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DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID 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 COMPLETED B. WING 09/25/2023 155064 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 PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL DEFICIENCY) REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE TAG E 0000 Bldg. --A Post Survey Revisit (PSR) to the Emergency E 0000 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 0037 403.748(d)(1), 416.54(d)(1), 418.113(d)(1), SS=F 441.184(d)(1), 482.15(d)(1), 483.475(d)(1), Bldg. --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 10/16/2023 Jeff Attinger **RVP of Operations**

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.

000025

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID 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 COMPLETED 155064 B. WING 09/25/2023 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 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. Event ID: QG5122 Facility ID: 000025 Page 2 of 12 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155064		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 09/25/2023		
	PROVIDER OR SUPPLIER		3518	T ADDRESS, CITY, STATE, ZIP S LAFOUNTAIN ST OMO, IN 46902	COD	
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION		(X5)
PREFIX TAG	[×]	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	PREFIX TAG	CROSS-REFERENCED TO THI DEFICIENCY)	E APPROPRIATE	COMPLETIO DATE
TAG	 (vi) If the emerger and procedures at hospice must con- updated policies a procedures. *[For PRTFs at §4 program. The PRT following: (i) Initial training in policies and proce existing staff, individual training under arrangemen consistent with the (ii) After initial training preparedness training (iii) Demonstrate se emergency proced (iv) Maintain docu preparedness training (v) If the emergen and procedures at PRTF must condu- policies and proced *[For PACE at §46 organization must (i) Initial training in policies and proced 	icy preparedness policies re significantly updated, the duct training on the ind 41.184(d):] (1) Training IF must do all of the emergency preparedness induces to all new and viduals providing services at, and volunteers, eir expected roles. hing, provide emergency hing every 2 years. itaff knowledge of dures. mentation of all emergency hing. cy preparedness policies re significantly updated, the ict training on the updated idures. 60.84(d):] (1) The PACE do all of the following: emergency preparedness idures to all new and	TAG	DEFICIENCY)		DATE
	services under arr	viduals providing on-site angement, contractors, volunteers, consistent with es.				
	 (ii) Provide emerg at least every 2 ye (iii) Demonstrate s emergency proceed participants of what 	ency preparedness training ears.				

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CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/ AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155064		IDENTIFICATION NUMBER 155064	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		COMPLETED 09/25/2023
	PROVIDER OR SUPPLIE		3518 S	ADDRESS, CITY, STATE, ZIP C LAFOUNTAIN ST MO, IN 46902	COD
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	DROVIDED'S DI AN OF COP	(X5)
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TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	(v) If the emerge	ency preparedness policies			
		are significantly updated, the			
	PACE must cond	luct training on the updated			
	policies and proc				
		es at §483.73(d):] (1) n. The LTC facility must do all			
	(i) Initial training i	in emergency preparedness			
	1	edures to all new and			
		ividuals providing services			
	-	ent, and volunteers, neir expected role.			
		gency preparedness training			
	at least annually.				
		umentation of all emergency			
	preparedness tra				
		staff knowledge of			
	emergency proce	-			
	*[For CORFs at §	§485.68(d):](1) Training. The			
	CORF must do a	II of the following:			
	(i) Provide initial	training in emergency			
	preparedness po	licies and procedures to all			
	new and existing	staff, individuals providing			
		rrangement, and volunteers,			
		neir expected roles.			
	• • •	gency preparedness training			
	at least every 2 y				
		umentation of the training.			
		staff knowledge of			
		edures. All new personnel			
		and assigned specific			
		egarding the CORF's			
		within 2 weeks of their first			
		ining program must include			
		location and use of alarm			
		nals and firefighting			
	equipment.	ency preparedness policies			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155064	(X2) MULTIPLE C A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/25/2023	
	PROVIDER OR SUPPLIE		3518 S	ADDRESS, CITY, STATE, ZIP COD S LAFOUNTAIN ST MO, IN 46902	
APERIO (X4) ID PREFIX TAG	SUMMARY (EACH DEFICIE REGULATORY O failed to conduct a Emergency Prepar facility must do all training in emerge procedures to all n individuals provid and volunteers, cor roles; (ii) Provide training at least an documentation of a training; (iv) Dema emergency proced 483.73(d) (1). This all residents in the Findings include: Based on record re Nursing (DON) an on 09/25/23 at 04: documentation of a but it was incompl listed on the Emergin-service sign in s had signed it. The correction was 09/ the time of records agreed that not all	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION nnual training for the edness Program (EPP). The LTC of the following: (i) Initial ncy preparedness policies and ew and existing staff, ing services under arrangement, nsistent with their expected emergency preparedness nually; (iii) Maintain all emergency preparedness onstrate staff knowledge of ures in accordance with 42 CFR of deficient practice could affect facility.	KOKO ID PREFIX TAG	MO, IN 46902 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPF DEFICIENCY) will be accomplished for thos residents found to have been affected by the deficient pract No residents were affected by this alleged defice practice II. How other residents h the potential to be affected b same deficient practice will b identified and what corrective action(s) will be taken; All residents have the potential to be affected by th alleged deficient practice. Al completed emergency preparedness training. III. What measures will b into place and what systemic changes will be made to ens that the deficient practice do recur; All staff were trained the updated emergency preparedness plan including risk assessment and policies procedures. The facility will conduct annual staff training the emergency preparedness	ENATE COMPLET DATE DATE DATE DATE DATE DATE DATE
	This finding was r at the exit conferen	eviewed with the DON and MD ace.		the month after the IDT com the annual review. Emergen preparedness training was a to new employee orientation significate change is made to emergency preparedness pla staff training will be schedule review the changes. The fac will ensure all health care occupancy personnel are	cy dded . If a o the an a ed to

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155064	(X2) MULTIPLE C A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/25/2023	
	OVIDER OR SUPPLIE		3518 S	ADDRESS, CITY, STATE, ZIP COD 5 LAFOUNTAIN ST MO, IN 46902	
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIO DATE
				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 i place; The administrator or designee will audit the inservice sign in sheet annually to ensure all staff have been inserviced th month after the annual IDT revit The admin or designee will revit all new employee files monthly ensure training has occurred. If significate changes are made to the plan the admin or designee audit to ensure a training of the changes occurred. Ongoing, the Administrator or designee will monitor training documentation ensure all employees of health care occupancies have received instruction in life safety procedures and devices to ensu- continued compliance. Results the monitoring will be reviewed during the facility's Quality Assurance meeting; monitoring will be ongoing	e I nto e e e e w to o will e to d u r e of
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Bldg. 01					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155064		(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING		(X3) DATE SURVEY COMPLETED 09/25/2023		
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 STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		ID PROVIDER'S PLAN OF COL PREFIX (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE TAG DEFICIENCY)		BE	(X5) COMPLETION DATE
			ens not ass pla will we of c out On des oxy sig Re rev Qu	How the corrective ion(s) will be monitored to sure the deficient practice recur i.e., what quality surance program will be p ce; The maintenance di audit the oxygen rooms ekly to ensure the transfe oxygen signs remain in p side of all oxygen rooms going, the Administrator signee will monitor the lice /gen storage/transfer room nage to ensure compliant sults of the monitoring w iewed during the facility? ality Assurance meeting; nitoring will be ongoing.	e will put into irector erring place s. or quid om nce. ill be s	

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