFPA 101 Gas Equipment - Transfilling Cylinders Gas Equipment - Transfilling Cylinders Transfilling of oxygen from one cylinder to another is in accordance with CGA P-2.5, Transfilling of High Pressure Gaseous Oxygen Used for Respiration. Transfilling of any gas from one cylinder to another is prohibited in patient care rooms. Transfilling to liquid oxygen containers or to portable containers over 50 psi comply with conditions under 11.5.2.3.1 (NFPA 99). Transfilling to liquid oxygen containers or to portable containers under 50 psi comply with conditions under 11.5.2.3.2 (NFPA 99).			

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	11.5.2.2 (NFPA 99) Based on observation and interview, the facility failed to ensure 1 of 1 oxygen storage/transfer location was provided with a sign indicating that transferring is occurring. NFPA 99 Health Care Facilities Code, 2012 Edition, Section 11.5.2.3.1(3) states, the area is posted with signs indicating that transfilling is occurring and that smoking is the immediate area is not permitted. This deficient practice could affect residents, staff, and visitors while in the same smoke compartment as the oxygen room. Findings include: Based on observation on 09/25/23 at 04:00 p.m. during a tour of the facility with the Maintenance Director while conducting the Post Survey Revisit, the oxygen storage/transfer room had four liquid oxygen containers. The door to this room lacked a sign indicating that transferring of oxygen occurs in this location during the Annual Life Safety Code Recertification survey conducted 08/16/23. The facility had installed a sign indicating occupied or vacant. The Maintenance Supervisor said that he thought the sign was adequate, but it does not indicate if oxygen transfilling is occurring. The correct sign must show whether oxygen transfilling is occurring. This finding was reviewed with the Director of Nursing and Maintenance Supervisor at the exit conference. 3.1-19(b)	K 0927	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; No residents were affected by this alleged deficient practice II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; 20 residents have the potential to be affected by this alleged deficient practice. A transfilling of oxygen is occurring no smoking in the area sign was added to the oxygen room. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Nursing staff were inserviced on proper transferring of oxygen and signs that must remain in place. The facility will ensure the liquid oxygen storage/transfer room is provided with signage that specifically indicates when liquid oxygen transfilling is occurring. The NFPA 99 definition of transfilling is the process of transferring a medical gas in gaseous or liquid state from one container or cylinder to another container or	09/26/2023

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			cylinder. IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; The maintenance director will audit the oxygen rooms weekly to ensure the transferring of oxygen signs remain in place outside of all oxygen rooms. Ongoing, the Administrator or designee will monitor the liquid oxygen storage/transfer room signage to ensure compliance. Results of the monitoring will be reviewed during the facility's Quality Assurance meeting; monitoring will be ongoing.	