STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			SURVEY		
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING COMPLETI			ETED
		155064	B. W	NG		08/23/	2022
				_			
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
					LAFOUNTAIN ST		
APERION	N CARE KOKOMO			KOKON	ИО, IN 46902		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID			(X5)
PREFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'		COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		DATE
E 0000							
Bldg							
Diag.	An Emergency Pren	paredness Survey was	E 00	000	This Plan of Correction is the		
		diana Department of Health in		<i>,</i>	center's credible allegation of		
	accordance with 42	•			compliance.		
	accordance with 42	CIR 403.73.			Compliance.		
	Survey Date: 08/23	/22			Preparation and/or execution of	of.	
	Sarvey Date. 00/23	, <u>22</u>			this plan of correction does no		
	Facility Number: 00	00025			constitute admission or agreer		
	Provider Number: 1				by the provider of the truth of t		
	AIM Number: 1002						
	Anvi Number. 1002	274030		facts alleged or conclusions set		τι.	
	At this Emarganou I	Preparedness survey, Aperion	forth in the statement of				
	Care Kokomo was f				deficiencies. The plan of		
		nergency Preparedness			correction is prepared and/or		
	-	ledicare and Medicaid			executed solely because it is		
		lers and Suppliers, 42 CFR			required by the provisions of federal and state law.		
	483.73.	iers and Suppliers, 42 CFR			rederal and state law.		
	463./3.						
	The facility has 105	certified beds. At the time of					
	the survey, the cens						
	the survey, the cens	us was 37.					
	O1' D'	1-4-4 08/20/22					
	Quality Review com	npieted on 08/29/22					
E 0004	402 749(a) 416 E	1(a) 419 112(a)					
SS=C	403.748(a), 416.54						
Bldg	484.102(a), 485.62	5(a), 483.475(a), 483.73(a),					
ыug							
	485.727(a), 485.92						
	491.12(a), 494.62(	• /					
	<u>=</u>	Review and Update					
	Annually	(EA/a) \$440 442/a)					
	- ' ' -	5.54(a), §418.113(a),					
	. , ,	0.84(a), §482.15(a),					
	- , , -	475(a), §484.102(a),					
	- , , -	625(a), §485.727(a),					
	- , , -	5.360(a), §491.12(a),					
	§494.62(a).						
	Th - 14 - 22 - 3	and the state of t					
	rne [racility] must	comply with all applicable					

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

TITLE (X6) DATE

Jeff AttingerRVP of Operations02/06/2023

Any defiency statement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155064		ILDING	NSTRUCTION	(X3) DATE COMPL 08/23/	ETED	
	PROVIDER OR SUPPLIER	· ·	STREET ADDRESS, CITY, STATE, ZIP COD 3518 S LAFOUNTAIN ST KOKOMO, IN 46902					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE	
	preparedness req must develop esta comprehensive en program that mee section. The emer program must incit the following elem (a) Emergency Pladevelop and main preparedness pla and updated at lemust do all of the * [For hospitals at §485.625(a):] Emor CAH] must con Federal, State, an preparedness req CAH] must develocomprehensive en program that mee section, utilizing at * [For LTC Facilitie Emergency Plan. develop and main preparedness pla and updated at lemergency Plan. develop and main	an. The [facility] must tain an emergency in that must be [reviewed], ast every 2 years. The plan following:  §482.15 and CAHs at ergency Plan. The [hospital inply with all applicable and local emergency uirements. The [hospital or op and maintain a mergency preparedness at the requirements of this in all-hazards approach.  es at §483.73(a):]  The LTC facility must tain an emergency in that must be reviewed, ast annually.  Ities at §494.62(a):]  The ESRD facility must tain an emergency in that must be [evaluated], in that must be [evaluated], in that must be [evaluated],						
		view and interview, the facility and maintain an emergency	E 00	04	What corrective     action(s) will be accomplished	d for	10/04/2022	

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155064	, ,	JILDING	NSTRUCTION	(X3) DATE : COMPL 08/23/	ETED
	PROVIDER OR SUPPLIER		•	3518 S	ADDRESS, CITY, STATE, ZIP COD LAFOUNTAIN ST 10, IN 46902		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	preparedness plan to at least annually in 483.73(a). This define occupants.  Findings include:  Based on review of Preparedness Plan of to 10:36 a.m., document the most recent two available for review plan available has in past 12 months with date being listed as interview at the time. Administrator states been reviewed, but showed a small part and no review date. Emergency plan its with the facility Repared to 10:36 a.m., document to	hat was reviewed and updated accordance with 42 CFR icient practice could affect all on 08/23/22 between 10:05 a.m. mentation for a complete a reviewed by the facility within live-month period was not on the last documented review 02/14/2019. Based on e of record review, the did that he thought the plan had documentation presented only to of the plan had been reviewed was added to the actual elf. During the exit conference gional Vice President, the raining, and the Maintenance and no additional information or provided contrary to this			those residents found to have been affected by the deficient practice; No residents were affected by alleged deficient practice  II. How other residents having the potential to be affected by the same deficient practice be identified and what correcting action(s) will be taken; All residents have the potential be affected by this alleged deficient practice. The IDT reviewed and updated the complete emergency program.  III. What measures will put into place and what system changes will be made to ensure that the deficient practice does recur; The IDT was inserviced on the emergency management requirements. A complete revior the emergency plan was add to the QAPI calendar every 12 months.  IV. How the corrective action(s) will be monitored to ensure the deficient practice whot recur i.e., what quality assurance program will be put place; The admin or designee will revite QAPI calendar monthly an also check the date of the last update of the emergency preparedness plan to ensure in	be cted will ve I to be nice a not ded will into view d	

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CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES			OMB NO. 0938-039
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	<u></u>	COMPLETED
		155064	B. WING		08/23/2022
	PROVIDER OR SUPPLIER	8	3518	T ADDRESS, CITY, STATE, ZIP COD S LAFOUNTAIN ST DMO, IN 46902	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
E 0013 SS=C Bldg	484.102(b), 485.6 485.727(b), 485.9 491.12(b), 494.62 Development of E §403.748(b), §416 §441.184(b), §466 §483.73(b), §485. §485.68(b), §485. §485.920(b), §486 §494.62(b).  (b) Policies and proper paredness polition on the emergency (a) of this section, paragraph (a)(1) communication places are propertied in the properties on the properties of the emergency (a) of this section, paragraph (a)(1) communication places are properties on the policies are properties on the policies are properties on the emergency (b) of this section, paragraph (a)(1) of this section. The policies are properties of the pr	5(b), 483.475(b), 483.73(b), 25(b), 485.68(b), 20(b), 486.360(b), (b) P Policies and Procedures 5.54(b), §418.113(b), 0.84(b), §482.15(b), 475(b), §484.102(b), 625(b), §485.727(b), 5.360(b), §491.12(b),		reviewed at least every 12 m The results of these audits w reviewed in Quality Assurance Meeting monthly x12 months until an average of 100% compliance is achieved x12 consecutive months. The QA Committee will identify any tr or patterns and make recommendations to revise the plan of correction as indicate	rill be ce s or A rends

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develop and implement emergency

preparedness policies and procedures, based

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	OF CORRECTION	IDENTIFICATION NUMBER  155064	l í	JILDING	NSTRUCTION	COMPL 08/23/	ETED
	PROVIDER OR SUPPLIER	8		3518 S	ADDRESS, CITY, STATE, ZIP COD LAFOUNTAIN ST IO, IN 46902		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	on the emergency (a) of this section, paragraph (a)(1) of communication playsection. The policities:  *Additional Require ESRD Facilities:  *[For PACE at §46 procedures. The develop and imple preparedness policities on the emergency (a) of this section, paragraph (a)(1) of communication playsection. The policities management on the emergency limited to: Fire; equipment of the particular of the policies and previewed and upd  *[For ESRD Faciliar of the particular of the policies and procedures. In the policies and previewed and imple preparedness policies of the particular of the pa	risk assessment at of this section, and the an at paragraph (c) of this sies and procedures must updated at least annually.  The ments for PACE and PACE organization must ement emergency cies and procedures, based or plan set forth in paragraph risk assessment at of this section, and the an at paragraph (c) of this sies and procedures must ement emergency cies and procedures must enter the paragraph (c) of this sies and procedures must enter of medical and gencies, including, but not uipment, power, or water and emergencies; and natural threaten the health or cipants, staff, or the public. Procedures must be atted at least every 2 years.  The dialysis facility must ement emergency cies and procedures, based			CROSS-REFERENCED TO THE APPROPRIA	TE	
	(a) of this section, paragraph (a)(1) c communication places section. The policibe reviewed and uyears. These eme	r plan set forth in paragraph risk assessment at of this section, and the an at paragraph (c) of this sies and procedures must updated at least every 2 orgencies include, but are equipment or power					

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	OF CORRECTION	IDENTIFICATION NUMBER  155064	A. BUILDING B. WING		JNSTRUCTION	COMPL 08/23/	ETED
	PROVIDER OR SUPPLIER	1	STREET ADDRESS, CITY, STATE, ZIP COD 3518 S LAFOUNTAIN ST KOKOMO, IN 46902		LAFOUNTAIN ST		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	(X5) COMPLETION DATE
	failures, care-relat supply interruption likely to occur in the area.  Based on record reversible to develop an preparedness police reviewed and updat accordance with 42 practice could affect.  Based on review of Preparedness Plan of to 10:36 a.m., docur procedures reviewed most recent twelve-available for review plan available has no past 12 months with date being listed as interview at the time. Administrator-in-Time plan had been reviewed to the actual Emergical conference with the President, the Admin Maintenance Direct	the facility's geographic view and interview, the facility d maintain emergency is and procedures that was ed at least annually in CFR 483.73(a). This deficient t all occupants.  the facility's Emergency on 08/23/22 between 10:05 a.m. mentation of policies and d by the facility within the month period was not v. The emergency preparedness of been reviewed within the in the last documented review 02/14/2019. Based on e of record review, the raining stated that he thought eviewed, but documentation and no review date was added ency plan itself. During the exit facility Regional Vice inistrator-in-Training, and the cor at 3:50 p.m., no additional ence could be provided	E 0		I. What corrective action(s) will be accomplished those residents found to have been affected by the deficient practice; No residents were affected by alleged deficient practice.  II. How other residents having the potential to be affected by the same deficient practice be identified and what correcti action(s) will be taken; All residents have the potential be affected by this alleged deficient practice. The emerge preparedness policies and procedures were reviewed and updated.  III. What measures will put into place and what system changes will be made to ensure that the deficient practice does recur; The IDT was inserviced on the emergency management requirements. A review and up of the emergency preparedness added to the QAPI calendar end 12 months.	s cted will live al to ency d be mic re s not e odate ss	10/05/2022

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### DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTERS FO	R MEDICARE & MEDIC	AID SERVICES				OM	IB NO. 0938-039
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155064	A. BU	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			survey eted /2022
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP COD 3518 S LAFOUNTAIN ST KOKOMO, IN 46902			•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	ARY STATEMENT OF DEFICIENCIE ICIENCY MUST BE PRECEDED BY FULL RY OR LSC IDENTIFYING INFORMATION		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE
					IV. How the corrective action(s) will be monitored to ensure the deficient practice on the recur i.e., what quality assurance program will be purplace;  The admin or designee will rethe QAPI calendar monthly are also check the date of the last update of the emergency preparedness policies and procedures to ensure it is reviat least every 12 months. The results of these audits will be reviewed in Quality Assurance Meeting monthly x12 months until an average of 100% compliance is achieved x12 consecutive months. The QAC Committee will identify any tree or patterns and make recommendations to revise the plan of correction as indicated.	t into  view  nd  t  ewed  e  or  ends	
E 0029 SS=C Bldg	484.102(c), 485.6 485.727(c), 485.9 491.12(c), 494.62 Development of C §403.748(c), §416 §441.184(c), §460 §483.73(c), §483. §485.68(c), §485.	5(c), 483.475(c), 483.73(c), 25(c), 485.68(c), 20(c), 486.360(c),					

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§494.62(c).

(c) The [facility] must develop and maintain

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155064	, ,	JILDING	ONSTRUCTION	(X3) DATE COMPL 08/23	LETED
	PROVIDER OR SUPPLIER	₹	STREET ADDRESS, CITY, STATE, ZIP COD 3518 S LAFOUNTAIN ST KOKOMO, IN 46902				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION Eparedness communication		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΙΤΕ	(X5) COMPLETION DATE
	plan that complies local laws and must least every 2 ye facilities]. Based on record revialled to develop an preparedness commutath Federal, State, with 42 CFR 483.7 could affect all occiliation of the facility of the faci	The facility's Emergency on 08/23/22 between 10:05 a.m. mentation for a communications he facility within the most he period was not available for ency preparedness plan the reviewed within the past 12 at documented review date 4/2019. Based on interview at the eview, the the raining stated that he thought the eviewed, but documentation and no review date was added the ency plan itself. During the exiter facility Regional Vice inistrator-in-Training, and the tor at 3:50 p.m., no additional tence could be provided	E 0	029	I. What corrective action will be accomplished for those residents found to have been affected by the deficient pract. No residents were affected by this alleged deficient practice.  II. How other residents have the potential to be affected by same deficient practice will be identified and what corrective action(s) will be taken;  All residents have the potential to be affected by this alleged deficient practice. The entire emergency plan was reviewed and updated by the linto place and what systemic changes will be made to ensu that the deficient practice doe recur;  The IDT was inservice the emergency preparedness requirements. A complete rev of the emergency plan was act to the QAPI calendar every 12	ice; ent  aving the  a	10/04/2022
					months.  IV. How the corrective action(s) will be monitored to		

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	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155064	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		ONSTRUCTION	(X3) DATE SURVEY  COMPLETED  08/23/2022	
	ROVIDER OR SUPPLIER		<u>,                                      </u>	3518 S	ADDRESS, CITY, STATE, ZIP COD LAFOUNTAIN ST MO, IN 46902		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
E 0036 SS=C Bldg	484.102(d), 485.6 485.727(d), 485.9 491.12(d), 494.62 EP Training and T §403.748(d), §416 §441.184(d), §460 §483.73(d), §485. §485.68(d), §485. §485.920(d), §486. §494.62(d). *[For RNCHIs at § Hospice at §418.1 PACE at §460.84, HHAs at §484.102 CAHs at §486.625	5(d), 483.475(d), 483.73(d), 25(d), 485.68(d), 20(d), 486.360(d), (d)			ensure the deficient practice won to recur i.e., what quality assurance program will be put place;  The admin or designee will review the QAPI calendar mor and also check the date of the update of the emergency preparedness plan to ensure i reviewed at least every 12 mo. The results of these audits will reviewed in Quality Assurance Meeting monthly x12 months ountil an average of 100% compliance is achieved x12 consecutive months. The QA Committee will identify any treor patterns and make recommendations to revise the plan of correction as indicated.	t into  II  Inthly  I last  I is  I be  I or  I dele	

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Event ID:

R0LA21

Facility ID: 000025

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PRINTED: 03/03/2023 FORM APPROVED OMB NO. 0938-039

	OF CORRECTION	IDENTIFICATION NUMBER  155064	A. Bl	A. BUILDING  B. WING			COMPLETED  08/23/2022	
	PROVIDER OR SUPPLIER			3518 S	DDRESS, CITY, STATE, ZIP COD LAFOUNTAIN ST IO, IN 46902			
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR §486.360, and RH	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION C/FHQs at §491.12:] (d)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE	
	Training and testing develop and maining preparedness trains that is based on the in paragraph (a) or assessment at paragraph (b) of this section, policies and (b) of this section, plan at paragraph training and testing reviewed and updates and testing. The Land maintain an etraining and testing the emergency plates of this section, risk (a)(1) of this section at paragraph (b) or communication plates to communication plates and testing. The ICF/IIDs at § testing. The ICF/II maintain an emergence and testing programs.	ig. The [facility] must rain an emergency program are emergency plan set forth af this section, risk ragraph (a)(1) of this and procedures at paragraph and the communication (c) of this section. The grogram must be ated at least every 2 years.  The facility must develop mergency preparedness grogram that is based on an set forth in paragraph (a) assessment at paragraph (b) assessment at paragraph (c) of this and procedures are at paragraph (c) of this and updated at least (d) Training and testing program and updated at least (d) Training and (d						
	this section, risk a (a)(1) of this section at paragraph (b) o communication plasection. The train must be reviewed 2 years. The ICF/I	et forth in paragraph (a) of seessment at paragraph on, policies and procedures of this section, and the an at paragraph (c) of this ing and testing program and updated at least every ID must meet the vacuation drills and training						

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Facility ID: 000025

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155064	(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED 08/23/2022		
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP COD 3518 S LAFOUNTAIN ST KOKOMO, IN 46902				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE		
	Training, testing, a dialysis facility multiple emergency prepared and patient orients on the emergency (a) of this section, paragraph (a)(1) of procedures at parand the community of this section. The orientation prograupdated at every a Based on record regarded to develop an preparedness training was reviewed and to	riew and interview, the facility d maintain an emergency and testing program that pdated at least annually in CFR 483.73(d). This deficient	E 0036	I. What corrective actions will be accomplished for those residents found to have been affected by the deficient praction. No residents were affected by this alleged deficient practice.	ce;		
	Preparedness Plan of to 10:36 a.m., docu training program re the most recent twe available for review plan available has repast 12 months with date being listed as interview at the tim Administrator-in-Tithe plan had been represented only show had been reviewed to the actual Emerg conference with the	the facility's Emergency on 08/23/22 between 10:05 a.m. mentation of a testing and viewed by the facility within live-month period was not v. The emergency preparedness of been reviewed within the in the last documented review 02/14/2019. Based on the of record review, the raining stated that he thought eviewed, but documentation and no review date was added the ency plan itself. During the exit facility Regional Vice inistrator-in-Training, and the		II. How other residents ha the potential to be affected by same deficient practice will be identified and what corrective action(s) will be taken;  All residents have the potential to be affected by this alleged deficient practice. The entire emergency plan was reviewed and updated by the I  III. What measures will be into place and what systemic changes will be made to ensur that the deficient practice does	DT. put		

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PRINTED: 03/03/2023 FORM APPROVED OMB NO. 0938-039

	OF CORRECTION	IDENTIFICATION NUMBER  155064	A. BUILDING B. WING	JNSTRUCTION	COMPLETED 08/23/2022
	ROVIDER OR SUPPLIER		3518 S	ADDRESS, CITY, STATE, ZIP COD LAFOUNTAIN ST MO, IN 46902	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
		or at 3:50 p.m., no additional ence could be provided cient finding.		recur;  The IDT was inservice the emergency preparedness requirements. A complete rev of the emergency plan was act to the QAPI calendar every 12 months.  IV. How the corrective action(s) will be monitored to ensure the deficient practice v not recur i.e., what quality assurance program will be purplace;  The admin or designee wireview the QAPI calendar monand also check the date of the update of the emergency preparedness plan to ensure reviewed at least every 12 months and also check these audits will reviewed in Quality Assurance Meeting monthly x12 months until an average of 100% compliance is achieved x12 consecutive months. The QA Committee will identify any tree or patterns and make recommendations to revise the plan of correction as indicated.	vill vill t into II nthly e last it is onths. I be e or
K 0000					
Bldg. 01	Licensure Survey w	Recertification and State as conducted by the Indiana th in accordance with 42 CFR	K 0000	This Plan of Correction is the center's credible allegation of compliance.  Preparation and/or execution this plan of correction does no	of

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155064		(X2) MULTIPLE A. BUILDING B. WING	CONSTRUCTION  01	(X3) DATE SURVEY COMPLETED 08/23/2022	
	PROVIDER OR SUPPLIER		3518	T ADDRESS, CITY, STATE, ZIP COD S LAFOUNTAIN ST OMO, IN 46902	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	BE COMPLETION
	Kokomo was found Requirements for Pa Medicare/Medicaid Life Safety from Fin National Fire Protect Life Safety Code (Life Safety Code (Life Safety Code) This one-story facil Type II (111) const The facility has a find detection in the corrorridors and batter all resident sleeping capacity of 105 and of this visit.  All areas where residence is the safety of the saf	Code survey, Aperion Care not in compliance with articipation in 42 CFR Subpart 483.90(a), re and the 2012 edition of the etion Association (NFPA) 101, asc), Chapter 19, Existing ancies and 410 IAC 16.2. Articipation and fully sprinkled. The alarm system with smoke reidors, spaces open to the y powered smoke detectors in a rooms. The facility has a had a census of 57 at the time dents have customary access d all areas providing facility clered.		constitute admission or agriby the provider of the truth facts alleged or conclusion forth in the statement of deficiencies. The plan of correction is prepared and/executed solely because it required by the provisions federal and state law.	of the s set /or is
K 0200 SS=E Bldg. 01	Means of Egress I List in the REMAR Section 18.2 and requirements that provided K-tags, b information, along Safety Code or NR	Requirements - Other Requirements - Other RKS section any LSC 19.2 Means of Egress are not addressed by the out are deficient. This with the applicable Life FPA standard citation, d on Form CMS-2567.			

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STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	<u>01</u>	COMPL	ETED
		155064	B. WI	NG		08/23/	2022
				CTREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	ROVIDER OR SUPPLIER	8					
ADEDIO	LOADE KOKOMO			l	LAFOUNTAIN ST		
APERIO	N CARE KOKOMO			KUKUN	MO, IN 46902		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DDOVIDED'S DI AN OF CODDECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	rc	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	· C	DATE
	Based on observation	on and interview, the facility	K 0	200			10/04/2022
	failed to ensure 1 of	f 3 doors to the kitchen was			I. What corrective action	(s)	
		latches that required only one			will be accomplished for those		
	operation to open. LSC 19.2.2.1 states doors		· · · · · · · · · · · · · · · · · · ·		residents found to have been		
	complying with 7.2.1 shall be permitted.				affected by the deficient practi	ce.	
	7.2.1.5.10.2 requires the releasing mechanism shall				No residents had the		
	-	with not more than one			potential to be affected by this		
	-	This deficient practice could			alleged deficient practice.		
	affect all staff in the	-			agod donoion praodoo.		
		- 111021011 UZ UUI			II. How other residents ha	vina	
	Findings include:				the potential to be affected by	-	
					same deficient practice will be		
	Based on observations made during a tour of the				identified and what corrective		
	facility with Maintenance Director and the				action(s) will be taken;		
		raining on 08/23/22 at 2:14 p.m.,			No residents had the		
		ading to the main dining room	potential to be affected by this				
		an independent dead bolt in	alleged deficient practice. The				
		knob. Based on interview at			deadbolt lock was removed from		
		tion, The Maintenance			the kitchen door. An inspection		
		lged the kitchen door to the			1 ·	101	
		having an independent dead			all doors were completed to ensure on doors that need to be		
	-	or handle with a latching					
		ted that he would fix the issue			locked, there was only one loc mechanism.	KIIIG	
		find the time to do so. During			mechanism.		
		with the facility Regional Vice					
		inistrator-in-Training, and the			\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\		
		_			I. What measures wil	I	
		tor at 3:50 p.m., no additional			be put into place and what	- 4-	
		ence could be provided			systemic changes will be made		
	contrary to this defi	cient finding.			ensure that the deficient practi	ce	
	2.1.10(1)				does not recur;		
	3.1-19(b)				The maintenance director will		
					complete the door inspection f	orm	
					before adding a locking		
					mechanism to the door to ensu	ure	
					one is not already in place.		
					IV. How the corrective		
			1		action(s) will be monitored to		

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STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	<u>01</u>	COMPLETED
		155064	B. WING		08/23/2022
	PROVIDER OR SUPPLIEI	<b>?</b>	3518	ET ADDRESS, CITY, STATE, ZIP COD S LAFOUNTAIN ST OMO, IN 46902	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDENCE NAME CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
				ensure the deficient practice of not recur i.e., what quality assurance program will be purplace;  The maintenance director designee will audit all locking doors monthly to ensure only locking mechanism is in place. The results of these audits will reviewed in Quality Assurance. Meeting monthly x6 months of until an average of 90% compliance or greater is achied as consecutive months. The committee will identify any tree or patterns and make recommendations to revise the plan of correction as indicated.	t into ctor ng one e. Il be er r eved QA ends
K 0211 SS=E Bldg. 01	discharges, exit lot in accordance with of egress is continual obstructions to emergency, unless through 18/19.2.1, 18.2.1, 19.2.1, 7.7.1) Based on observe facility failed to make from obstructions in facility. LSC 19.2.3 required width shall equipment, provide conditions are met:  (a) The wheeled eq	ays, corridors, exit ays, corridors, exit ays, corridors, exit acations, and accesses are and the means are all the control of	K 0211	I. What corrective action will be accomplished for those residents found to have been affected by the deficient pract No residents were affected by this alleged deficient practice	ice;

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155064	B. W	ING		08/23	/2022
				STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF 1	PROVIDER OR SUPPLIEI	₹			LAFOUNTAIN ST		
APFRI∩	N CARE KOKOMO				MO, IN 46902		
	1				T 10002		T
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	-	TAG	DEFICIENCY		DATE
	in. (1525 mm.)				II. How other residents ha	_	
		occupancy fire safety plan and			the potential to be affected by		
		ddress the relocation of the			same deficient practice will be		
	wheeled equipment during a fire or similar				identified and what corrective		
	emergency.				action(s) will be taken;		
	(c) The wheeled equipment is limited to the				12 residents had the		
	following:				potential to be affected by this		
	i. Equipment in use and carts in use				alleged deficient practice. Wh		
	ii. Medical emergency equipment not in use iii. Patient lift and transport equipment				were added to the identified P		
	This deficient practice could affect approximately				containers. The scale was mo	ved	
	12 residents, 2 staff and 1 visitor.				out of the corridor.		
	12 residents, 2 staff and 1 visitor.						
	Findings include:				III. What measures will be	nut	
	r manigs metade.				into place and what systemic	put	
	Based on observation	ons made during a tour of the			changes will be made to ensu	ıre	
		enance Director and the			that the deficient practice doe		
	I	Fraining on 08/23/22 at 1:40			recur;		
		nall plastic 3-drawer chest			The nursing and		
	_	outside resident room #301.			housekeeping staff were inse	rviced	
		t contained P.P.E. for staff, and			on maintaining a free,		
	it was not on wheel	s. Based on interview with the			unobstructed corridor in case	of an	
	Maintenance Direc	tor at the time of the			emergency. The maintenance	;	
	observation, he ack	nowledged the 3-drawer chest			director or designee will comp		
	as being stored in the	he corridor and agreed that it			walking rounds 5 days a week		
		During the exit conference			ensure the corridors remain		
	with the facility Re	gional Vice President , the			unobstructed and record the		
		raining, and the Maintenance			results on the preventative		
	_	n., no additional information or			maintenance log.		
	evidence could be p	provided contrary to this					
	deficient finding.				I. How the corrective	)	
					action(s) will be monitored to		
	3.1-19(b)				ensure the deficient practice v	vill	
					not recur i.e., what quality		
	1	ation and interview, the facility			assurance program will be pu	t into	
		f 5 means of egress were			place;		
	_	ained free of all obstructions			The administer or designee w		
	_	full instant use in the case of			audit all corridors weekly and		
	_	ency. This deficient practice			maintenance directors daily lo	g to	
	could affect approximately 12 residents, 2 staff				ensure the corridors remain		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155064		l í	JILDING	nstruction 01	(X3) DATE COMPL <b>08/23</b> /	ETED	
	PROVIDER OR SUPPLIER			3518 S	ADDRESS, CITY, STATE, ZIP COD LAFOUNTAIN ST MO, IN 46902		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
	from 9:38 a.m. to 9: by 48-inch scale for wheelchairs was sitt outside resident roo observations made of with Maintenance I Administrator-in-Tr the aforementioned position as it was do of the facility and w on interview with th time of the observat scale as being stored agreed that it was ne exit conference with President, the Adm Maintenance Direct	during a tour of the facility Director and the raining on 08/23/22 at 1:42 p.m., scale was located in the same uring the initial walk through ras not currently in use. Based the Maintenance Director at the raining, he acknowledged the d in the corridor and further of currently in use. During the in the facility Regional Vice inistrator-in-Training, and the or at 3:50 p.m., no additional tence could be provided			unobstructed. The results of the audits will be reviewed in Qual Assurance Meeting monthly xit months or until an average of compliance or greater is achie x3 consecutive months. The Committee will identify any treor patterns and make recommendations to revise the plan of correction as indicated	lity 6 90% ved QA nds	
K 0222 SS=E Bldg. 01	be equipped with a requires the use of egress side unless special locking arr CLINICAL NEEDS LOCKING Where special lockinical security needs	d means of egress shall not a latch or a lock that f a tool or key from the susing one of the following angements: SOR SECURITY THREAT king arrangements for the seds of the patient are sking device shall be					

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPI	LETED
		155064	B. W	ING		08/23	/2022
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIER	8			LAFOUNTAIN ST		
APERION	N CARE KOKOMO				/O, IN 46902		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	•	door and provisions shall					
		apid removal of occupants					
	-	l of locks; keying of all					
	locks or keys carried by staff at all times; or other such reliable means available to the staff at all times.  18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6						
	SPECIAL NEEDS LOCKING						
	ARRANGEMENTS						
	·	king arrangements for the					
	safety needs of the patient are used, all of						
	the Clinical or Security Locking requirements						
	_	addition, the locks must be					
		at fail safely so as to					
		of power to the device; the					
		ed by a supervised					
	· ·	er system and the locked					
		by a complete smoke					
	-	(or is constantly monitored					
		ation within the locked					
		the sprinkler and detection					
	-	ged to unlock the doors					
	upon activation.	0.0.5.0. TIA 40.4					
	18.2.2.2.5.2, 19.2.						
	DELAYED-EGRE						
	ARRANGEMENTS						
		lelayed-egress locking					
	•	in accordance with					
	7.2.1.6.1 shall be						
		g low and ordinary hazard					
		igs protected throughout by					
		ervised automatic fire					
	-	or an approved, supervised					
	automatic sprinkle						
	18.2.2.2.4, 19.2.2.						
	ACCESS-CONTR						
	LOCKING ARRAN						
		d Egress Door assemblies					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155064		(X2) MULTIPLE C A. BUILDING B. WING	construction 01	(X3) DATE SURVEY COMPLETED 08/23/2022	
	PROVIDER OR SUPPLIER N CARE KOKOMO		3518 \$	S ADDRESS, CITY, STATE, ZIP COD S LAFOUNTAIN ST MO, IN 46902	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	accordance with 7 on door assemblie throughout by an a automatic fire dete approved, supervi system.  18.2.2.2.4, 19.2.2. Based on observatic failed to ensure the 7 exits was readily a clinical diagnosis measures. Doors wi egress shall not be a that requires the use egress side unless o 19.2.2.2.4. Door-loopermitted in accord deficient practice of staff and 1 visitor memergency situation.  Findings include:  Based on observation facility with Mainte Administrator-in-Truste door near reside was marked as a facilocked, and could be four-digit code but the exit. The Administrator code was not posted residents from elopic conversation, under	BY EXIT ACCESS IGEMENTS It access door locking in I.2.1.6.3 shall be permitted as in buildings protected approved, supervised action system and an sed automatic sprinkler  2.4 In and interview, the facility means of egress through 1 of accessible for residents without requiring specialized security thin a required means of equipped with a latch or lock to of a tool or key from the therwise permitted by LSC cking arrangements shall be ance with 19.2.2.2.5.2. This build affect over 12 residents, 2 acceding to exit the facility in an and.  In the same during a tour of the mance Director and the raining on 08/23/22 at 1:40 p.m., ant room #129 on Harmony Hall callity exit, was magnetically a opened by entering a the code was not posted at the ator-in-Training stated that the all by the door to prevent	K 0222	I. What corrective action will be accomplished for those residents found to have been affected by the deficient pract. No residents were affected by this alleged deficient practice.  II. How other residents has the potential to be affected by same deficient practice will be identified and what corrective action(s) will be taken;  12 residents had the potential to be affected by this alleged deficient practice. The code was posted nest to the keypad for door near resident room #129  III. What measures will be into place and what systemic changes will be made to ensuthat the deficient practice doe recur;  The maintenance dire will check for door code place	ice; ent aving the e

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155064	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION  01	(X3) DATE SURVEY COMPLETED 08/23/2022
	PROVIDER OR SUPPLIER		3518 \$	ADDRESS, CITY, STATE, ZIP COD S LAFOUNTAIN ST MO, IN 46902	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	(X5) COMPLETION DATE
	Regional Vice Presi Administrator-in-Ti Director at 3:50 p.m	ference with the facility dent, the raining, and the Maintenance and, no additional information or rovided contrary to this		on all exit doors without a de egress weekly to ensure the remain in place and record to results on the preventative maintenance log.	y
	3.1-19(b)			IV. How the corrective action(s) will be monitored to ensure the deficient practice not recur i.e., what quality assurance program will be p place;  The administrator or designee will audit the door placement checks weekly. T results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months until an average of 90% compliance or greater is ach x3 consecutive months. The Committee will identify any to or patterns and make recommendations to revise the plan of correction as indicated.	will ut into  code he e ce or ieved e QA rends
K 0321 SS=E Bldg. 01	barrier having 1-he (with 3/4 hour fire automatic fire exti- accordance with 8 approved automat option is used, the from other spaces	- Enclosure are protected by a fire our fire resistance rating rated doors) or an aguishing system in .7.1 or 19.3.5.9. When the ic fire extinguishing system areas shall be separated by smoke resisting rs in accordance with 8.4.			

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	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	î ´		ONSTRUCTION 01	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155064	A. BU B. WI	ILDING NG	01	08/23	
NAME OF I	PROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP COD LAFOUNTAIN ST		
APERIO	N CARE KOKOMO			KOKOM			
(X4) ID		STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTION			(X5)
	`				CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	
PREFIX TAG	automatic-closing nonrated or field-ado not exceed 48 the door. Describe the floor hazardous areas at REMARKS. 19.3.2.1, 19.3.5.9  Area Separation a. Boiler and Fuel b. Laundries (largent c. Repair, Mainter d. Soiled Linen Regallons) e. Trash Collection (exceeding 64 galfover 50 square for g. Laboratories (if Hazard - see K32) Based on observation failed to ensure the a hazardous area sure a Bio-hazard room, combustible supplied was provided with a would cause the dolatch into the door for could affect  Findings include:  Based on observation facility with Mainter f	lons) orage Rooms/Spaces eet) classified as Severe	K 03	PREFIX TAG		n(s) ice. ent aving the	TOMPLETION DATE  10/04/2022
	Dogwood Room", a	the room identified as "the a room that had been converted			potential to be affected by this alleged deficient practice. All	3	
	to a storage room, of	lid not have a self-closing			doors on rooms considered		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 155064		î ´	JILDING	onstruction  01	(X3) DATE SURVEY  COMPLETED  08/23/2022		
	ROVIDER OR SUPPLIER			3518 S	ADDRESS, CITY, STATE, ZIP COD LAFOUNTAIN ST MO, IN 46902		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	over 200 boxes of a approximately 400 sapproximately 20 fe interview at the time Maintenance Direct hazardous and state self-closing device storage to another a he could. During the facility Regional Vi Administrator-in-Tr Director at 3:50 p.m.	a. This room contained well assorted P.P.E. and was square feet in size or set by 20 feet. Based on an ele of the observation, the or agreed that the room was do that he would add a so the door or move the appropriate location as soon as the exit conference with the ce President, the raining, and the Maintenance and additional information or rovided contrary to this			hazardous areas were audited a self-closing device. a self-closing storage room.  III. What measures will be into place and what systemic changes will be made to ensure that the deficient practice does recur;  A weekly inspection of doors on all rooms considered hazardous area was added to preventive maintenance log.  IV. How the corrective action(s) will be monitored to ensure the deficient practice who trecur i.e., what quality assurance program will be put place;  The administrator or designee will audit the weekly door inspection on the maintenance log monthly. 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 achie x3 consecutive months. The Committee will identify any tre or patterns and make recommendations to revise the plan of correction as indicated.	put re s not a the ved QA nds	
K 0345 SS=F Bldg. 01	NFPA 101 Fire Alarm System Maintenance Fire Alarm System	-					

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	OF CORRECTION	IDENTIFICATION NUMBER	ì í	JILDING	01	COMPL	
		155064	B. W			08/23	
				STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	ROVIDER OR SUPPLIER	2			LAFOUNTAIN ST		
APERION	N CARE KOKOMO				MO, IN 46902		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
TAG	Maintenance A fire alarm syster in accordance with complying with the National Electric Continuation of System and testing are respected to ensure 1 of maintained in accordance with complete the System and testing are respected, and maintained in accordance and maintained in accordance with complete the System of the Syste	m is tested and maintained h an approved program e requirements of NFPA 70, Code, and NFPA 72, m and Signaling Code. n acceptance, maintenance	K 0		I. What corrective action will be accomplished for those residents found to have been affected by the deficient practice.  II. How other residents hat the potential to be affected by same deficient practice will be identified and what corrective action(s) will be taken;  All residents had the potential to be affected by this alleged deficient practice.  III. What measures will be into place and what systemic changes will be made to ensu that the deficient practice does recur;  The sensitivity testing documentation was obtained showing sensitivity was tested becember of 2020 and is scheduled to be completed agin December of 2022. Addition copies of all fire suppression	ice; ice; it aving the e	10/04/2022
	condition and stated	that he would contact the			equipment will be maintained	in	

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER  155064		 JILDING	01	COMPL 08/23/	ETED	
	PROVIDER OR SUPPLIER		3518 S	ADDRESS, CITY, STATE, ZIP COD LAFOUNTAIN ST MO, IN 46902		
(X4) ID PREFIX TAG	SUMMARY S	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	vendor for additional the exit conference of documentation could review. During the de Regional Vice Presi Administrator-in-Tr Director at 3:50 p.m. evidence could be presidence finding.  3.1-19(b)	at 3:50 p.m., this d still not be provided for exit conference with the facility		the administrators office.  IV. How the corrective action(s) will be monitored to ensure the deficient practice wont recur i.e., what quality assurance program will be put place; The maintenance director or designee will audit the fire suppression equipment testing records monthly. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance of greater is achieved x3 consecution months. The QA Committee widentify any trends or patterns make recommendations to reverthe plan of correction as indicated.	into r utive vill and ise	
K 0351 SS=F Bldg. 01	by construction type throughout by an a sprinkler system in 13, Standard for the Systems. In Type I and II constituted for springer areas where state sprinklers. In hospitals, sprinkled clothes closets of	Installation  nd hospitals where required				

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155064		UILDING	ONSTRUCTION  01	(X3) DATE COMPL 08/23/	ETED
	PROVIDER OR SUPPLIER N CARE KOKOMO			3518 S	ADDRESS, CITY, STATE, ZIP COD LAFOUNTAIN ST MO, IN 46902		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
	the closet footprin Standard for Insta Systems.  19.3.5.1, 19.3.5.2  19.3.5.5, 19.4.2, 1  Based on observation failed to ensure that sprinkler system we overhang. NFPA 13  Sprinkler Systems, states sprinklers shar roofs, canopies, por or similar projection width. Section 8.15 permitted to be omi porte-cocheres, bald projections are consuncombustible or retardant. This deficile least 15 residents, 4 main entry to the fair Findings include:  Based on observation facility with Mainter Administrator-in-Truthe framing for the entrance of the facility canopy extend inches feet from the sprinkled underneas of the overhang at the constructed of wood time of the observation four feet from the bottom feet feet from the bottom feet feet from the bottom feet feet feet feet feet feet feet fee	sprinkler coverage covers t as required by NFPA 13, llation of Sprinkler  19.3.5.3, 19.3.5.4, 19.3.5.10, 9.7, 9.7.1.1(1)  19. and interview, the facility a complete automatic as provided for 1 of 1 exterior 13, Standard for Installation of 12010 Edition, Section 8.15.7.1 all be installed under exterior 15.7.2 states sprinklers shall be 16.7.2 states sprinklers shall be 17.2 states sprinklers shall be 18.7.2 states sprinklers shall be 19.7.2 states sprinklers shall be 19.7.3 states are climited combustible, or fire 19.7.4 states are 19.7 structed with materials that are 19.7 structed with materials that are 19.7 structed with materials that are 19.7 structed or 19.7 states are 19.7 structed with materials that are 19.7 structed with materials that are 19.7 structed or 19.7 struc	K 0	351	I. What corrective action will be accomplished for those residents found to have been affected by the deficient pract. No residents were affected by this deficient pract.  II. How other residents hat the potential to be affected by same deficient practice will be identified and what corrective action(s) will be taken;  15 residents had the potential to be affected by this alleged deficient practice. A complete sprinkler system will added to the exterior overhan.  III. What measures will be into place and what systemic changes will be made to ensurthat the deficient practice doe recur;  Before any new construction occurs, it will be reviewed for the need of a spring system.  IV. How the corrective action(s) will be monitored to ensure the deficient practice who trecur i.e., what quality assurance program will be put	ice; ice; tice. aving the e  b  be g  put  re s not	03/28/2023

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	T OF DEFICIENCIES  OF CORRECTION	IDENTIFICATION NUMBER  155064	A. BUILDING B. WING	01	COMPLETED 08/23/2022
	ROVIDER OR SUPPLIER		3518 S	ADDRESS, CITY, STATE, ZIP COD LAFOUNTAIN ST MO, IN 46902	
(X4) ID PREFIX TAG	(EACH DEFICIENC REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	President, the Adm Maintenance Direct	facility Regional Vice inistrator-in-Training, and the or at 3:50 p.m., no additional ence could be provided cient finding.		place; The administrator will review the physical plant monthly to ensure no new construction has occurred. The results of these audits will reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achie x3 consecutive months. The Committee will identify any tre or patterns and make recommendations to revise the plan of correction as indicated	re be ved QA nds
K 0353 SS=F Bldg. 01	Sprinkler System - Automatic sprinkle are inspected, test accordance with N Inspection, Testing Water-based Fire Records of system inspection and tes secure location an a) Date sprinkler  b) Who provided  c) Water system  Provide in REMAR coverage for any r automatic sprinkle 9.7.5, 9.7.7, 9.7.8,	supply source  RKS information on non-required or partial r system.  and NFPA 25			
	1) Based on record i	review and interview, the ure 1 of 1 automatic sprinkler	K 0353	I. What corrective action	(s) 10/04/2022

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155064	B. W	ING		08/23/	/2022
		l	<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIEF	8			LAFOUNTAIN ST		
ΔPERI∩N	N CARE KOKOMO				MO, IN 46902		
AI LINIUI	TOAKE KOROWO			NONON	, III <del>1</del> 0002		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		examined for internal			will be accomplished for those	;	
		conditions exist that could			residents found to have been		
	cause obstructed piping as required by NFPA 25,			affected by the deficient practice;			
		tandards for the Inspection,			No residents had the		
	Testing and Maintenance of Water-Based Fire				potential to be affected by this		
	Protection Systems, Section 14.2.1. Section 14.2.1				alleged deficient practice.		
	_	scussed in 14.2.1.1 and			l., ., ., ., ., ., ., ., ., .		
	14.2.1.4 an inspection of piping and branch line				II. How other residents ha	-	
	conditions shall be conducted every 5 years by				the potential to be affected by		
	opening a flushing connection at the end of one				same deficient practice will be		
main and by removing a sprinkler toward the end				identified and what corrective			
	of one branch line for the purpose of inspecting				action(s) will be taken;		
	for the presence of foreign organic and inorganic				All residents had the		
		ient practice affects all			potential to be affected by this		
	residents, staff, and	visitors.			alleged deficient practice. An		
	F: 1: 1 1				inspection of the internal pipes		
	Findings include:				and repair of the fire hydrate v	VIII	
	D 1 1				be completed		
		view with Maintenance					
		Iministrator-in-Training on			III. What measures will be	put	
	_	m., documentation for a current			into place and what systemic		
		investigation for the facility			changes will be made to ensu		
		uld not be provided for review.			that the deficient practice does	s not	
		at the time of record review,			recur;		
		rector acknowledged the adition and stated that he			The sprinkler system	ماريام	
		endor for additional			maintenance and testing sche	uule	
		ne time of the exit conference at			was added to the preventive		
	1 ^ ^	imentation could still not be			maintenance log and will be		
		. During the exit conference			verified monthly		
	1 ~	gional Vice President, the			IV. How the corrective		
	1	raining, and the Maintenance					
		n., no additional information or			action(s) will be monitored to ensure the deficient practice w	vill	
	_	provided contrary to this			not recur i.e., what quality	VIII	
	deficient finding.	To vided contrary to time			assurance program will be put	tinto	
	deficient initing.				l . ' • '	iiilo	
	3.1-19(b)				place; The administrator or		
	3.1-17(0)						
	2) Rased on observe	ation and interview, the facility			designee will audit the		
		f 1 private fire hydrant was			maintenance log monthly The results of these audits will be	;	
ı	I Talled to elibule 1 0.	i i piivate ine nyutant was			r results of these addits will be		1

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155064	(X2) MULTIPLE C A. BUILDING B. WING	O1	(X3) DATE SURVEY COMPLETED 08/23/2022
	PROVIDER OR SUPPLIER		3518 \$	ADDRESS, CITY, STATE, ZIP COI S LAFOUNTAIN ST MO, IN 46902	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APP DEFICIENCY)	CTION (X5)  JLD BE COMPLETION ROPRIATE DATE
	continuously maintained in reliable operating condition and inspected and tested periodically.  NFPA 25, 2011 Edition, the Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, Table 7.1.1.2 requires wet and dry barrel hydrants to be inspected annually and after each operation. This deficient practice affects all residents in the facility.  Findings include:			reviewed in Quality Assu Meeting monthly x6 mon until an average of 90% compliance or greater is x3 consecutive months. Committee will identify a or patterns and make recommendations to reviplan of correction as indi	ths or achieved The QA ny trends see the
	Director and the Acc 08/23/22 at 2:20 p.1 entitled 'Fire Hydra 09/14/2021 stated the Further review understated, "Hydrant will "FROZEN" and will Based on an interview Director at 2:20 p.n provided to show the repaired, or any act inspection. During the facility Regional View Administrator-in-Trubirector at 3:50 p.n.	view with Maintenance Iministrator-in-Training on m., the fire hydrant document int Inspection" dated that the inspection failed. The comments section Il not open, the valve is Il require excavation to repair." The with the Maintenance m., no documentation could be the fire hydrant had been to taken as a result of this the exit conference with the the exit conference with the training, and the Maintenance m., no additional information or provided contrary to this			
K 0355 SS=F Bldg. 01	installed, inspecte	nguishers guishers are selected, d, and maintained in NFPA 10, Standard for			

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Facility ID: 000025

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	<u>01</u>	COMPL	ETED
		155064	B. W	NG		08/23/	2022
				CTREET	ADDRESS SITE STATE SID COD		
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
ADEDION	LOADE KOKOMO				LAFOUNTAIN ST		
APERION	N CARE KOKOMO			KUKUK	MO, IN 46902		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TF	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	18.3.5.12, 19.3.5.	12, NFPA 10					
	Based on observation	on and interview, the facility	K 0	355			10/04/2022
	failed to inspect all	portable fire extinguishers			I. What corrective action	(s)	
	_	NFPA 10, Standard for Portable			will be accomplished for those	. ,	
	_	Section 7.2.1.2 says Fire			residents found to have been		
	_	be inspected either manually or			affected by the deficient practi	ce:	
	-	tronic device / system at a			No residents were	,	
	_	intervals. This deficient			affected by this alleged deficie	nt	
	-	t all residents, staff, and			practice.		
	visitors within the fa				praedice.		
		3			II. How other residents ha	vina	
Findings include:				the potential to be affected by	-		
1 manigo metado			same deficient practice will be				
	Based on observations made during a tour of the			identified and what corrective			
		nance Director and the			action(s) will be taken;		
	-	raining on 08/23/22 at 1:00 p.m.,			No residents had the		
		inguisher located immediately		potential to be affected by this			
	-	nissions Directors office was			alleged deficient practice. The		
		22 monthly inspection. Further			portable fire extinguishers wer		
		during the continuing tour of			inspected	C all	
		l portable fire extinguishers			Inspected		
	-	the facility were in fact			III. What measures will be	nut	
	_	22 monthly inspection. Based			into place and what systemic	put	
		ne time of each observation,		changes will be made to ensure			
		rector stated that he must			that the deficient practice does		
		forgot to do the monthly			recur;	, 1101	
		uisher inspections in July of			The maintenance direct	etor	
		it conference with the facility			will audit the portable fire	,	
	Regional Vice Presi	•			extinguishers week to ensure	thev	
		raining, and the Maintenance			are inspected at least monthly	•	
		anning, and the Mannenance			record the results of audit on the		
	•	rovided contrary to this			preventive maintenance log.	110	
	deficient finding.	10 ridea contrary to time			proventive maintenance log.		
	actional initing.				IV. How the corrective		
	3.1-19(b)				action(s) will be monitored to		
	J.1-17(0)				ensure the deficient practice w	rill	
					1	· · · · · · · · · · · · · · · · · · ·	
					not recur i.e., what quality	into	
					assurance program will be put	ווונט	
					place;		
					The administrator or		

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R0LA21

Facility ID: 000025

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	OF CORRECTION	IDENTIFICATION NUMBER  155064	 JILDING	01	COMPL 08/23/	ETED
	ROVIDER OR SUPPLIER		3518 S	DDRESS, CITY, STATE, ZIP COD LAFOUNTAIN ST 10, IN 46902		
AI LINIOI	TOAKE KOKOWO		 KOKON	10, 114 40902		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
K 0363 SS=E Bldg. 01	than required enchexits, or hazardous of smoke and are solid-bonded core capable of resistin minutes. Doors in compartments are passage of smoke to rooms containin combustible mater hardware. Roller la CMS regulation. Tapply to auxiliary sflammable or combustible covering is not except to the door closed what applied. There is a closing of the door release when the	wood or other material g fire for at least 20 fully sprinklered smoke only required to resist the . Corridor doors and doors g flammable or ials have positive latching atches are prohibited by hese requirements do not		designee will review the maintenance log monthly. 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 achie x3 consecutive months. The C Committee will identify any treor patterns and make recommendations to revise the plan of correction as indicated	ved QA nds	

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Facility ID: 000025

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	
		155064	B. W.	NG		08/23	/2022
NAME OF I	PROVIDER OR SUPPLIER	}	•	STREET A	ADDRESS, CITY, STATE, ZIP COD		
		· ·			LAFOUNTAIN ST		
APERIO	N CARE KOKOMO			KOKOMO, IN 46902			
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY		DATE
		re permitted. Dutch doors 6 are permitted. Door					
	_	beled and made of steel or					
	other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are						
	allowed per 8.3. In sprinklered compartments						
	there are no restrictions in area or fire						
	resistance of glass or frames in window						
	assemblies.						
	19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as						
	fire protection ration	ngs, automatics closing					
	devices, etc.						
		on and interview, the facility	K 0	1 0363			10/04/2022
		f 49 sets of resident room		I. What corrective action(s)			
		or would close completely and		will be accomplished for those			
		frame. This deficient practice			residents found to have been		
		imately 40 residents, as well as			affected by the deficient practi	ce;	
	staff and visitors.				No residents were		
	F. 1				affected by this deficient pract	ice.	
	Findings include:						
	Donad or street	one made dumine e t £41			II. How other residents ha	•	
		ons made during a tour of the enance Director and the			the potential to be affected by		
		raining on 08/23/22 from 12:45			same deficient practice will be identified and what corrective		
		the following was noted:			action(s) will be taken;		
	a.m. w 2.51 p.m. u	to following was noted.			40 residents had the		
	1) Resident room #	162 door failed to fully and			potential to be affected by this		
		the frame because a privacy			deficient practice. All fire rated		
	curtain obstructed t				doors were opened and close		
		117 door failed to close and			ensure they all closed correctl		
	latch into the frame				and latched. The doors identif	-	
		108 door failed to close and			on the 2567 were the only doc		
	latch into the frame				noted not to close and latch		
	4) Resident room #	109 door failed to close and			properly. The doors will be		
	latch into the frame				adjusted or replaced to ensure	)	
		102 door failed to close and			they properly close and latch		

CENTERS FOR	R MEDICARE & MEDIC				OMB NO. 0938-039
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	01	COMPLETED
		155064	B. WING		08/23/2022
NAME OF I	PROVIDER OR SUPPLIER			T ADDRESS, CITY, STATE, ZIP COD S LAFOUNTAIN ST	
APERIO	N CARE KOKOMO			OMO, IN 46902	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	to close and failed to 7) Resident room # into the frame 8) Resident room # to close and failed to	111 door was extremely difficult to latch into the frame 123 failed to close and latch 127 door was extremely difficult to latch into the frame		III. What measures will be into place and what systemic changes will be made to ensuthat the deficient practice doe recur;  The maintenance dire	ire s not ctor
	· ·	306 failed to close and latch		will open and close all fire rate	
	into the frame			doors monthly to ensure they	
				close and latch properly. the	
	Based on an interview at the time of observations, the Maintenance Director acknowledged the			results will be documented on	
				preventative maintenance log	j.
		nditions stating that he would			
		as soon as he had time to do		IV. How the corrective	
		conference with the facility		action(s) will be monitored to	
	Regional Vice Pres			ensure the deficient practice v	vill
		raining, and the Maintenance		not recur i.e., what quality	
	_	n., no additional information or		assurance program will be pu	t into
	evidence could be p	provided contrary to this		place;	
	deficient finding.			The administrator or	
	3.1-19(b)			designee will audit the maintenance log monthly to	
				ensure are doors are inspected	èd be
				and repairs are made as need	
				The results of these audits wi	
				reviewed in Quality Assurance	
				Meeting monthly x6 months o	
				until an average of 90%	
				compliance or greater is achie	eved
				x3 consecutive months. The	
				Committee will identify any tre	ends
				or patterns and make	
				recommendations to revise th	e
				plan of correction as indicated	d.
K 0374	NFPA 101				
SS=E	Subdivision of Bu	ilding Spaces - Smoke			
Bldg. 01	Barrie				
	Subdivision of Bu	ilding Spaces - Smoke			

Barrier Doors

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155064	B. W	ING _		08/23/	/2022
			<u> </u>	STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	8			LAFOUNTAIN ST		
APFRIO	N CARE KOKOMO				MO, IN 46902		
	1				T		<u> </u>
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCIT		DATE
	2012 EXISTING						
		arriers are 1-3/4-inch thick					
		d-core doors or of					
	construction that resists fire for 20 minutes.  Nonrated protective plates of unlimited height						
	· ·	-					
	•	ors are permitted to have					
		assemblies per 8.5. Doors					
	_	automatic-closing, do not and are not required to swing					
		egress travel. Door opening					
	provides a minimum clear width of 32 inches for swinging or horizontal doors.						
		6, 19.3.7.8, 19.3.7.9					
		on and interview, the facility	l <sub>K</sub> 0	374			10/04/2022
		f 6 sets of barrier doors would	IK 0	<i>31</i> <b>T</b>	I. What corrective action	(s)	10/04/2022
		ent of smoke for at least 20			will be accomplished for those	` '	
		ion 19.3.7.8 requires that doors		residents found to have been			
		nall comply with LSC, Section			affected by the deficient practi	ce:	
		8.5.4.1 requires doors in smoke			No residents were	,	
		opening leaving only the			affected by this deficient pract	ice.	
		e necessary for proper operation					
	which is defined as	1/8 inch to restrict the			II. How other residents ha	ving	
	movement of smok	e. This deficient practice			the potential to be affected by	-	
	affects 32 residents	, as well as 4 staff and 2			same deficient practice will be		
	visitors.				identified and what corrective		
					action(s) will be taken;		
	Findings include:				32 residents had th	ne	
					potential to be affected by this		
		ons made during a tour of the			alleged deficient practice. All		
		enance Director and the			barrier doors were inspected to	0	
		raining on 08/23/22 from 12:45			ensure proper closure. The 3		
	_	e following was noted:			barrier doors listed on the 256		
		nearest to the Activities room			were the only doors not to clos	se	
		leaving a three-inch gap when			properly and were adjusted.		
	coming together to						
		nearest to the "Dogwood			III. What measures will be	put	
		ly close leaving a two-inch gap			into place and what systemic		
		her to the closed position.			changes will be made to ensu		
		nearest to Resident room #304			that the deficient practice does	s not	
	failed to fully close	leaving a three-inch gap when			recur;		

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155064	, ,	JILDING	onstruction 01	(X3) DATE COMPL <b>08/23</b> /	ETED
	PROVIDER OR SUPPLIER			3518 S	ADDRESS, CITY, STATE, ZIP COD LAFOUNTAIN ST MO, IN 46902		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
	the Maintenance Di aforementioned con work on the doors a so. During the exit of Regional Vice Presi Administrator-in-Tr Director at 3:50 p.m	ew at the time of observations, rector acknowledged the ditions stating that he would s soon as he had time to do conference with the facility			All barrier doors will be inspected monthly to ensure proper closure. The results of inspection will be documented the preventative maintenance  IV. How the corrective action(s) will be monitored to ensure the deficient practice wont recur i.e., what quality assurance program will be put place;  The administrator will audit the maintenance log mon to ensure doors are inspected functioning properly.  The results of these audits will reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achie x3 consecutive months. The Committee will identify any tre or patterns and make recommendations to revise the plan of correction as indicated	the on log.  vill into  hthly and libe change  ved QA nds	
K 0741 SS=E Bldg. 01	shall include not le provisions: (1) Smoking shall ward, or compartn liquids, combustib used or stored and location, and such signs that read NO						

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155064	B. W	NG _		08/23	/2022
				CTREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIEF	2			LAFOUNTAIN ST		
ADEDIO	N CARE KOKOMO						
AFERIO	N CARE KOKOWO			KOKOK	MO, IN 46902		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	smoking.						
	(2) In health care	occupancies where					
	smoking is prohib						
		d at all major entrances,					
	secondary signs with language that prohibits						
	smoking shall not						
	(3) Smoking by patients classified as not						
	responsible shall be prohibited.						
	(4) The requirement of 18.7.4(3) shall not apply where the patient is under direct						
	supervision.	ent is under direct					
	•	ncombustible material and					
	. ,						
	safe design shall be provided in all areas where smoking is permitted.						
		ers with self-closing cover					
	' '	n ashtrays can be emptied					
		railable to all areas where					
	smoking is permit						
	18.7.4, 19.7.4	ieu.					
		on and interview, the facility	$ _{K0}$	7.4.1			10/04/2022
		f 1 area where smoking was	KU	/41	I What corrective action	(a)	10/04/2022
		and residents was maintained in			I. What corrective action	` '	
	_				will be accomplished for those		
		.7.4. LSC 19.7.4 requires			residents found to have been		
	-	bustible material and safe			affected by the deficient practi	ce;	
		vided in all areas where			No residents were	4	
		ed. Metal containers with a			affected by this alleged deficie	ent	
	_	levices into which ashtrays			practice.		
	_	ll be readily available to all			l		
		g is permitted. This deficient			II. How other residents ha	-	
	_	et all smoking residents and			the potential to be affected by		
	staff as well as visit	tors in the facility.			same deficient practice will be		
					identified and what corrective		
	Findings include:				action(s) will be taken;		
					All residents that smok	-	
		ons made during a tour of the			have the potential to be affected		
		enance Director and the			by this alleged deficient praction		
		raining on 08/23/22 at 1:30 p.m.,			The smoker area was cleaned		
		lon plastic bucket half full of			and the non-approved contain	er	
	_	150 cigarette butts, and 8			was removed.		
	empty cardboard ci	garette containers sitting on					
	I		1				I

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	IT OF DEFICIENCIES OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155064	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 08/23/2022
	PROVIDER OR SUPPLIER	3	3518 \$	ADDRESS, CITY, STATE, ZIP COD S LAFOUNTAIN ST MO, IN 46902	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION designated smoking area. This	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	DATE
	container was not a with a self-closing interview at the tim Maintenance Direct approved container	designated smoking area. This in approved metal container device on it. Based on it is of observation, the stor agreed that this was not an and removed it from the area. It is removed prior to my exiting of		III. What measures will be into place and what systemic changes will be made to ensith the deficient practice do recur;  All staff and smoking residents will be inserviced or proper disposal of smoking material. The housekeeping department will audit the smoking material are a daily to ensure no unapproved containers are in and that smoking material are properly disposed of. The reswill be documented on the smoking area inspection audit was unable to ensure the deficient practice not recur i.e., what quality assurance program will be poplace;  The admin or designed will audit the smoking area inspection audit weekly to ensure the deficient practice not recur i.e., what quality assurance program will be poplace;  The admin or designed will audit the smoking area inspection audit weekly to ensure the deficient properly disposed of.  The results of these audits wereviewed in Quality Assurance Meeting monthly x6 months of the months of the properly disposed of	ure es not  on  oking on place e sults  lit  o will  ut into ee  nsure ly  vill be ce or ieved e QA eends he

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		JILDING	01	COMPLETED		
		155064	B. W	ING	_	08/23/2022		
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 3518 S LAFOUNTAIN ST KOKOMO, IN 46902				
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	BROWNERS N. AN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TC	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	.16	DATE	
K 0914	NFPA 101							
SS=F	Electrical Systems	s - Maintenance and						
Bldg. 01	Testing							
	Electrical Systems	s - Maintenance and						
	Testing							
	Hospital-grade rec	eptacles at patient bed						
	locations and whe	re deep sedation or general						
	anesthesia is administered, are tested after							
	initial installation, i	replacement or servicing.						
	Additional testing i	is performed at intervals						
	defined by documented performance data.							
	Receptacles not listed as hospital-grade at							
	these locations are tested at intervals not							
	exceeding 12 months. Line isolation monitors							
	(LIM), if installed, are tested at intervals of							
	less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which							
		ıal and audible alarm. For						
		utomated self-testing, this						
	-	formed at intervals less						
		2 months. LIM circuits are						
	tested per 6.3.3.3.2 after any repair or							
	renovation to the electric distribution system.							
		tained of required tests and						
	associated repairs							
		oom or area tested, and						
	results.							
	6.3.4 (NFPA 99)	1 . 1	17.0	014			10/04/2022	
		on, record review and	K 0	914	\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	(-)	10/04/2022	
		ty failed to ensure all			I. What corrective action	` '		
		lectrical receptacles at ons were tested at least			will be accomplished for those residents found to have been	:		
		Health Care Facilities Code on 6.3.4.1.3 states receptacles			affected by the deficient practi  No residents were	∪ <del>e</del> ,		
		l-grade, at patient bed			affected by this alleged deficie	nt		
		ations where deep sedation or			practice	ii IL		
		s administered, shall be tested			practice			
	at intervals not exce				II. How other residents ha	vina		
		on 6.3.3.2, Receptacle Testing			the potential to be affected by	_		
	-	ms requires the physical			same deficient practice will be			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 155064 B. WING 08/23/2022 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 3518 S LAFOUNTAIN ST APERION CARE KOKOMO **KOKOMO, IN 46902** (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE integrity of each receptacle shall be confirmed by identified and what corrective visual inspection. The continuity of the action(s) will be taken; grounding circuit in each electrical receptacle shall All residents have the be verified. Correct polarity of the hot and neutral potential to be affected by this connections in each electrical receptacle shall be alleged deficient practice. All confirmed; and retention force of the grounding outlets were tested as for polarity blade of each electrical receptacle (except and retention with all outlets locking-type receptacles) shall be not less than passing 115 gram (4 ounces). This deficient practice could affect all residents. What measures will be put into place and what systemic Findings include: changes will be made to ensure that the deficient practice does not Based on record review with Maintenance recur: Director and the Administrator-in-Training on The maintenance director 08/23/22 at 11:20 a.m., there was receptacle was inserviced on outlet testing. retention testing documentation to test the Semi-annual outlet testing for physical integrity, continuity, or polarity of the polarity and retention will be resident room receptacles available for review, but conducted every September and it was incomplete. Only roughly one-quarter of the March. rooms tested were complete with the rest of the document being left blank. Based on interview at How the corrective the time of records review, the Maintenance action(s) will be monitored to Director stated that he started the test, but must ensure the deficient practice will have overlooked completing it. not recur i.e., what quality assurance program will be put into 3.1-19(b) place: The admin will audit receptacle retention testing form every October and April to ensure completion. 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

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155064	(X2) MULTIPLE ( A. BUILDING B. WING	O1	(X3) DATE SURVEY COMPLETED 08/23/2022				
	PROVIDER OR SUPPLIER		3518	STREET ADDRESS, CITY, STATE, ZIP COD  3518 S LAFOUNTAIN ST  KOKOMO, IN 46902					
(X4) ID PREFIX TAG	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE				
				plan of correction as indicated	l.				
K 0920 SS=E Bldg. 01	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION  NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 Based on observation and interview, the facility failed to ensure 2 of 37 resident rooms did not use flexible cords as a substitute for fixed wiring. LSC 9.1.2 requires electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code. NFPA 70, 2011 Edition, Article 400.8 requires that, unless specifically permitted,		K 0920	I. What corrective action will be accomplished for those residents found to have been affected by the deficient pract. No residents were affected by this alleged deficient practice	ice;				
		wiring of a structure. This fects as many as 12 residents,		II. How other residents ha	aving				

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		X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	a. building <u>01</u>		01	COMPLETED		
		155064	B. WINC	j		08/23/	2022	
			<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF PROVIDER OR SUPPLIER					LAFOUNTAIN ST			
APERION CARE KOKOMO					MO, IN 46902			
			<u> </u>	IXOIXOIV				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PR	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	4 staff and 1 visitor	·.			the potential to be affected by			
					same deficient practice will be			
	Findings include:				identified and what corrective			
					action(s) will be taken;			
		ons made during a tour of the			12 residents have the			
	-	enance Director and the			potential to be affected by this			
		raining on 08/23/22 at 1:38 p.m.,			alleged deficient practice. The			
	^	strip in use and dangling from			power strip was immediately			
	_	le in the Harmony Hall nurses			removed.	ļ		
		n interview at the time of the						
	observation, the Ma				III. What measures will be	put		
		use of the power strip,			into place and what systemic			
	1 00	emoved it from the area. This			changes will be made to ensu			
	-	oved prior to exiting of the			that the deficient practice does	s not		
facility.				recur;				
				All staff were inservice				
	3.1-19(b)				on appropriate power strip usa	ige.		
					IV. How the corrective	ļ		
					action(s) will be monitored to			
					ensure the deficient practice v	√ill		
					not recur i.e., what quality			
					assurance program will be put	into		
					place;	ļ		
					The maintenance direc	ctor		
					or designee will round the buil	ding		
					monthly to ensure no imprope	•		
					power strips are used and will			
					document the results on the p			
					strip audit.	ļ		
					The results of these audits wil	be		
					reviewed in Quality Assurance	<del>)</del>		
					Meeting monthly x6 months or			
					until an average of 90%	ļ		
					compliance or greater is achie	ved		
					x3 consecutive months. The			
					Committee will identify any tre	nds		
					or patterns and make	ļ		
					recommendations to revise the	е		
				plan of correction as indicated				

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		IDENTIFICATION NUMBER  155064	 JILDING	01	COMPL 08/23	ETED		
	ROVIDER OR SUPPLIER	2	STREET ADDRESS, CITY, STATE, ZIP COD 3518 S LAFOUNTAIN ST KOKOMO, IN 46902					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE		
K 0923 SS=E Bldg. 01	Storage Greater than or ed Storage Greater than or ed Storage locations and ventilated in a and 5.1.3.3.3.  >300 but <3,000 d Storage locations enclosure or within space of non- or li construction, with that can be secure stored with flamma from combustibles sprinklered) or enconcombustible of minimum 1/2 hr. fit Less than or equal in a single smoke cylinders available patient care areas of less than or equivalent care areas of less than or equiv	are outdoors in an an enclosed interior mited- combustible door (or gates outdoors) ed. Oxidizing gases are not ables, and are separated by 20 feet (5 feet if closed in a cabinet of construction having a re protection rating.  I to 300 cubic feet compartment, individual efor immediate use in with an aggregate volume and to 300 cubic feet are not red in an enclosure.  I handled with precautions 6.2.  Ign readable from 5 feet is gate of a cylinder storage ign includes the wording as FION: OXIDIZING GAS(ES)						

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. B	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 08/23/2022		
NAME OF PROVIDER  APERION CARE			STREET ADDRESS, CITY, STATE, ZIP COD 3518 S LAFOUNTAIN ST KOKOMO, IN 46902				
(X4) ID PREFIX (EA		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	.TE	(X5) COMPLETION
		R LSC IDENTIFYING INFORMATION  Cylinders stored in the open		TAG	DEFICIENCY)		DATE
are pro 11.3.1,	tected fron	· ·					
99) Based of failed to gases so falling. Edition nonflar (300 cc (3000 of through cylinder 11.6.2 cylinder in a propractice vicinity. Finding Based of facility Admin a small upright station properly stand of observation acknown standing and was proper small of the state of th	on observation of the control of the	on and interview, the facility of 2 cylinders of nonflammable on were properly secured from Health Care Facilities Code, 2012 .3.2 states storage for segreater than 8.5 cubic meters call comply with 11.3.2.1 NFPA 99, Section 11.3.2.6 states or restraints shall comply with 1.6.2.3(11) states freestanding roperly chained or supported extand or cart. This deficient of 24 staff and visitors in the storage and transfilling room.  The storage and transfilling room.  The consumption of the demance Director and the raining on 08/23/22 at 1:36 p.m., and of the Harmony Hall nurses of the Harmony Hall nurses of the Harmony Hall nurses of the Harmony and was not resupported in a proper cylinder on interview at the time of the storage of the Med room by chained or supported in a and or cart. He then removed the der and returned it to the	KO	923	I. What corrective action will be accomplished for those residents found to have been affected by the deficient practice.  No residents were affected by this alleged deficient practice.  II. How other residents had the potential to be affected by same deficient practice will be identified and what corrective action(s) will be taken;  24 residnets have the potential to be affected by this alleged deficient practice. The oxygen tank was returned to the oxygen room  III. What measures will be into place and what systemic changes will be made to ensure that the deficient practice does recur;  The nursing staff were inserviced on proper oxygen storage and transfer. The maintenance director will mak weekly rounds to ensure oxygis properly stored and transfer and will document the results.	ent  aving the  he  put  re s not  e en rred on	10/04/2022
	ficiency was	ling room where it belonged. s removed prior to exiting of			IV. How the corrective action(s) will be monitored to	yy.	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155064	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 08/23/2022	
NAME OF PROVIDER OR SUPPLIER  APERION CARE KOKOMO			3518 S	ADDRESS, CITY, STATE, ZIP COD LAFOUNTAIN ST MO, IN 46902		
(X4) ID PREFIX TAG	4) ID SUMMARY STATEMENT OF DEFICIENCIE EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION MEACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)  ensure the deficient practice we not recur i.e., what quality assurance program will be put place;  The administrator or designee will audit the maintenance log monthly to ensure proper storage and trate of oxygen is occurring.  The results of these audits will reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achied x3 consecutive months. The Committee will identify any tree or patterns and make recommendations to revise the	vill nsfer I be eved QA ends	(X5) COMPLETION DATE
				plan of correction as indicated	_	

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