STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155064	A. BUILDING 00 B. WING	07/13/2022

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
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: July 6, 7, 8, 11, 12 and 13, 2022. Facility number: 000025 Provider number: 155064 AIM number: 100274850 Census Bed Type: SNF/NF: 52 Total: 52 Census Payor Type: Medicare: 5 Medicaid: 39 Other: 8 Total: 52 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review was completed on July 20, 2022.	F 0000		
F 0578 SS=D Bldg. 00	483.10(c)(6)(8)(g)(12)(i)-(v) Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155064	A. BUILDING 00 B. WING	07/13/2022

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
	medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.			
	Based on interview and record review, the facility failed to ensure a resident's representative had signed for code status preferences for 1 of 1 residents reviewed for advanced directives (Resident 41). Finding includes:	F 0578	**F578** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of*	08/10/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155064	A. BUILDING 00 B. WING	07/13/2022

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
	The record for Resident 41 was reviewed on 7/8/22 at 3:10 p.m. Diagnoses included, but were not limited to, delusional disorder, ventricular fibrillation, major depressive disorder, chronic obstructive pulmonary disease, history of a traumatic brain injury and an old myocardial infarction. An Indiana Living Will Declaration, dated 9/28/2018 and signed by the resident, indicated the resident did not want to receive artificially supplied nutrition and hydration if the effort to sustain life was futile or excessively burdensome to him. The Living Will Declaration did not include if the resident wanted to be resuscitated or not. A physician's order, dated 11/18/21, indicated DNR (do not resuscitate). A progress note, dated 7/6/22 at 4:08 p.m., indicated the Power of Attorney (POA) gave consent for the DNR and the code status remained the same. The progress notes did not include conversations with the resident or resident's POA prior to 7/6/22 about the residents code status. A POST (Physician Orders for Scope of Treatment) form, dated 7/6/22, indicated do not attempt resuscitation (DNR) if the resident had no pulse and was not breathing. The optional additional order section of the form, indicated the POA gave verbal consent for the code status on the phone and the code status remained the same. The physician signed the form on 7/6/22. During an interview, on 7/11/22 at 4:47 p.m., the		*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) Immediate actions taken for those residents identified:** **Resident #41's code status was updated at the time of survey.** **2) How the facility identified other residents:** **An audit of all Advanced Directives will be reviewed to ensure the documents are completed properly and any issues identified will be corrected. All residents have to potential to be affected; therefore, this plan of correction applies to residents currently residing in the facility.** **3) Measures put into place/ System changes:** **SSD was re-educated on request/refuse/discontinue treatment/formulate advanced**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155064	A. BUILDING 00 B. WING	07/13/2022

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
	Director of Nursing (DON) indicated she did not know why the POST form was not completed until 7/6/22 and would need to look into the delay. During an interview, on 7/13/22 at 12:23 p.m., the DON indicated the only POST form the resident had was completed on 7/6/22. She did not know the reason the form was not completed until then to provide the information on the resident and the POA for determination of resuscitation status. A current policy, titled "Advance Directives," dated as revised 8/14/18 and received from the DON on 7/13/22 at 12:26 p.m., indicated "...To ensure that all residents and/or resident representatives are informed concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive...For purposes of this policy and procedure 'Advanced Directives' means a written instrument, such as a living will or life prolonging procedure declaration, appointment of health care representative and power of attorney for health care purposes. These directives are established under state law and relate to the provision of medical care when the individual is incapacitated...At the time of admission each resident will be asked if they have made advanced directives and provided educational information regarding state and federal law...The Social Service and/or Admissions Director will be responsible for providing copies of state statutes, regulations, and information regarding Advance Directive[s], to resident, legal representatives upon admission and also to families who wish to receive such information and assistance regarding Advanced Directive [s]and decisions regarding life sustaining measures and in no event shall give legal advice on the need for medical care directives...The resident, the legal representative,		**directives, including but not limited to, ensuring residents have specified a code status upon admission.** **How the corrective actions will be monitored:** **ED, or designee, will conduct an audit of all new admissions at least 2 X a week times 4 weeks, then weekly X 4 weeks to ensure code status has been specified. Any identified concerns will be promptly addressed with the responsible individual(s).** **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: August 10, 2022.**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155064	A. BUILDING 00 B. WING	07/13/2022

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
	or the will individual who has been authorized as the resident health care representative will be asked if an Advanced Directive, as recognized under the state law, has been executed. Documentation concerning this inquiry and the individual response shall include the date the entry was made and the individual making this inquiry. This information shall be documented in the resident's medical record...If the individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed and advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law...." 3.1-3(u)(3)			
F 0583 SS=D Bldg. 00	483.10(h)(1)-(3)(i)(ii) Personal Privacy/Confidentiality of Records §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155064	A. BUILDING 00 B. WING	07/13/2022

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
	delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law.			
	Based on observation, interview and record review, the facility failed to ensure a resident's personal information was protected for 1 of 1 resident reviewed for confidentially. (Resident 46) Finding includes: The record for Resident 46 was reviewed on 07/08/22 at 10:57 a.m. Diagnoses included, but were not limited to, congestive heart failure, type 2 diabetes mellitus, end stage renal disease, atrial fibrillation, seizures and hypertension. A physician's order, dated 7/6/22, indicated kayexalate (used to treat high blood potassium) 15 mg (milligrams)/60 ml (milliliters) to give 60 ml by mouth daily. During an observation, on 07/07/22 at 9:19 a.m., LPN 1 opened a bottle of kayexalate and poured the medication in a medication cup. LPN 1 then placed the empty bottle into the medication cart's trash. The bottle of kayexalate had a label with the resident's personal information.	F 0583	**F583** *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) Immediate actions taken for those residents identified:** **Please note that LPN #1 realized right away that the medication label was on the**	08/10/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155064	A. BUILDING 00 B. WING	07/13/2022

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
	During an interview, on 07/07/22 at 9:19 a.m., LPN 1 indicated she should not have thrown the medication bottle in the trash with the resident's information on the bottle. She should have taken the label off the bottle and put it in the sharps container. During an interview, on 07/13/22 at 2:51 p.m., the Director of Nursing indicated the labels for medication should be removed and put in the sharps container when the medication was finished. There were no policy provided at the time of exit. 3.1-3(o)		**bottle and retrieved it from the trash, without being prompted by IDOH surveyor. The label for Resident 46 was then removed from the bottle and disposed in shredder.** **2) How the facility identified other residents:** **All residents have the potential to be affected; therefore, this plan of correction applies to those residents.** **3) Measures put into place/ System changes:** **Nursing staff was re-educated on personal privacy/confidentiality of records, including but not limited to, protecting resident's personal information.** **How the corrective actions will be monitored:** **DON, or designee, will conduct observations on varied shifts at least 3 X a week times 4 weeks, then 2 X a week times 4 weeks to ensure personal information is discarded appropriately. Any identified concerns will be promptly addressed with the responsible individual(s).**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155064	A. BUILDING 00 B. WING	07/13/2022

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
			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: August 10, 2022.** Desk review is requested for this deficiency	
F 0600 SS=D Bldg. 00	483.12(a)(1) Free from Abuse and Neglect §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; Based on interview and record review, the facility failed to ensure residents were free from hearing cursing and threatening language by a staff	F 0600	**F600** *This Plan of Correction is the*	08/10/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155064	A. BUILDING 00 B. WING	07/13/2022

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
	member for 2 of 2 residents reviewed for abuse (Resident 4 and 24). Findings include: 1. During an interview, on 7/11/22 at 1:40 p.m., Resident 4 indicated CNA 6 said she was going to "throw my head in (the) hall" while the resident was in the dining room. This happened in June of 2022. The resident told the nurse and the nurse told her to talk to the Administrator in training (AIT). The resident told the AIT and he filled out a paper and he watched the video of the dining room incident. The video did not have sound. During an interview, on 7/11/22 at 1:46 p.m., CNA 6 indicated she had worked at the facility for 7 to 8 years and usually worked the 2-10 p.m. shift. She had not had any residents indicate concerns about the care she provided. She indicated the residents would tell her she did a great job. She indicated Resident 4 had a history of making false accusations about the staff so they provided care to this resident in pairs. There was one female resident who did not reside in the facility any longer who CNA 6 was not able to provide care for since the resident was "always saying things". During an interview, on 7/11/22 at 3:27 p.m., the AIT indicated Resident 4 did not tell him CNA 6 had told her she was going to throw her head in the hall. Resident 4 just told him CNA 6 did not like her. There was an incident in the dining room with the resident and CNA 6 and he watched the camera. CNA 6 did not have any interactions with the resident on the video of the dining room when it was reviewed. The incident was not substantiated and no other resident interviews were completed. Resident 4 and Resident 24 had not indicated CNA 6 had verbally threatened them		*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) Immediate actions taken for those residents identified:** **1 & 2. CNA #6 was suspended, pending investigation, and is no longer employed.** **2) How the facility identified other residents:** **All residents have the potential to be affected; therefore, this plan of correction applies to those residents.** **3) Measures put into place/ System changes:** **Staff was re-educated on free from abuse and neglect, including but not limited to, ensuring that residents are free from hearing cursing and**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155064	A. BUILDING 00 B. WING	07/13/2022

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
	prior to this conversation. The issue with CNA 6 previously was not determined to be abuse but a customer service issue. The record for Resident 4 was reviewed on 7/11/22. Diagnoses included, but were not limited to chronic obstructive pulmonary disease, respiratory failure with hypoxia, asthma, morbid obesity and hypertension. 2. During an interview, on 7/6/2022 at 3:59 p.m., Resident 24 indicated CNA 6 worked the first and second shifts. CNA 6 yelled at the resident 2-3 months ago and the facility did not let the CNA in the resident's room any more. CNA 6 was always yelling and would say f***ing this and f***ing that. The resident did not think it was professional for the CNA to use those words. The record for Resident 24 was reviewed on 7/7/22 at 2:19 p.m. Diagnoses included, but were not limited to, multiple sclerosis, emphysema, seizures, chronic pulmonary embolism, chronic pain syndrome, schizoaffective disorder and major depressive disorder. During an anonymous interview, the anonymous interviewee indicated some of the staff had attitudes. CNA 6 would "cuss like a sailor" and she had an attitude. During an interview, on 7/11/22 at 3:14 p.m., the Director of Nursing (DON) indicated CNA 6 had complaints from residents and the residents commented they did not like CNA 6's personality. The residents would make all kinds of complaints and the staff would follow up and accommodate what the resident wanted. CNA 6 was not allowed to work with Resident 24 since Resident 24 did not like the way the CNA talked. CNA 6 did not		**threatening language by staff.** **How the corrective actions will be monitored:** **DON, or designee, will conduct observed rounds on varied shifts at least 3 X a week times 4 weeks, then 2 X a week times 4 weeks to observe for appropriate staff interaction with residents. Will interview at least 5 alert and orientated residents per week regarding abuse and staff treatment X 4 weeks, 3 residents per week X 4 weeks and then 2 residents X 4 weeks. Any identified concerns will be promptly addressed with the responsible individual(s).** **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: August 10, 2022.** **Desk review is requested for this deficiency**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155064	A. BUILDING 00 B. WING	07/13/2022

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

talk abusive, the resident just didn't like the way she talked. The scheduler was notified to not schedule CNA 6 with Resident 24 although the DON had not talked to CNA 6 about the situation. There was no entry made in the personnel record of CNA 6 or any other place about her not being able to take care of Resident 24. The other staff and residents were not interviewed about their interactions with CNA 6.

During an interview, on 7/11/22 at 3:27 p.m., the AIT indicated Resident 24 had indicated CNA 6 was cursing a lot in the hallway. CNA 6 was talking with other CNAs. It was a customer service issue and the DON talked with CNA 6 either one or two weeks ago. The DON told CNA 6 not to work with Resident 24 anymore. The staff were given education. We apologized for the inconvenience and it was very unprofessional. Resident 24 was not able to give an exact date and time of the incident. Other residents were not interviewed.

During an interview, on 7/12/22 at 10:54 a.m., Resident 35 indicated there was a CNA who was always on her phone and told him to shut up. He did not know the name of the CNA. She was disrespectful and had also cussed at him.

During an interview, on 7/12/22 at 11:01 a.m., LPN 5 indicated the night shift nurse had reported a CNA was rude to residents and the nurse reported the CNA a couple of weeks ago. LPN 5 could not remember the CNA's name. The CNA was still working at the facility.

During an interview, on 7/13/22 at 2:49 p.m., the AIT indicated the verbal abuse allegation for CNA 6 was not completed. There was a customer service issue and he wanted to interview the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155064	A. BUILDING 00 B. WING	07/13/2022

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

residents again because they have a history of changing stories.

A current policy, titled "Abuse Prevention and Reporting-Indiana," revised on 12/17/21 and received at the entrance conference from the AIT, indicated "...The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation...Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish...It includes verbal abuse, sexual abuse, physical abuse and mental abuse...Orientation and Training of Employees...During orientation of new employees, the facility will cover at least the following topics...Sensitivity to resident rights and resident needs...What constitutes abuse, neglect, exploitation and mistreatment...How to recognize and deal with burnout, frustration, and stress that may lead to inappropriate responses or abusive reactions to residents...This facility desires to prevent abuse, neglect, exploitation, mistreatment and misappropriation of resident property by establishing a resident sensitive and resident secure environment...Resident and family concerns will be recorded, reviewed, addressed, and responded to using the facility's grievance procedures...Any incident or allegation involving abuse, neglect, exploitation, mistreatment or misappropriation of resident property will result in an investigation...Employees of this facility who have been accused of abuse, neglect, exploitation, mistreatment or misappropriation of resident property will be removed from resident contact immediately until the results of the investigation have been reviewed by the administrator...."

3.1-27(b)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155064	A. BUILDING 00 B. WING	07/13/2022

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
F 0623 SS=D Bldg. 00	483.15(c)(3)-(6)(8) Notice Requirements Before Transfer/Discharge §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155064	A. BUILDING 00 B. WING	07/13/2022

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
	required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155064	A. BUILDING 00 B. WING	07/13/2022

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
	Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).			
	Based on interview and record review, the facility failed to ensure a bed hold was sent to the hospital and the Ombudsmen was notified for 2 of 4 residents reviewed for hospitalization. (Resident 31 and 33) Findings include: 1. The record for Resident 31 was reviewed on 07/08/22 at 9:32 a.m. Diagnoses included, but were not limited to, dementia, Alzheimer's disease, glaucoma, hypertension and pacemaker. A nurse's note, dated 02/12/22, indicated the resident had a change in condition and was sent to the hospital. The facility nurse called [hospital] and the resident was being admitted with acute renal failure and metabolic acidosis (too much acid accumulated in the body).	F 0623	**F623** *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.*	08/10/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155064	A. BUILDING 00 B. WING	07/13/2022

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
	2. The record for Resident 33 was reviewed on 07/08/22 at 11:21 a.m. Diagnoses included, but were not limited to, acute kidney failure, type 2 diabetes mellitus, chronic kidney disease, atrial fibrillation, delusional disorders, depressive disorder, vascular dementia with behavioral disturbance, pseudobulbar affect, impulse disorder and hypertension. A nurse's note, dated 04/17/22, indicated the resident had a change in condition. The resident was sent to [hospital] and admitted with pneumonia and acute kidney injury (kidneys suddenly stop working properly). During an interview, on 07/13/22 at 2:08 p.m., the Director of Nursing (DON) indicated there was no documentation for a bed hold sent with Resident 31 and 33 to the hospital. The Ombudsman was not notified of the residents hospitalization. A current policy, titled "Discharge/Transfer of Resident," not dated and received from the DON on 7/13/22 at 9:26 a.m., indicated "...To provide safe departure from the facility...Review and adhere to current federal regulations as found in Resident Rights and Transfer and Discharge Policies...." 3.1-12(a)(6)(A)(iv) 3.1-12(a)(25)(A) 3.1-12(a)(25)(B)		**1) Immediate actions taken for those residents identified:** **1 & 2. Ombudsman was notified of the transfers of resident 31 and 33.** **2) How the facility identified other residents:** **All residents who are transferred or discharged from the facility have the potential to be affected; therefore, this plan of correction applies to those residents.** **3) Measures put into place/ System changes:** **SSD was re-educated on notice requirements before transfer/discharge, including but not limited to, ensuring bed hold policy is sent with residents when sending to the hospital and notifying the Ombudsmen at least monthly of residents transferred/discharged in the preceding month.** **4) How the corrective actions will be monitored:** **ED, or designee, will review transfers and/or discharges as**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155064	A. BUILDING 00 B. WING	07/13/2022

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
			they occur within 72 hours to ensure appropriate notice and bed hold policy was issued, and the discharge log will be reviewed monthly for accuracy prior to submitting to the Ombudsman. **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: August 10, 2022** Desk review is requested for this deficiency	
F 0641 SS=D Bldg. 00	483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. Based on record review and interview, the facility failed to ensure a Minimum Data Set (MDS) assessment was coded accurately to reflect the nutritional status of a resident for 1 of 16 residents reviewed for MDS accuracy. (Resident 38) Finding includes: The record for Resident 38 was reviewed on	F 0641	**F641** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not*	08/10/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155064	A. BUILDING 00 B. WING	07/13/2022

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
	07/08/22 at 1:30 p.m. Diagnoses included, but were not limited to, end stage renal disease, diabetes mellitus, and congestive heart failure (a condition when the heart doesn't pump blood as it should causing fluid to build up in the lungs). The resident's weight was reviewed and indicated the following: a. On 03/09/22, weight was 190.0 lbs. (pounds) This was the resident's admission weight. b. On 04/04/22, weight was 187.6 lbs. (1.2% weight loss within 30 days) c. On 05/01/22, weight was 187.2 lbs. d. On 06/01/22, weight was 183.0 lbs. (2.24% weight loss in 30 days and 2.45% weight loss within 3 months) e. On 07/05/22, weight was 184.2 lbs. A significant change MDS assessment, dated 06/03/22, indicated the resident had a significant weight loss of more than 5% in the last month. During an interview, on 07/11/22 at 11:31 a.m., the RD (Registered Dietician) indicated the resident's weights have been stable and the resident did not have a significant weight loss from her admission weight through her current weight. During an interview, on 07/11/22 at 11:59 a.m., the MDS Coordinator indicated the significant weight loss indicated on the resident's MDS assessment was a data entry error and there was not a policy on MDS accuracy. The facility followed the Resident Assessment Instrument (RAI) manual. The October 2017 RAI Manual indicated "...Code 0, no or unknown: if the resident has not experienced weight loss of 5% or more in the past 30 days or 10% or more in the last 180 days or if information about prior weight is not available...."		*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) Immediate actions taken for those residents identified:** **Resident #38's MDS assessment was corrected at the time of survey.** **2) How the facility identified other residents:** **All MDS submitted in the last 30 days will be reviewed for accuracy and corrections made as identified.** **3) Measures put into place/ System changes:** **The MDS Coordinator was re-educated on accuracy of assessments, including but not limited to, ensuring nutritional status of a resident is coded accurately on the MDS.** **4) How the corrective actions will be monitored:**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155064	A. BUILDING 00 B. WING	07/13/2022

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
	3.1-31(d)		**DON, or designee, will audit all MDS will be reviewed by DON or designee prior to submission weekly.** **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: August 10, 2022** **Desk review is requested for this deficiency**	
F 0644 SS=D Bldg. 00	483.20(e)(1)(2) Coordination of PASARR and Assessments §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155064	A. BUILDING 00 B. WING	07/13/2022

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
	§483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. Based on interview and record review, the facility failed to ensure another PASARR (Preadmission Screening and Resident Review) was completed when the resident had a new mental health diagnosis and was prescribed an antipsychotic medication and to ensure PASARR Level II recommendations were followed for 2 of 2 residents reviewed for PASARR (Resident 24 and 39). Findings include: 1. The record for Resident 24 was reviewed on 7/7/22 at 2:19 p.m. Diagnoses included, but were not limited to, multiple sclerosis, emphysema, seizures, chronic pulmonary embolism, chronic pain syndrome, schizoaffective disorder and major depressive disorder. A PASARR level II, dated 3/10/22, indicated the resident had a diagnoses of major depressive disorder severe without psychotic features and generalized anxiety disorder. A physician's order, dated 8/29/2020, indicated abilify (an antipsychotic medication) 10 mg (milligram) at bedtime related to schizoaffective disorder. A diagnosis of schizoaffective disorder was added on 8/19/2020 and a diagnosis of bipolar disorder was added on 8/12/2020.	F 0644	**F644** *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) Immediate actions taken for those residents identified:** **1. A new Level of Care was completed for Resident #24.** **2. Resident #39 is being referred to counseling by outside vendor in facility.** **2) How the facility identified other residents:** **An audit was conducted to identify any residents who**	08/10/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155064	A. BUILDING 00 B. WING	07/13/2022

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
	During an interview, on 7/12/22 at 4:09 p.m., the Director of Nursing (DON) indicated the resident did not have another PASARR level II completed when the new diagnoses of schizoaffective disorder and the antipsychotic medication was added. 2. The record for Resident 39 was reviewed on 7/7/22 at 3:53 p.m. Diagnoses included, but were not limited to, schizoaffective disorder, bipolar disorder, schizophrenia, generalized anxiety disorder, obsessive compulsive disorder and recurrent depressive disorder. A PASARR level II, dated 3/3/21, indicated the resident would need specialized services and rehabilitative services. The resident was to get individual therapy from mental health services to help the resident better manage his symptoms. During an interview, on 7/11/22 at 12:10 p.m., the Assistant Director of Nursing (ADON) indicated the resident was not receiving mental health therapy services. During an interview, on 7/11/22 at 4:48 p.m., the DON indicated the business office manager would receive the completed PASARR and then would give it to the Social Service Director (SSD) to review the PASARR II recommendations. The SSD would be in charge of implementing the PASARR recommendations for the resident. A current policy, titled "Preadmission Screening and Annual Resident Review [PASARR]," dated as revised on 11/17/17 and received from the DON on 7/12/22 at 4:24 p.m., indicated "...It is the policy to screen all potential admissions on an individual basis....Based upon the Level I screen, the facility will not admit an individual with a mental disorder		**have received a new psychiatric diagnosis, have an increase in antipsychotic medication, have been newly prescribed anti-psychotic medication, or have had a new, or updated, PASARR in the past 6 months. This plan of correction would apply to identified residents.** **3) Measures put into place/ System changes:** **SSD was re-educated on coordination of PASARR and assessments, including but not limited to, ensuring residents with new psychiatric diagnoses or newly prescribed anti-psychotic medication have a new PASARR completed, and that any recommendations made on Level 2 assessments are followed.** **4) How the corrective actions will be monitored:** **ED, or designee, will audit all residents with new psychiatric diagnoses and/or newly prescribed anti-psychotic medications to ensure a new PASARR is completed. Additionally, ED, or designee, will audit all PASARR and Level 2s completed to ensure recommendations are being**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155064	A. BUILDING 00 B. WING	07/13/2022

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
	or intellectual disability until the Level II screening process has been completed and the recommendations allow for a nursing facility admission and the facility's ability to provide the specialized services determined in the Level II screen...Annually and with any significant change of status, the facility will complete the PASARR Level I screen for those individuals identified per the Level II screen requiring specialized services. The facility will report any changes as identified via the screen to the state mental health authority or state intellectual disability authority promptly...The objective of the PASARR policy is to ensure that individuals with mental illness and intellectual disabilities receive the care and services that they need in the most appropriate setting. The PASARR will be evaluated annually and upon any significant change for those individuals identified...Upon completion of the Level II screen, the facility will review the screen recommendations and determine the facility's ability to provide the specialized services outlined...Upon admission, the facility will include the PASARR level II determination and evaluation report into the residents' assessment, comprehensive care plan...The facility will care plan and provide the specialized services as indicated in the level II determination. The services will be provided under the direction of the qualified personnel indicated...The facility will refer all level II residents and all resident with newly evident or possible serious mental disorder, intellectual disability, or related condition for a level II review upon a significant change in status assessment to the State PASARR representative...." 3.1-16(d)(1)(A) 3.1-16(d)(1)(B)		**followed through.** **These audits will be conducted 2 X a week times 4 weeks, then weekly X 4 weeks. Any identified concerns will be promptly addressed with the responsible individual(s).** **The results of these audits will be reviewed in Quality 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: August 10, 2022** **Desk review is requested for this deficiency**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155064	A. BUILDING 00 B. WING	07/13/2022

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
F 0656 SS=D Bldg. 00	483.21(b)(1) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155064	A. BUILDING 00 B. WING	07/13/2022

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
	appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.			
	Based on interview and record review, the facility failed to develop a person-centered comprehensive care plan which addressed the physical, mental and psychosocial needs of a resident who smoked for 1 of 1 resident reviewed for smoking. (Resident 26) Finding includes: The record for Resident 26 was reviewed on 07/08/22 at 11:20 a.m. Diagnoses included, but were not limited to, anxiety disorder, major depressive disorder and tobacco use. A Smoking Safety Assessment, dated 05/24/22, indicated the resident currently smoked independently. The resident's record did not contain a smoking care plan. During an interview, on 07/12/22 at 4:25 p.m., the SSD (Social Service Director) indicated she was responsible to develop care plans for residents who smoke and was unsure if the resident had care plan developed to address his preference to smoke. During an interview, on 07/13/22 at 10:32 a.m., the DON (Director of Nursing) indicated she could not provide a smoking care plan for the resident and he should have had one in place. A current policy, titled "Comprehensive Care Plan," dated as revised on 11/17/17 and provided	F 0656	**F656** *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)Immediate actions taken for those residents identified:** **Resident #26s care plan was updated at the time of survey to reflect smoking status.** **2) How the facility identified other residents:** **An audit was conducted to identify all residents who are smokers. The care plans for these residents were reviewed**	08/10/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155064	A. BUILDING 00 B. WING	07/13/2022

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
	by the ADON (Assistant Director of Nursing) on 07/12/22 at 4:31 p.m., indicated "...The comprehensive care plan must describe the following: The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being...Any specialized services...." 3.1-35(a)		**and revised, as necessary, to reflect smoking status.** **3) Measures put into place/ System changes:** **SSD was re-educated on Develop/Implement Comprehensive Care Plan, including but not limited to, ensuring residents who smoke have a person-centered care plan addressing the same.** **4) How the corrective actions will be monitored:** **ED, or designee, will audit all new admission charts will be reviewed within 72 hours as they occur to ensure smoking assessment and person-centered care plan is in place.** **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.**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155064	A. BUILDING 00 B. WING	07/13/2022

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
			5) Date of compliance: August 10, 2022 **Desk review is requested for this deficiency**	
F 0657 SS=E Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.			
	Based on interview and record review, the facility failed to ensure care plan meetings were completed quarterly for 4 of 4 residents reviewed	F 0657	**F657**	08/10/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155064	A. BUILDING 00 B. WING	07/13/2022

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
	for care plan meetings. (Resident 24, 39, 41 and 38) Findings include: 1. During an interview, on 7/6/22 at 4:03 p.m., Resident 23 indicated she had missed the only care plan meeting she was invited to because the staff did not come to get her. This happened last winter and she had not had a care plan meeting since then. The record for Resident 24 was reviewed on 7/7/22 at 2:19 p.m. Diagnoses included, but were not limited to, multiple sclerosis, emphysema, seizures, chronic pulmonary embolism, chronic pain syndrome, schizoaffective disorder and major depressive disorder. A care plan meeting invite was dated 5/6/21. There was no care plan meeting notes in the electronic record after the care meeting invite dated 5/6/21. A care plan meeting invite was dated 8/9/21. There was no care plan meeting notes in the electronic record after the care meeting invite dated 8/9/21. 2. During an interview, on 7/6/22 at 4:21 p.m., Resident 39 indicated he had not been to any care plan meetings and did not know what a care plan meeting was. The record for Resident 39 was reviewed on 7/7/22 at 3:38 p.m. Diagnoses included, but were not limited to, schizoaffective disorder, bipolar disorder, type 2 diabetes mellitus, anemia, fracture of the shaft of the left arm humerus and sleep		*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)Immediate actions taken for those residents identified:** **1., 2., 3., & 4. Care Plan meetings have been conducted for Resident #s 23, 24, 39, 41, and 38.** **2) How the facility identified other residents:** **An audit was completed to identify those residents who have not had a care plan meeting conducted in the last 90 days; this plan of correction applies to residents identified in this audit.** **3) Measures put into place/**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155064	A. BUILDING 00 B. WING	07/13/2022

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
	apnea. During an interview, on 7/8/22 at 3:38 p.m., the Social Service Director (SSD) indicated she had not completed a care plan meeting with this resident since she had been employed at the facility and his last care plan meeting was in March or April. During an interview, on 7/8/22 at 3:38 p.m., the Director of Nursing (DON) indicated there was only one care plan meeting on 3/7/22 and she could not locate any more care plan meetings in the electronic health record. 3. The record for Resident 41 was reviewed on 7/8/22 at 3:10 p.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease, bipolar disorder, history of traumatic brain injury and old myocardial infarction. The electronic health record did not include documentation on care plan meetings. During an interview, on 7/8/22 at 4:25 p.m., the Assistant Director of Nursing (ADON) indicated the previous social worker had been completing care plan meetings although she was not documenting them in the electronic health record.4. During an interview, on 07/06/22 at 12:08 p.m., the resident indicated she and her son had two appointments for a care plan meeting but the facility changed the time and her son could not make it. The record for Resident 38 was reviewed on 07/08/22 at 1:30 p.m. Diagnoses included, but were not limited to, diabetes mellitus, high blood pressure and anxiety disorder.		**System changes:** **SSD was re-educated on care plan timing and revision, including but not limited to, ensuring residents have a care plan meeting conducted at least quarterly.** **4) How the corrective actions will be monitored:** **ED, or designee, will audit the care plan schedule to ensure care plan meetings are being conducted.** **These audits will be conducted 2 times a week X 4 weeks, then weekly times 4 weeks. Any identified concerns will be promptly addressed with the responsible individual(s).** **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: August 10, 2022**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155064	A. BUILDING 00 B. WING	07/13/2022

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
	A care plan note, dated 05/04/22 at 11:01 a.m., indicated "Care Plan Meeting resident had concerns, concerns were addressed. Resident's son unable to participate d/t [due to] work called in early. SSD [Social Service Director], AD [Activities Director], and DON [Director of Nursing] attended care plan meeting." During an interview, on 07/12/22 at 4:00 p.m., the SSD indicated care plan meetings should be every quarter and both family and the resident were invited. It was not just the residents' concerns which are to be discussed in the meetings but also basic nursing care needs, medications, current orders, diet, diagnoses, therapy orders and discharge planning as well. The meeting notes should be included in the resident's record in either a care plan assessment note or in a general progress note. Resident 38's documented care plan note indicated only her concerns and was not a thorough and complete meeting addressing the other pertinent areas of care. During the exit conference, on 7/13/22 at 5:20 p.m., the Administrator indicated the interim SSD had only been able to complete the 72 hour new admission care plans and had not completed the quarterly care plan meetings. A current policy, titled "Comprehensive Care Plan," dated as revised on 11/17/17 and provided by the Assistant Director of Nursing on 07/12/22 at 4:31 p.m., indicated "...The comprehensive care plan must describe the following: The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being...Any specialized services...the resident's preference and potential for future discharge...The care plan should be revised on an ongoing basis to reflect changes in		**Desk review is requested for this deficiency**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155064	A. BUILDING 00 B. WING	07/13/2022

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
	the resident and the care that the resident is receiving...The resident and/or resident representative shall be invited to review the plan of care with the interdisciplinary team either in person, via telephone or video conference...at least quarterly...." 3.1-35(d)(2)(B)			
F 0660 SS=D Bldg. 00	483.21(c)(1)(i)-(ix) Discharge Planning Process §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and- (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. (ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes. (iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan. (iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs. (v) Involve the resident and resident			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155064	A. BUILDING 00 B. WING	07/13/2022

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
	representative in the development of the discharge plan and inform the resident and resident representative of the final plan. (vi) Address the resident's goals of care and treatment preferences. (vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community. (A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose. (B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities. (C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why. (viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences. (ix) Document, complete on a timely basis based on the resident's needs, and include in			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155064	A. BUILDING 00 B. WING	07/13/2022

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
	the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer.			
	Based on interview and record review, the facility failed to have a discharge care plan for 1 of 2 residents reviewed for discharge planning. (Resident 53) Finding includes: The record for Resident 53 was reviewed on 07/08/22 at 10:17 a.m. Diagnoses included, but were not limited to, intervertebral disc degeneration lumber region, asthma, anxiety disorder, cellulitis, depression, hypertension and chronic pain. During the record review, Resident 53 did not have discharge care planning in place. During an interview, on 07/12/22 at 3:39 p.m., the Director of Nursing (DON) indicated there was no discharge care plan for Resident 53. A current policy, titled "Comprehensive Care Plan," dated as revised on 11/17/17 and received from the Assistant Director of Nursing (ADON) on 7/12/22, indicated "...The facility will develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive	F 0660	**F660** *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)Immediate actions taken for those residents identified:** **Resident #53 no longer resides at the facility; therefore, no further corrective action could be taken for this resident.** **2) How the facility identified other residents:**	08/10/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155064	A. BUILDING 00 B. WING	07/13/2022

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
	assessment...The resident's preference and potential for future discharge, including the resident's desire to return to the community and any referrals to local contact agencies and/or other appropriate entities...Discharge plans in the comprehensive care plan, as appropriate...." 3.1-12(a)(18)(19)		**All residents admitted to the facility, whether short term, or long term, have the potential to be affected. Thus, this plan of correction applies to all residents of the facility.** **3) Measures put into place/ System changes:** **SSD was re-educated on discharge planning process, including but not limited to, ensuring all residents have a discharge care plan in place to address their long term goals, whether it be short term admission or long term placement.** **4) How the corrective actions will be monitored:** **ED, or designee will audit all new admissions will be reviewed within 72 hours as they occur to ensure discharge planning and resident centered care plan is in place.** **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**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155064	A. BUILDING 00 B. WING	07/13/2022

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
			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: August 10, 2022** **Desk review is requested for this deficiency**	
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.			
	Based on observation, interview and record review, the facility failed to assess and document skin conditions for edema for 2 of 3 residents reviewed for skin conditions. (Resident 4 and 17) Findings include: 1. During an observation, on 7/6/22 at 12:54 p.m., Resident 4 had swelling of both lower legs and the swelling was worse on the left side. During an observation, on 7/11/22 at 1:40 p.m., the resident was sitting up on the edge of her bed and both of her legs remained swollen.	F 0684	**F684** *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*	08/10/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155064	A. BUILDING 00 B. WING	07/13/2022

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
	During a requested observation with the Assistant Director of Nursing (ADON), on 7/12/22 at 12:19 p.m., the ADON indicated the resident always had edema, now had more edema than usual and the resident always had her legs dangling. The record for Resident 4 was reviewed on 7/11/22 at 2:15 p.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease, chronic respiratory failure with hypoxia, asthma and hypertension. A care plan, dated 4/21/22, indicated the resident was at a risk for alteration in fluid balance related to chronic obstructive pulmonary disease, respiratory failure with hypoxia, morbid obesity, hypertension and chronic kidney disease. The interventions included, but were not limited to, observe for peripheral edema and report finding to physician. A nursing progress note, dated 6/24/22 at 3:54 a.m., indicated the resident had been awake all night, had sat on the edge of the bed with her legs down. The resident's left thigh was swollen from sitting on the edge of her bed. The resident had the following weights: a. The weight on 6/1/22 was 293 pounds. b. The weight on 7/5/22 was 301 pounds which was an increase of 8 pounds. A weekly skin assessment, dated 7/7/22 at 1:00 p.m., indicated the resident had continued treatment on her abdominal folds. The skin assessment did not include edema of the legs.		*executed solely because it is required by the provisions of federal and state law.* **1)Immediate actions taken for those residents identified:** **1. & 2. Resident #s 4 and 17 were re-assessed, NP notified, and plan of care adjusted accordingly.** **2) How the facility identified other residents:** **A skin sweep was completed to identify any residents with unidentified skin concerns or edema. All residents have the potential to be affected; therefore, this plan of correction applies to those residents.** **3) Measures put into place/ System changes:** **Nursing staff was re-educated on quality of care, including but not limited to, ensuring a skin assessment is complete and accurate, including assessing for edema.** **4) How the corrective actions will be monitored:** **DON, or designee, will verify at least 5 skin assessments**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155064	A. BUILDING 00 B. WING	07/13/2022

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
	During an interview, on 7/12/22 at 2:20 p.m., the ADON indicated the resident's edema was more than had ever been noted before. The Nurse Practitioner (NP) was notified and ordered stat (urgent) labs, stat chest X-ray and tubi grips (support for the management of swelling) and Lasix (a diuretic) 40 mg (milligram) to give today. An SBAR (situation, background, assessment, recommendation) Communication Form, dated 7/12/22, indicated the resident had edema and shortness of breath. The NP ordered Lasix 40 mg x 1 now, stat labs, stat chest X-ray and compression/tubi grips to bilateral lower extremities to be put on in the morning and take of at bedtime. The chest X-ray report, dated 7/12/22, indicated the resident had a small left lower lobe infiltrate with trace left pleural effusion. During an interview, on 7/12/22 at 4:11 p.m., the Director of Nursing (DON) indicated she could not find any progress notes for the identification of the resident's edema other than on 6/24/22 and 7/12/22. 2. During an observation, on 7/6/22 at 1:43 p.m., Resident 17 had very reddened lower legs and swelling noted in the left lower leg. During an observation, on 7/7/22 at 3:49 p.m., the resident was ambulating in the hallway, his lower legs remained reddened with swelling on the left lower leg. The record for Resident 17 was reviewed on 7/12/22 at 10:55 a.m. Diagnoses included, but were not limited to, hemiplegia and hemiparesis (weakness and paralysis) following a cerebral		**completed weekly by visual observation to confirm accuracy X 4 weeks, then 2 skin assessments weekly X 4 weeks.** **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: August 10, 2022** **Desk review is requested for this deficiency**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155064	A. BUILDING 00 B. WING	07/13/2022

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

infarction affecting the left non dominant side, chronic pain syndrome, seizures and lack of coordination.

A weekly skin assessment, dated 7/12/22 at 7:00 a.m., indicated the resident's skin was warm and dry and within normal limits and no foot concerns were noted.

The weekly skin assessment did not include the reddened legs or swelling of the legs.

During an interview, on 7/12/22 at 2:21 p.m., the ADON indicated the resident had about 2 plus edema, had natural coloring of his legs which was reddened and stated his socks were tight around his ankles. The NP was notified and ordered TED (thromboembolic deterrent) hose to start in the morning, labs in the morning and the NP will see the resident. The facility did a teachable moment with the nurse who completed the weekly skin assessment on 7/12/22.

During an interview, on 7/12/22 at 3:08 p.m., LPN 5 indicated the resident's legs were discolored and had edema which was noted after she completed the weekly skin assessment this morning. She would consider the discolored legs a concern although she had not documented anything about them yet.

A current policy, titled "Pressure Injury and Skin Condition Assessment," dated as revised on 1/17/18 and received from the clinical support on 7/13/22 at 4:05 p.m., indicated "...To establish guidelines for assessing, monitoring and documenting the presence of skin breakdown pressure injuries and other ulcers and assuring interventions are implemented...Residents identified will have a weekly skin assessment by a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155064	A. BUILDING 00 B. WING	07/13/2022

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
	licensed nurse...." 3.1-37(a)			
F 0757 SS=D Bldg. 00	483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.			
	Based on interview and record review, the facility failed to ensure a resident was given the physician ordered antibiotic to treat a urinary tract infection for 1 of 5 residents reviewed for unnecessary medications (Resident 26). Finding includes: The record for Resident 26 was reviewed on 07/08/22 at 11:20 a.m. Diagnoses included, but	F 0757	**F757** *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*	08/10/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155064	A. BUILDING 00 B. WING	07/13/2022

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
	were not limited to, neuromuscular dysfunction of the bladder (a condition where there was a lack of bladder control due to brain, spinal cord, or nerve problems), paraplegia (paralysis of the legs and lower body typically caused by a spinal cord injury) and urinary tract infections. A urine culture lab report, dated 07/07/22, indicated the resident had a urinary tract infection and the bacteria present in his urine was resistant to the antibiotic Bactrim (an antibiotic often used to treat urinary tract infections). A progress note, dated 07/08/22, indicated the ADON (Assistant Director of Nursing) notified the physician of the culture results and received a verbal nursing order from the physician to start Bactrim DS two times a day for 10 days. The resident's MAR (Medication Administration Record), for July 2022, indicated the resident received Bactrim DS from 8:00 p.m., on July 8th through 8:00 a.m., on July 13th. During an interview, on 07/13/22 at 3:37 p.m., the ADON indicated she received a verbal order from the physician to start Augmentin (an antibiotic also used to treat a urinary tract infection) but when she documented the order into the resident's record she wrote Bactrim DS and not Augmentin. She indicated this was a transcription medication error. A current policy, titled "Physician Orders-Entering and Processing," dated as revised on 01/31/18 and provided by the Clinical Support Nurse, on 07/13/22 at 4:05 p.m., indicated "Purpose: To provide general guidelines when receiving, entering, and confirming physician or prescribers orders...."		*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)Immediate actions taken for those residents identified:** **Resident 26 was re-assessed; MD was notified of medication error with new orders obtained.** **2) How the facility identified other residents:** **Residents requiring antibiotics to treat an infectious process have the potential to be affected; therefore, this plan of correction applies to those residents.** **3) Measures put into place/ System changes:** **Nursing staff was re-educated on new antibiotic orders to ensure the antibiotic entered is appropriate to treat the organism identified.** **4) How the corrective actions will be monitored:**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155064	A. BUILDING 00 B. WING	07/13/2022

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
	3.1-48(a)(4)		**DON or designee will review all new antibiotic orders as they occur during clinical review 5 X a week to ensure that the appropriate antibiotic is prescribed to treat the organism identified.** **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: August 10, 2022** **Desk review is requested for this deficiency**	
F 0758 SS=E Bldg. 00	483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155064	A. BUILDING 00 B. WING	07/13/2022

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
	Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.			
	Based on interview and record review, the facility failed to ensure psychotropic side effect testing was completed every 6 months, to recommend	F 0758	**F758** *This Plan of Correction is the*	08/10/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155064	A. BUILDING 00 B. WING	07/13/2022

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
	gradual dose reductions and to monitor for side effects of psychotropic medications for 4 of 6 residents reviewed for unnecessary medications. (Resident 39, 41, 33 and 35) Findings include: 1. During an interview, on 7/6/22 at 4:56 p.m., Resident 39 indicated he had Tardive dyskinesia (a movement disorder which caused symptoms of uncontrolled facial movements and movements of the limbs and torso). The record for Resident 39 was reviewed on 7/7/22 at 3:38 p.m. Diagnoses included, but were not limited to, schizoaffective disorder, bipolar disorder, secondary parkinsonism (when symptoms similar to Parkinson disease are caused by medicines), generalized anxiety disorder, unspecified dementia with behavioral disturbance, disturbance of salivary secretion, recurrent depressive disorder and obsessive compulsive disorder. A physician's order, dated 4/6/21, indicated clozaril (an antipsychotic to treat schizophrenia) 125 mg (milligram) in the morning related to schizophrenia and 200 mg at bedtime A physician's order, dated 1/15/21, indicated abilify (an antipsychotic medication) one time a day related to schizoaffective disorder. A review of AIMS (abnormal involuntary movement scale which is used to detect tardive dyskinesia and follow the severity of tardive dyskinesia) testing indicated the following: a. An AIMS test was completed on 6/25/21 b. An AIMS test was completed on 2/22/22		*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)Immediate actions taken for those residents identified:** **1. An AIMS was completed for Resident #39 at the time of survey. (Please note, although an AIMS User Defined Assessment was not in Resident #39's EMR, resident was being monitored for presence/absence of movement disorder by the psychiatric NP on a routine basis with no irregularities noted.)** **2. The medication regimen of Resident #41 was reviewed and discussed with resident's physician.** **3. As stated on page 40 of the 2567, an order to monitor for presence/absence of side effects relate to anti-psychotic medications was obtained for Resident #33 at the time of**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155064	A. BUILDING 00 B. WING	07/13/2022

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
	There was no AIMS test in the electronic health record for 12/2022. 2. The record for Resident 41 was reviewed on 7/6/22 at 3:10 p.m. Diagnoses included, but were not limited to, major depressive disorder, bipolar disorder, unspecified psychosis not due to a substance of known physiological condition, hallucinations, delusional disorder and history of traumatic brain injury. A physician order, dated 8/25/21, indicated olanzapine (an antipsychotic medication) 2.5 mg at bedtime for psychotic disorder. A physician's order, dated 8/26/21, indicated sertraline 50 mg one time a day for depression. During an interview, on 7/13/22 at 12:23 p.m., the Director of Nursing (DON) indicated the resident did not have any GDR requests or GDRs completed. There was no documentation in the electronic health record of any GDRs and she could not locate any GDR forms. 3. The record for Resident 33 was reviewed on 07/08/22 at 11:21 a.m. Diagnoses included, but were not limited to, acute kidney failure, type 2 diabetes mellitus, chronic kidney disease, atrial fibrillation, delusional disorders, depressive disorder and hypertension. A physician's order, dated 03/31/22, indicated to give risperidone (an antipsychotic medication) 1 mg (milligram) tablet by mouth at bedtime. A care plan, revised 12/26/21, indicated the resident was using antipsychotic medication. Interventions included, but were not limited to, monitor for side effects and effectiveness every shift.		**survey.** **4. The medication regimen of Resident #35 was reviewed and discussed with resident's physician.** **2) How the facility identified other residents:** **All residents receiving psychotropic medications have the potential to be affected; therefore, this plan of correction applies to those residents.** **3) Measures put into place/ System changes:** **Licensed nursing staff and SSD were re-educated on free from unnecessary psychotropic meds/prn use, including but not limited to, ensuring AIMS assessments, and/or assessment for presence/absence of movement disorder(s) are completed according to facility policy; side effect monitoring orders are present for all psychotropic medications ordered; and GDRs are discussed/implemented per policy.** **4) How the corrective actions will be monitored:** **DON, or designee, will audit**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155064	A. BUILDING 00 B. WING	07/13/2022

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
	During a record review, the MAR (Medication Administration Record) indicated the order for monitoring for antipsychotropic medication side effects was discontinued on 06/21/22 and restarted on 07/12/22. During an interview, on 07/12/22 at 4:20 p.m., the DON indicated the order for monitoring side effects for an antipsychotic medication was discontinued in 06/22. It should not have been taken off the MAR. The antipsychotic monitor for side effects was added 07/12/22. 4. The record for Resident 35 was reviewed on 07/07/22 at 3:06 p.m. Diagnoses included, but were no limited to, anxiety disorder, major depressive disorder and insomnia. A physician's order, dated 10/28/21, indicated the resident was to receive trazodone (a medication used to treat depression and insomnia) 50 mg (milligrams) at bed time for insomnia. A document, titled "Psychotropic & Sedative/Hypnotic Utilization By Resident," updated between 12/1/21 and 12/21/21 and provided by the DON on 07/13/22 at 11:39 a.m., indicated the resident's trazodone was ordered on 10/28/21 and was to be revaluated for a gradual dose reduction on 04/22. During an interview, on 07/13/22 at 11:37 a.m., the DON indicated she could not provide documentation where the resident's current order for trazodone had been revaluated and a gradual dose reduction was completed. A current policy, titled "Psychotropic Medication-Gradual Dosage Reduction," dated as revised on 2/1/18 and received from the DON on 7/13/22 at 12:26 p.m., indicated "...To ensure that		**the charts of at least 5 residents receiving psychotropic medications to ensure proper monitoring is being documented and potential GDR is discussed with physician/NP, and documented.** **These audits will be conducted weekly X 4 weeks and then monthly X 5 months. Any identified concerns will be promptly addressed with the responsible individual(s).** **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: August 10, 2022** **Desk review is requested for this deficiency**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155064	A. BUILDING 00 B. WING	07/13/2022

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
	residents are not given psychotropic drugs unless psychotropic drug therapy is necessary to treat a specific or suspected condition as per current standards of practice, and are prescribed at the lowest therapeutic dose to treat such conditions...The plan to alternatives to psychotropic medication and/or use of psychotropic shall be incorporated into the care plan with suitable goals and approaches. This will be initiated by the resident's needs/problems, goals and approaches as it relates to the use of psychotropic drug use...Residents on anti-psychotic drug therapy will be monitored for tardive dyskinesia side effects every 6 months through the use of the AIMS scale...Gradual Dosage Reductions[GDR]...Residents who use psychotropic drugs shall receive gradual dose reductions and behavior interventions, unless clinically contraindicated, in an effort to discontinue or reduce the medication. A gradual dose reduction shall be encouraged at least twice yearly unless previous attempts at reduction have been unsuccessful or reduction is clinically contraindicated. The drug reduction will continue until eliminated or the clinical condition of resident worsens...The time frames and duration of attempts to taper any medication must be consistent with accepted standards of practice...This reduction procedure will help ensure the resident is maintained on the lowest possible dose of psychotropic medication, and also will help to determine if psychotropic medication is still needed, and will help to detect signs of extra-pyramidal symptoms upon withdrawal of the masking effects of the neuroleptic...." A current policy, titled "AIMS Side Effect Monitoring," dated as revised on 1/11/18 and received from the DON on 7/13/22 at 9:26 a.m.,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155064	A. BUILDING 00 B. WING	07/13/2022

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
	indicated "...Abnormal Involuntary Movement Scale [AIMS]-records the occurrence of tardive dyskinesia [TD-a neurological disorder characterized by involuntary movements of the face and jaw] of residents receiving psychotropic medications. To assess the presence of movement and non-movement side effects, and to follow the severity of TD over time...AIMS examination procedure will be repeated at intervals of no less than every six [6] months...." 3.1-48(b)(2)			
F 0880 SS=E Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155064	A. BUILDING 00 B. WING	07/13/2022

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
	§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155064	A. BUILDING 00 B. WING	07/13/2022

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
	§483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. Based on observation, interview and record review, the facility failed to develop and implement written policies and procedures for infection control, to contain the spread of infections and the Covid-19 virus, when the facility failed to ensure staff wore gloves appropriately and a glucometer was cleaned with the appropriate disinfectant for 2 of 3 residents reviewed for medication administration (Residents 12 and 38), staff wore PPE (personal protective equipment) into an isolation room for 1 of 2 residents reviewed for transmission based precautions (Resident 103) and a resident's bathroom floor was free from cardboard boxes for 1 of 8 bathrooms observed on the 100 hall (Room 103). Findings include: 1. During an observation, on 07/07/22 at 9:15 a.m., LPN 1 administered 1 drop of rhopressa (used to treat high eye pressure) 0.25% eye drop to the right eye of Resident 12. LPN 1 was not wearing gloves and touched Resident 12's right upper eyelid with her left hand. LPN 1 left the resident's room and did not wash or sanitize her hands. During an interview, on 07/07/22 at 9:16 a.m., LPN1 indicated she should had worn gloves when doing the residents eye drops and sanitized her hands. LPN 1 stated she did not have gloves. The record for Resident 12 was reviewed on 07/08/22 at 10:09 a.m. Diagnoses included, but were not limited to, Parkinson's disease, dementia,	F 0880	F 880 Infection Prevention and Control *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) Immediate actions taken for those residents identified: 1. & 2. LPN #1 was re-educated at the time of survey. No residents were adversely affected by this practice. 3. The boxes were removed from the bathroom in Room 103 at the time of survey. No resident was adversely affected. 4. CNA #s 3 & 4 were addressed at the time of survey. No residents were adversely	08/10/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155064	A. BUILDING 00 B. WING	07/13/2022

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
	type 2 diabetes mellitus, glaucoma, anxiety disorder, hypertension, depression disorder and bipolar disorder. A physician's order, dated 12/09/21, indicated to instill 1 drop of rhopressa solution in right eye twice a day. 2. During an observation, on 07/07/22 at 9:23 a.m., LPN 1 put on gloves at the medication cart located in front of Room 100. She walked down the hall to Room 107. LPN 1 injected 10 units of Humalog (to treat diabetes) subcutaneous (applied under the skin) in Resident 12's left lower abdomen. The same gloves were used to give the resident 1 drop of brimonide timolol 0.2-0.5% in right eye. The nurse exited Room 107 wearing the dirty gloves and walked back to her medication cart in front of Room 100. During an interview, on 07/07/22 at 9:26 a.m., LPN 1 indicated she should have changed her gloves between medication and washed her hands. She also should not walk in the hall wearing dirty gloves. A physician's order, dated 03/07/21, indicated to give brimonidine tartrate-timolol (treat glaucoma) 0.2-0.5%, instill 1 drop in the right eye twice a day. A physician's order, dated 06/22/22, indicated to inject 10 units of Humalog 100 unit/ml subcutaneously before meals. 3. During an observation, on 07/06/22 at 12:14 p.m., in Room 103 the bathroom had boxes on the floor. The resident not able to access the toilet. During an interview, on 07/06/22 at 12:20 p.m., the Assistant Director of Nursing (ADON) indicated		affected by this practice. 2) How the facility identified other residents: All residents currently residing in the facility have the potential to be affected. Thus, this plan of correction applies to all residents. The facility infection control self-assessment will be reviewed to ensure accuracy and will be revised, as necessary. 3) Measures put into place/system changes: Root Cause Analyses (RCA) were conducted. As a result of the RCAs, facility staff will be educated relative to infection control guidelines, including but not limited to, proper PPE use during medication administration and for Yellow Zone rooms, proper donning, and doffing, of PPE prior to entering/exiting a resident room; proper storage of boxes, and sanitization techniques for multi-use resident equipment by 8/10/22. 4) How the corrective actions will be monitored: The IP nurse/DON/designee will complete random visual rounds daily, on scheduled days of work, for 6 weeks, and until continued	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155064	A. BUILDING 00 B. WING	07/13/2022

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
	the boxes on the bathroom floor were personal dishes and Christmas decorations.4. During tour of the facility, on 07/06/2022 at 12:14 p.m., Resident 103 was observed from the hallway to be lying in bed. A bright yellow warning sign on the resident's door indicated "Quarantine/Observation," "Yellow Zone," "Droplet & Contact Precautions". Instructions on the sign for all entering the room indicated, "Full PPE (Personal Protection Equipment) to be used when entering the room" including N95, face shield, gown and gloves. A large 3-drawer bin, stocked with gowns, gloves, eye protection and N95 masks was next the door outside the resident's room and a wall mounted ABHR (alcohol based hand rub) station was mounted on the wall in the hall next to the entrance to the room. CNA 4 entered the resident's room wearing a surgical mask. The CNA walked to the resident's bedside and talked with the resident about what kind of drink she would like for her lunch meal. During her conversation with the resident, CNA 4 was observed with her bare hands to rearrange items on the resident's over-the-bed table and touch the resident's bed and bed linens. Upon exiting the room, CNA 4 was interviewed regarding why the resident was in transmission based precautions. The CNA indicated "Oh, I don't know," looked at the 3-drawer bin of PPE and quickly walked down the hall. Approximately 3 minutes later, CNA 3 was observed to enter Resident 103's room carrying the resident's lunch tray. Immediately following her was CNA 4. Both CNAs wore surgical masks into the room and were not observed to be wearing gloves. The lunch tray was placed on the resident's over-the-bed table. After some discussion with the resident, CNA 3 and CNA 4 used their bare hands to reposition the resident in bed, touching the resident and the bed linens. When the CNAs		compliance is maintained, to ensure staff are practicing appropriate Infection Control Practices, including but not limited to, proper PPE use during medication administration and for Yellow Zone rooms, proper donning, and doffing, of PPE prior to entering/exiting a resident room; proper storage of boxes, and sanitization techniques for multi-use resident equipment The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months, or until 100% compliance is achieved for 3 consecutive months. The QA Committee will review, update, and make changes, as necessary, to this plan of correction to ensure substantial compliance for no less than 6 months. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months. Completion Date: August 10, 2022 Desk review is requested for this deficiency	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155064	A. BUILDING 00 B. WING	07/13/2022

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
	exited the resident's room, CNA 3 was observed to utilize the wall mounted ABHR to sanitize her hands and CNA 4 did the same. During an interview, at the time of the exit regarding the resident being in precautions, CNA 3 indicated she was "unsure" why the resident was in precautions adding she thought the resident may have "edema or something". When the 2 CNAs were questioned regarding the required PPE listed on the yellow warning sign, they did not answer and walked away down the hall.5. The record for Resident 38 was reviewed on 07/08/22 at 1:30 p.m. Diagnoses included, but were not limited to, end stage kidney disease, high blood pressure and diabetes mellitus. a. During a blood glucose assessment observation for Resident 38, on 07/06/22 at 12:22 p.m., LPN 5 was observed to place the glucose machine directly on her medication cart without a clean barrier between the cart and machine, briefly (less than 30 seconds), wipe the blood glucose machine with an alcohol swab and immediately place the glucose machine into her medication cart. During an interview, at that time, LPN 5 indicated she always used an alcohol swab to clean the glucose machine and then put it in her cart. b. During a medication administration observation, on 07/06/22 at 12:25 p.m., LPN 5 was observed to inject 4 units of Humalog Insulin (a quick acting medication used to lower an elevated blood sugar) subcutaneously (an injection just under the skin) to Resident 38 in her upper left arm without wearing gloves. During an interview, at that time, she indicated she should have put gloves on before giving the injection. A current policy, titled "Medication			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155064	A. BUILDING 00 B. WING	07/13/2022

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

Administration Injection - Insulin Preparation & Administration," undated indicated "...Equipment...4. Glove on non-dominant hand...."

A current policy, titled "Ophthalmic Drops and Ointments," dated as revised 02/02/18 and received from the Administer in Training on 07/11/22 at 12:00 p.m., indicated "...Eye drops, ointments and discs are applied to the eye for diagnostic and therapeutic purposes...Procedure: Verify medication order on MAR. Check medication and label...Identify resident. Explain procedure. Perform hand hygiene...If multiple eye drops are to be administered, wait 5 minutes between medications...Document dose administered. Perform had hygiene...."

A current policy, titled "Glucometer Cleaning," dated as revised on 11/17/17 and provided by the Assistant Director of Nursing on 07/07/22 at 10:42 a.m., indicated "...4. Wipe meter with 1:10 solution bleach wipe/towel until all surfaces of the glucometer are visibly wet. 5. Discard bleach wipe. 6. Place glucometer on a clean surface such as a paper towel and allow to air dry for not less than 3 minutes..."

3.1-18(b)
3.1-18(l)